N311 Care Plan #4

Lakeview College of Nursing

Dakota Clayton

Demographics (5 points)

Date of Admission 8/11/2021	**Client Initials** B.B.	**Age** 83	**Gender** F
Race/Ethnicity White	**Occupation** Housewife	**Marital Status** Widowed	**Allergies** Aspirin – hives Penicillin - hives
Code Status Full code	**Height** 67 in.	**Weight** 57.8 Kg (127.4 lbs)	

Medical History (5 Points)

Past Medical History: Dementia (patient did not report date)

Gastroesophageal reflux disease (GERD) [patient did not report date]

Diabetes mellitus type 2 (patient did not report date)

Pneumonia (August 2021)

Past Surgical History: Patient did not state any surgical history.

Family History: Patient did not state any family history.

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

From patient's chart, the patient has a history of alcoholism. The patient did not state any past or current alcohol, tobacco, or other drug use.

Admission Assessment

Chief Complaint (2 points): Stomach cramping

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

Patient stated her stomach has been cramping from approximately 1 week. Patient states the pain is localized to the upper abdominal area. The cramping pain is dull and intermittent, with the pain being the worst at night. Patient states that eating "a lot of sugar" makes the pain worse, and going to the bathroom makes it better. The patient has not sought treatment for the stomach cramping before.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Dementia

Secondary Diagnosis (if applicable): GERD

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

Capriotti and Frizzell (2020) define dementia as, “the decline of reasoning, memory, judgement, and other cognitive functions” (p. 905). Emmady and Tadi (2022), further this definition, by including, “cognitive decline involving memory and at least 1 of the other domains, including personality, praxis, abstract thinking, language, executive functioning, complex attention, social skills, and visuospatial skills” (para. 3). Capriotti and Frizzel (2020) explain that dementia isn’t simply memory loss from old age – dementia is a serious illness that causes individuals to lose many cognitive abilities they’ve had their whole life. Approximately 4-5 million individuals in the United States live with dementia, a number that is expected to climb as the nation’s population continues to age (Capriotti & Frizzell, 2020). According to Emmady and Tadi (2022), individuals with dementia will spend approximately $200,000 more on care that an individual without dementia (para. 3). Overall, dementia is a burden to all who battle it, and is a significant cause of illness in the United States.

Capriotti and Frizzell (2020) explain that there are multiple diseases and conditions that cause dementia, with the major conditions including Alzheimer’s disease, vascular disease, and Lewy body dementia (LBD). While my patient did not have a specific diagnoses tied to her dementia, I will touch on the disease processes of these conditions briefly. Emmady and Tadi (2022) explain that Alzheimer’s disease (AD) is caused by, “the deposition of neurofibrillary tangles and senile plaques in the brain” (para. 5). These tangles and plagues in turn leads to the degeneration of neuron structures in the brain (Capriotti & Frizzell, 2020). AD is the most

common form of dementia, with approximately 70% of cases being due to AD (Emmady & Tadi, 2022, para. 4). According to Emmady and Tadi (2022), vascular dementia is the next common form, accounting for approx. 5-10% of dementia cases. According to Capriotti and Frizzell (2020), vascular dementia is an irreversible form, and is causes by an individual suffering multiple strokes. Lastly, Lewy body dementia also accounts for approx. 5-10% of dementia cases (Emmady & Tadi, 2022). Capriotti and Frizzell (2020) explain that Lewy body dementia is caused by "alpha-synuclein deposits in the brain," which disrupt neuron function (p. 906). All the listed forms of dementia affect the body's cognitive processes in some way, including but not limited to critical thinking, ability to perform activities of daily living, and performing personal care (Capriotti & Frizzell, 2020).

There are numerous signs and symptoms of dementia, ranging from early-dementia symptoms to late-dementia symptoms. Capriotti and Frizzell (2020) describe early symptoms of dementia as "subtle," and include amnesia, disorientation, and poor judgement (p. 906). As the dementia develops further, new symptoms may include anomia, or the forgetting of names of things and people, as well as apraxia, or difficulty performing familiar tasks, and agnosia, or forgetting the purpose of familiar items (Capriotti & Frizzell, 2020, p. 906). Capriotti and Frizzell (2020) describe symptoms of severe dementia as problems with language, the loss of desire to perform activities, and sundowning, which is the individual exhibiting disorientation and mood swings late in the day (p. 906).

