N321 Care Plan 1

Roxanne Balag

Lakeview College of Nursing

N31 Adult Health 1

Professor Kristal Henry

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Demographics (3 points)

Date of Admission 1/19/23	**Client Initials** EB	**Age** 71	**Gender** F
Race/Ethnicity African American, non-Hispanic	**Occupation** Retired	**Marital Status** Widowed	**Allergies** No Known Allergies
Code Status Full	**Height** 170.2 cm	**Weight** 112.6 kg	

Medical History (5 Points)

Past Medical History: COPD, Asthma, Hypertension, CKD stage III, Systolic murmur, Acute chronic renal failure, Arthritis, Encephalopathy, Hyperlipidemia, elevated Troponin, confusion

Past Surgical History: C-Section

Family History: Hypertension- Mother, Father, Self, Sister. Schizophrenia- Sister. Asthma- Self and Sister. Breast Cancer- Daughter.

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

Assistive Devices: Bed rails, Reacher/grabber tool

Living Situation: Living Alone

Education Level: Some College

Admission Assessment

Chief Complaint (2 points): Generalized Weakness

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

The client came in on January 19th for general weakness, altered mental status, and poor appetite. Per client's son, the client is lethargic and tired for the past week from admission. The client takes Norco at home. Denies short of breath, fever, headaches, and chest pain. Upon physical assessment, client and daughter is unable to answer the history of the present illness.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Right Lower lobe Pneumonia

Secondary Diagnosis (if applicable): N/A

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

According to Capriotti, author of the book *Pathophysiology Introductory Concepts and Clinical Perspectives*, Pneumonia is most commonly caused by inhaling droplets that contain bacteria or other pathogens. The droplets enter the upper airways and then enter the lung tissue. Pathogens then stick to the respiratory epithelium, and an inflammatory reaction is stimulated. The acute inflammation spreads to the lower respiratory tract and alveoli. Vasodilation occurs at the sites of inflammation, and neutrophils travel out of capillaries into the air spaces. The neutrophils phagocytize microbes and kill them using reactive oxygen species, antimicrobial proteins, and degradative enzymes. Mucus is excreted after the release of excessive stimulation of respiratory goblet cells. Mucous and exudative edema accumulates between the alveoli and capillaries. The alveoli attempt to open and close against the purulent exudate, but not all can open. Lung Crackles sounds are heard with the stethoscope over the alveoli opening from fluid exudate. Infectious exudate and a layer of edema at the capillary and alveoli can cause impaired gas exchange. The patient can become hypercapnic and experience hypoxia with an obstructed exchange of CO2 and O2 at the pulmonary capillaries.

According to an article from *Drugs.com*, in Lobar Pneumonia, there is a consolidation of part of lobe or the entire lobe. In the first stage of Lobar pneumonia, congestion of the lungs starts. On a microscopic level, there is vascular engorgement. Inflammation and congestion begin in this stage which leads to fluid exudate and neutrophil leak from congested capillaries into the

alveolar spaces. The lungs will then become dry, airless, and liver-like consistency which is a result of edema in the alveoli that makes the lungs softer in texture; hence the stage is called Stage of Red Hepatization. There is now a massive exudation of RBCs, neutrophils, and fibrin in the alveolar space. The next stage is Grey Hepatization which the lobes become brown grey in color and still have liver consistency. In this stage, RBCs disintegrate, and traces of neutrophil and fibrin persist which is called Fibrino-suppurative exudate. Lastly, the last stage of Lobar Pneumonia is the Stage of Resolution. In this stage, edema resolves, the lungs become aerated, and the texture of the lungs becomes normal. On the microscopic level, there is degenerated granular and semi-fluid debris that are expectorated through sputum, and few macrophages in the alveoli that clear up the waste by phagocytosis.

Pathophysiology References (2) (APA):

Anderson, L. A. (2021, June 12). *What are the 4 stages of pneumonia?* Drugs.com. Retrieved February 3, 2023, from https://www.drugs.com/medical-answers/4-stages-pneumonia-3558984/.

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives* (2nd ed.). F. A. Davis Company.