There are a variety of factors and tests that go into a dementia diagnosis. Capriotti and Frizzell (2020) explain that a full history and physical examination need to be completed, as well as a complete blood count and other blood and organ function tests. Additionally, magnetic resonance imaging (MRI) and/or computerized tomography (CT) tests can provide evidence for a

dementia diagnosis in the form of changes to brain structure (Capriotti & Frizzell, 2020). My patient did have a routine blood test done, as well as a complete physical examination and health history taken. Additionally, my patient had a cerebral MRI completed to contribute to her dementia diagnosis.

After a dementia diagnosis has been confirmed, there are a variety of different treatment methods available. Capriotti and Frizzell (2020) explain both pharmacological and nonpharmacological treatments can be used. Pharmacologically, cholinesterase inhibitors is one medication that is used, and helps slow the progression of dementia (Capriotti & Frizzell, 2020). Capriotti and Frizzell (2020) describe nonpharmacological approaches including reality orientation, validation therapy, physical activity, and nutrition. My patient was not prescribed any medications specific to her dementia diagnosis, but she is continuously encouraged to participate in facility activities and her food intake is monitored.

Pathophysiology References (2) (APA):

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

Emmady, P.D., & Tadi, P. (2022). *Dementia*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK557444/

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	4.0 – 4.9 $x10^6$/ mcL (Females)	N/A	4.57 $x10^6$ /mcL	
Hgb	12 -16 g/dL (F)	N/A	13.4 g/dL	
Hct	37 – 48%	N/A	39.5%	
Platelets	150 - 400 K/ mcL	N/A	237 K/mcL	
WBC	4 – 10 KmcL	N/A	6.8 KmcL	
Neutrophils	40 – 80%	N/A	48.9%	
Lymphocytes	20 – 40%	N/A	37.8%	
Monocytes	2 – 10%	N/A	8%	
Eosinophils	1 – 7%	N/A	4.5%	
Bands	0 -10%	N/A	N/A	*Band assessment was not completed

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	135 mmol/L	
K+	3.5 – 5.2 mmol/L	N/A	4.1 mmol/L	
Cl-	95 – 105 mmol/L	N/A	101 mmol/L	
CO2	21-31 mmol/L	N/A	29 mmol/L	
Glucose	117-137 mg/dL	N/A	143 mg/dL	While the patient did not specifically discuss her diabetes, she is on an unrestricted diet, and using

				multiple sugar packets in her food and drink. The patient does not comprehend how to correctly manage her diabetes mellitus, causing her diabetes to be uncontrolled and causing the high blood glucose level. Van Leeuwen and Bladh (2021) explain that elevated blood glucose levels are the gold standard for diagnosing diabetes mellitus.
BUN	8 – 25 mg/dL	N/A	7 mg/dL	Van Leeuwen and Bladh (2021) explain that damage to the liver can cause decreased BUN levels, as BUN is synthesized in the liver (p. 1212). My patient had a health history of alcoholism, and while she has ceased use, the long-term effects of alcohol use are still effecting her liver function.
Creatinine	0.6 – 1.3 mg/dL	N/A	0.69 mg/dL	
Albumin	3.4 – 5.0 g/dL	N/A	3.7 g/dL	
Calcium	8.7 – 10 mg/ dL	N/A	8.5 mg/dL	Capriotti and Frizzell (2020) describe alcohol abuse as the main cause of liver cirrhosis (p. 700). With her diagnosis of previous alcoholism, the patient's liver is damaged, and is unable to adequately metabolize calcium (Van Leeuwen & Bladh, 2021, p. 264).
Mag	1.5 – 2.5 mg/dL	N/A	N/A	*Magnesium assessment was not completed
Phosphate	2.5 – 4.5 mg/dL	N/A	N/A	*Phosphate assessment was not completed
Bilirubin	0.3 – 1.0 mg/dL	N/A	0.6 mg/dL	
Alk Phos	35 – 150 units/mL	N/A	53 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	Yellow and cloudy	According to the Cleveland Clinic (2021), diabetes mellitus is a common cause of cloudy urine. With the other diabetes-related urine findings with this patient, the cloudiness is also diabetes-related.
pH	4.5- 7.8	N/A	6.0	
Specific Gravity	1.005 – 1.03	N/A	1.013	
Glucose	Negative	N/A	200	According to Van Leeuwen and Bladh (2021), increased glucose levels in the urine are indicative of a diabetes mellitus diagnosis, which my patient has. The elevated glucose levels in the urine are indicative that my patient does not control her diabetes mellitus.
Protein	Negative	N/A	Negative	
Ketones	Negative	N/A	1+	Due to the patient's uncontrolled diabetes mellitus, her blood glucose is continuously elevated, also known as hyperglycemia. Van Leeuwen and Bladh (2021) explain that hyperglycemia is one of the main causes for increased ketones in the urine.
WBC	< 5	N/A	2	
RBC	< 5	N/A	2	
Leukoesterase	Negative	N/A	Negative	

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

Lab Correlations Reference (1) (APA):

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

Cleveland Clinic. (2021, September 28). *Cloudy urine*. Cleveland Clinic. https://my.clevelandclinic.org/health/symptoms/21894-cloudy-urine

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

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):

In July 2021, my patient had cerebral magnetic resonance imaging (MRI) completed. The purpose of this MRI was to contribute to my patient's dementia diagnosis. According to Harper et al. (2017), MRIs and other imaging are commonly used to support dementia diagnoses. Harper et al. (2017) also explains that these imaging tests are used to identify brain atrophy, which can help further predict and diagnose dementia. The impression provided from my patient's MRI in July 2021 was significant brain atrophy, which helps support her diagnosis of dementia, and provides rationale for why the MRI was completed.

Diagnostic Imaging Reference (1) (APA):

Harper, L., Bouwman, F., Burton, E.J., Barkhof, F., Scheltens, P., O'Brien, J.T., Fox, N.C., Ridgway, G.R., & Schott, J.M. (2017). Patterns of atrophy in pathologically confirmed dementias: A Voxelwise analysis. *Journal of Neurology, Neurosurgery & Psychiatry, 88,* 908-916. doi: 10.1136/jnnp-2016-314978

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

Medications (5 required)

Brand/ Generic	Riomet/ Metformin	Dulcolax/ Bisacodyl	Mylanta/ Magnesium hydroxide/ Aluminum hydroxide	Novolog/ Insulin aspart	Tylenol/ Acetaminophen
Dose	500 mg	10 mg	30 mL	Sliding scale (1-5 units)	500 mg
Frequency	BID	PRN	PRN every 4 hours	Daily	PRN every 6 hours
Route	PO	Rectal	PO	Sub-cut	PO
Classification	T: Antidiabetic P: Biguanides (Vallerand & Sanoski, 2023).	T: Laxatives P: Stimulant laxatives (Vallerand & Sanoski, 2023).	T: Antiulcer agent P: Antacid (Vallerand & Sanoski, 2023).	T: Antidiabetic P: Pancreatic (Vallerand & Sanoski, 2023).	T: Antipyretic P: None listed (Vallerand & Sanoski, 2023).
Mechanism of Action	Medication is used to increase sensitivity to insulin, decrease glucose production, and decrease glucose absorption (Vallerand & Sanoski, 2023).	Medication opposes constipation by stimulating peristalsis and increasing fluid volume in the GI system. (Vallerand & Sanoski, 2023).	"Medication neutralizes gastric acid following dissolution in gastric contents" (Vallerand & Sanoski, 2023, p. 825).	"Medication lowers blood glucose by stimulating glucose uptake in skeletal muscle and fat and inhibiting hepatic glucose production" (Vallerand & Sanoski, 2023, p. 721).	Medication opposes the production of prostaglandins, which may cause subsequent fever initiation (Vallerand & Sanoski, 2023).
Reason Client Taking	Diabetes mellitus management	Constipation management	GERD management	Blood glucose management	Pain management
Contraindications (2)	1. History of liver disease, alcoholism, heart failure 2. Renal	1. Abdominal pain 2. Nausea and vomiting (Vallerand &	1. Abdominal pain with unknown cause 2. Renal	1. Hypoglycemia 2. Stress and infection	1. Hepatic impairments 2. Chronic alcohol abuse (Vallerand &