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 (1/19)	Today's Value (1/27)	Reason for Abnormal Value
RBC	3.80-5.30	4.31	3.69	Reasons for decrease in RBC counts are bleeding or hemorrhage, anemia and chronic illness. (Pagana et al., 2020). The patient has likely to have an anemia
Hgb	12.0-15.8	10.2	8.7	Reasons for decrease in Hgb are anemia, recent hemorrhage, fluid retention, chronic illness, renal failure (Brassard, 2023). The patient is likely to have anemia.
Hct	36.0-47.0	32.4	27.3	Low Hematocrit can be a result of anemia, hemorrhage, pregnancy, chronic disease, renal disease (Brassard, 2023). The cause of low Hct on the patient is likely because of anemia.
Platelets	140-440	117	121	Low Platelet count can be a result of transfusion reactions, sepsis, decreased production from bone marrow, overactive spleen (Brassard, 2023). The patient is likely to have decreased production of platelets.
WBC	4.00-12.00	4.10	5.40	N/A
Neutrophils	47.0-73.0	61.5	N/A	N/A
Lymphocytes	18.0-42.0	33.6	N/A	N/A
Monocytes	4.0-12.0	3.4	N/A	Low Monocytes level can be from chemotherapy, bone marrow suppression, and immunosuppression (Brassard, 2023). The patient is likely having immunosuppression.
Eosinophils	0.0-5.0	0.6	N/A	N/A
Bands	0-500	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 (1/19)	Today's Value (1/27)	Reason For Abnormal
Na-	136-145	137	137	N/A
K+	3.5-5.1	3.2	3.2	Low Potassium level can be a result

				from excess insulin, diarrhea, vomiting, NG suction (Brassard, 2023).
Cl-	98-107	99	106	N/A
CO2	22-30	26	24	N/A
Glucose	70-99	107	110	Factors that may cause increase of glucose in blood are DM, stress, pancreatitis, chronic renal failure, Corticosteroid therapy (Brassard, 2023). The patient has likely had a meal that is high in sugar to have caused the increase of glucose in blood.
BUN	10-20	47	9	An increase renal failure, CHF, MI, Kidney disease, shock, dehydration, excessive protein intake, DM, GI bleed, urinary tract obstruction while a decrease in BUN level may be a result from liver failure, over-hydration, inadequate protein intake, and pregnancy (Brassard, 2023). The reason why patient's BUN level is high is likely because of malnutrition and dehydration and patient's low level of BUN is likely because of low protein intake.
Creatinine	0.60-1.00	2.18	0.90	An increase in creatinine level is a result from levels of creatinine indicate impaired kidney function, renal disease, CHF, dehydration, shock, and hyperparathyroidism (Brassard, 2023). The reason why the patient level is high is likely because of renal failure.
Albumin	3.5-5.0	3.1	3.1	Low Albumin level can be a result from liver and kidney diseases, Crohn's disease, low protein diet, celiac disease (Brassard, 2023). The patient is likely to have low protein diet that led to low level of albumin.
Calcium	8.7-10.5	10.5	9.2	N/A

Mag	1.6-2.6	2.2	N/A	N/A
Phosphate	40-150	48	N/A	N/A
Bilirubin	5-34	0.5	N/A	A low level of Bilirubin indicates a poor liver function by taking NSAIDS, barbiturates, penicillin, and caffeine (Pagana et. al., 2020). The reason why the level is low is likely because of NSAID intake.
Alk Phos	0-55	48	N/A	N/A
AST	5-34	14	14	N/A
ALT	0-55	7	7	N/A
Amylase	60-120	46	N/A	N/A
Lipase	0-160	38.2	N/A	N/A
Lactic Acid	Venous blood: 5–20 mg/dL Arterial blood: 3–7 mg/dL o	1.4	N/A	Measurement of Lactic acid is to identify tissue hypoxemia (Brassard, 2023). The reason why the patient's abnormal level is likely because of renal failure.