	impairment (Vallerand & Sanoski, 2023).	Sanoski, 2023).	failure (Vallerand & Sanoski, 2023).	(Vallerand & Sanoski, 2023).	Sanoski, 2023).
Side Effects/ Adverse Reactions (2)	1. Abdominal bloating 2. Diarrhea (Vallerand & Sanoski, 2023).	1. Abdominal cramps 2. Hypokalemia (Vallerand & Sanoski, 2023).	1. Diarrhea 2. Hypermagnesemia (Vallerand & Sanoski, 2023).	1. Hypokalemia 2. Pruritus (Vallerand & Sanoski, 2023).	1. Hepatotoxicity 2. Pancytopenia (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:**	Patient was A and O x2, and was alert to person and place. Patient was lying comfortably, well-groomed, and in no acute distress. Patient was extremely hard of hearing and her hearing aids were not charging properly, so the assessment was completed using written questions, which the patient was open to.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 20** **Drains present: Y☐ N ☒** **Type:**	Skin color was white and appropriate for ethnicity. Skin was warm and dry upon palpation. Skin turgor displayed slight tenting, and returned to place in < 4 seconds. Expected hair quantity, distribution, and texture. No rashes, bruising, wounds, or drains noted. Edema was palpated in the lower extremities, with 2+ pitting edema in the lower right extremity, and 1+ pitting edema in the lower left extremity. Capillary refill was < 3 seconds in fingers bilaterally. No clubbing or cyanosis noted in fingers bilaterally. Patient's Braden score was 20, which indicates very low risk for the development of pressure ulcers.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck symmetrical, trachea midline without deviation. Lymph nodes of head and neck nonpalpable throughout. Auricles symmetrical with no palpated or inspected lumps, lesions, or deformities bilaterally. No noted drainage from ears bilaterally. Patient's sclera white bilaterally, conjunctiva pink and moist bilaterally. Eye lids pink and moist bilaterally with no noted lesions or drainage. Patient stated weakness in left eye, but no changes, deformities, or drainage was assessed. PERRLA bilaterally. EOMs intact bilaterally. Nose symmetrical with septum midline. No noted drainage or bleeding from nose. Posterior pharynx and tonsils pink and moist with no noted exudate or lesions. Tonsils 1+. Uvula midline. Soft palate rises and falls symmetrically. Hard palate intact. Dentition absent, and patient states she is supposed to see the dentist about dentures soon. Overall oral mucosa pink and moist with no noted lesions or exudate.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):**	S1 and S2 heart sounds present with no murmurs, gallops, or rubs. Normal cardiac rate and rhythm. Radial, ulnar, and brachial pulses palpated and 2+. Capillary refill was < 3 seconds

Peripheral Pulses: **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema: Lower extremities**	in fingers bilaterally. No neck vein distention noted. Edema was palpated in the lower extremities, with 2+ pitting edema in the lower right extremity, and 1+ pitting edema in the lower left extremity.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations symmetrical with expected respiratory rate, depth, and rhythm. Breath sounds clear throughout anterior/posterior bilaterally. Right lobe auscultated. No adventitious breath sounds noted, no accessory muscle use noted. No cough or other respiratory signs or 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's diet at home is regular and unrestricted, with her current diet being mechanical soft in texture due to her loss of dentition. Patient's height is 67 in and weight is 57.8 Kg. Bowel sounds were auscultated in all four quadrants and active at a rate of 5-34 a minute. Patient reported her last bowel movement was "last night" on 10/19/22. Abdomen soft and nontender upon palpation, with no noted masses in all four quadrants. No noted distention, incisions, scars, drains, or wounds. Patient does not have an ostomy, nasogastric tube, or feeding tube.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine color, character, and quantity was not assessed. Patient did not report any pain with urination, and is not on dialysis. Inspection of patient's genitalia was not completed. Patient does not use a catheter. Patient voided once.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:**	Patient's neurovascular status is intact. Patient displays full active range of motion. Equal finger strength (4/5) and equal leg strength (5/5) noted.