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.8-1.1	1.1	N/A	N/A
PT	10.1-13.1	12.2	N/A	N/A
PTT	25-36	24	N/A	N/A
D-Dimer	<0.4	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A

HDL	>40	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	4.0-6.0	N/A	N/A	N/A
TSH	0.300-5.000	N/A	2.612 on 1/21	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	Clear/Yellow	Clear/ Yellow	Clear/ Yellow	N/A
pH	5.0-9.0	5.0	N/A	N/A
Specific Gravity	1.003-1.030	1.021	N/A	N/A
Glucose	Negative	Negative	N/A	N/A
Protein	Negative	Trace	N/A	A trace of protein in the urine can be a result from DM, glomerulonephritis, amyloidosis, and multiple myeloma (Pagana et. al., 2020)
Ketones	Negative	Trace	N/A	A trace of ketones in the urine can be a result form DM and hyperglycemia, and fatty acid catabolism (Pagana et. al., 2020).
WBC	0-5 hpF	0-5	N/A	N/A
RBC	0-2 hpF	Negative	N/A	N/A
Leukoesterase	Negative	N/A	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	1-10,000 CFU/mL Acceptable up to 100,000 CFU/mL	N/A	N/A	N/A
Blood Culture	Negative	Negative	N/A	No growth within 5 days
Sputum Culture	Normal URT	N/A	N/A	N/A
Stool Culture	Normal Intestinal Flora	N/A	Positive on 1/23	Positive stool culture can be a result from GI tumor, GI trauma, peptic diseases, Inflammatory bowel disease, and hemorrhoids and other anorectal problems (Pagana et. al., 2020).

Lab Correlations Reference (1) (APA):

Brassard, G. (2023, January). Lab Analysis/Diagnostics. In PowerPoint. Retrieved February 1, 2023.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's® Diagnostic and Laboratory Test Reference*. (15th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

EKG 12 Lead Impression are sinus rhythm with premature Atrial complexes with aberrant conduction and possible Left atrial enlargement.

CT Heart OR Brain WO Contract Impression is there is no detected evidence of acute intracranial pathology, and the Finding is no relevant prior studies available.

CT Abdomen and Pelvis with Contrast Findings are the following: Unremarkable lung bases, no hepatomegaly in the liver, normal bile ducts, spleen and adrenals, there is good excretion of contrast in kidneys-no renal calculi and no obstructive uropathy, contrast in small bowel and no obstruction, and no ascites or free air and fluid collection in the peritoneum, normal retroperitoneum and abdominal wall, degenerative changes in lumbar Spine. Impression: Contrast in the stomach with some prominence of mucosal folds. Filling defect in the posterior dependent portion of the stomach may be retained food materials. No small or large bowel obstruction. Diverticulitis of sigmoid colon. No CT evidence for acute diverticulitis. No free fluid in the pelvis. Uterus is unremarkable size. No adnexal mass. No free fluid in the pelvis. Simple cysts in both kidneys. No renal calculi or obstructive uropathy. Degenerative change of the lumbar spine with narrowing of the disc space of L4-5, L5-S1 with vacuum pneumonia. No other significant findings.

XR Chest Single View Portable Findings are grossly clear lungs, no infiltrate seen, and heart is grossly normal size. Impression: no acute disease.

Diagnostic Test Correlation (5 points):

Indication for EKG 12 Lead is to detect cardiac problems though measuring the electrical activity of the heart. Indication for CT is patient is having visual hallucination.

Indication for Chest X-ray is to detect Emphysema, Pneumonia and Pneumothorax.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's® Diagnostic and Laboratory Test Reference*. (15th ed.). Mosby.