Supportive devices: **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 40** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☐**	Patient uses a walker as an assistive device when ambulating and performing activities, and patient does require some assistance performing ADLs. Patient's fall score is a 40 on the Morse fall scale, indicating low risk for falls.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient moves all extremities well, with equal strength bilaterally throughout. PERRLA present bilaterally. Patient is A and O x2, and is alert to person and place. Patient's mental status is altered, likely due to her dementia diagnosis. Patient's speech is not limited. Patient has severe hearing impairment, and has hearing aids to use when functional. Patient's level of consciousness is alert.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient's coping mechanisms are relaxing in her room, and patient states she "wishes she had a phone" to communicate with other outside the facility. Patient's developmental level is low for her age, and she does not hold a high school diploma after leaving school in the 7th grade. Patient did not report religious affiliation. Patient states her brother Frank visits occasionally.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0940	96	126/74	12	37.1 C	96%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0945	0-10	N/A	0	N/A	N/A

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
100% of lunch 240 mL water 480 mL decaffeinated coffee	1 BM HS 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 injury related to alteration in cognitive functioning as evidenced by altered mental status, decreased	This nursing diagnosis was given due to the patient's severe hearing loss, altered mental status, and use of	1. Help the patient identify environmental barriers that can cause injuries, and help the patient understand the	1. Patient will remain free of physical injury, and is able to identify environmental barriers that are of potential injury to	The patient was somewhat confused with this nursing intervention, but after some further communication understood why

developmental status, and decreased knowledge of precautions.	supportive devices puts her at a much higher risk for falls, especially on an assisted living floor with less supervision.	dangers these barriers can pose to them. 2. Continuously monitor patient for developing sensory, cognitive, and/ or motor deficits, document these deficits, and identify new safety needs of patient.	the patient. The patient will also be able to effectively remove these barriers, or alter them to where they are no longer a potential danger.	action was being taken. The patient is in good health, and does not want to be injured from a preventable fall or other injury.
2. Impaired verbal communication related to an alteration in perception as evidenced by severely impaired hearing, difficulty comprehending communication, and disorientation to time.	This nursing diagnosis was given due to the interactions the student nurse and patient had during the assessment. The student nurse had difficulty communicating effectively with the patient, and noted the need for intervention.	1. Obtain communication aids for patient and caregiver use, such as dry-erase board, pen, paper, etc., and have these aids readily available in patient's room. 2. Continue to orient patient to reality – call patient by name, give patient information on the facility, use calendars, etc.	1. Patient and caregivers are able to use communication aids effectively. Subsequently, communication between staff and patient will improve and will be evidenced by the patient being more open to interaction, and less frustrated with the heard-language barrier.	The patient was open and happy that this nursing intervention was being implemented. While the patient wants to communicate, her severe hearing impairment makes this difficult for herself and other staff. This intervention will provide the necessary means for effective communication in the future.

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

Pain 0/10
Sugar is upsetting stomach
Seeks to visit with dentist for dentures
Seeks to have phone in room

Nursing Diagnosis/Outcomes

Risk for injury related to alteration in cognitive functioning as evidenced by altered mental status, decreased developmental status, and decreased knowledge of precautions.
Patient will remain free of physical injury, and is able to identify environmental barriers that are of potential injury to the patient. The patient will also be able to effectively remove these barriers, or alter them to where they are no longer a potential danger.
Impaired verbal communication related to an alteration in perception as evidenced by severely impaired hearing, difficulty comprehending communication, and disorientation to time.
Patient and caregivers are able to use communication aids effectively. Subsequently, communication between staff and patient will improve and will be evidenced by the patient being more open to interaction, and less frustrated with the heard-language barrier.

Objective Data

High blood glucose (143 mg/dL)
Elevated urine glucose (200)
Elevated urine ketones (1+)
Decreased calcium (8.5 mg/dL)
Decreased BUN (7 mg/dL)
MRI suggesting cerebral atrophy
Pitting edema in lower extremities
VS: P: 96 B/P: 126/74 R: 12 Temp: 37.1 C
O2: 96%

Client Information

83 year old, hard of hearing client with symptoms of dementia.
Patient complains of stomach pain causing multiple trips to the bathroom.

Nursing Interventions

Help the patient identify environmental barriers that can cause injuries, and help the patient understand the dangers these barriers can pose to them.
Continuously monitor patient for developing sensory, cognitive, and/or motor deficits, document these deficits, and identify new safety needs of patient.
Obtain communication aids for patient and caregiver use, such as dry-erase board, pen, paper, etc., and have these aids readily available in patient's room.
Continue to orient patient to reality – call patient by name, give patient information on the facility, use calendars, etc.