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

Home Medications (5 required)

Brand/ Generic	**Montelukast**	**Tizanidine (Zanaflex)**	**Carvedilol**	**Lovastatin**	**Lisinopril**
Dose	10 mg	4 mg	12.5 mg	40 mg	20-25 mg
Frequency	QD	Every 12 hour	QHS	Q HS	QD
Route	PO	PO	PO	PO	PO
Classification	Leukotriene receptor inhibitor/Anti asthmatic	$Alpha_2$-adrenergic agonist/antispastic	Beta-adrenergic blocker/Antihypertensive	HMG-CoA reductase inhibitor/ Antihyperlipidemic	ACE Inhibitor/Antihypertensive
Mechanism of Action	Binds to cysteinyl leukotriene receptors, inhibiting effects of leukotrienes on bronchial smooth muscle. Decreases bronchoconstriction, vascular permeability, mucosal edema, mucus production (Hodgson & Kizior, 2019).	Increases presynaptic inhibition of spinal motor neurons mediated by alpha2 -adrenergic agonists, reducing facilitation to postsynaptic motor neurons (Hodgson & Kizior, 2019).	Reduces cardiac output, exercise-induced tachycardia, reflex orthostatic tachycardia; reduces peripheral vascular resistance (Hodgson & Kizior, 2019).	Inhibits HMG-CoA reductase, the enzyme that catalyzes the early step in cholesterol synthesis. Decreases LDL, VLDL, triglycerides; increases HDL (Hodgson & Kizior, 2019).	Competitive inhibitor of angiotensin-converting enzyme (ACE). Decreases plasma angiotensin II, increases plasma renin activity, decreases aldosterone secretion. Reduces blood pressure (Hodgson & Kizior, 2019).
Reason Client Taking	Treatment for Asthma prevention	Treatment for Muscle Spasticity	Treatment for Hypertension	Prevention of hyperlipidemia	Treatment for Hypertension
Contraindications (2)	1. Systemic corticosteroid treatment reduction during montelukast	1. Patients with renal and hepatic disease. 2. Use of fluvoxaMIN	1. Contraindicated in patients with severe hepatic impairment. 2. Bronchial asthma or related	1. Active hepatic disease. 2. Pregnant and breastfeeding	1. History of angioedema. 2. Concomitant use of potassium supplements (Hodgson & Kizior,

	therapy 2. Not for use in acute asthma attacks (Hodgson & Kizior, 2019).	E and ciprofloxacin (Hodgson & Kizior, 2019).	bronchospastic conditions (Hodgson & Kizior, 2019).	women (Hodgson & Kizior, 2019).	2019).
Side Effects/Adverse Reactions (2)	1. Headache 2. Suicidal ideation and behavior, depression have been noted (Hodgson & Kizior, 2019).	1. Hypotension 2. Asthenia (Hodgson & Kizior, 2019).	1. Hypotension and Bradycardia if overdosed. 2. May mask symptoms of hypoglycemia (Hodgson & Kizior, 2019).	1. Potential for cataract development. 2. Occasionally produces myopathy manifested as muscle pain, tenderness, weakness with elevated creatine kinase (CK) (Hodgson & Kizior, 2019).	1. Postural hypotension. 2. Headache and dizziness (Hodgson & Kizior, 2019).
Nursing Considerations (2)	1. Take as prescribed, even without signs and symptoms as well as during exacerbations of asthma. 2. Monitor behavior, change in mood, depression and suicidal ideation (Hodgson & Kizior, 2019).	1. Depression with concurrent use of CNS depressants 2. Avoid sudden changes in posture (Hodgson & Kizior, 2019).	**1.** Monitor pulse rate and blood pressure before taking medication. **2.** Take with food (Hodgson & Kizior, 2019).	1. Avoid alcohol and grapefruit juice. 2. For women, question pregnancy possibility (Hodgson & Kizior, 2019).	1. To reduce hypotensive effect, slowly move from lying to standing and vice versa. 2. If for excessive hypotension occur, place client in supine position with feet elevated (Hodgson & Kizior, 2019).

Hospital Brand/ Generic	**Hydrochloro-thiazide**	**Amlodipine/ Norvasc**	**Metoclo pramide**	**Sucralfate**	**Pravas tatin**
Dose	12.5 mg	10 mg	5 mg	1 g	40 mg
Frequency	QD	QD	Every 6 hours	QID	Q HS
Route	PO	PO	IV	PO	PO
Classificatio n	Sulfonamide derivative/Thi azide diuretic, antihypertensi ve	Calcium Channel Blockers/Antihype rtensive, antianginal	DOPamine receptor antagonist/GI emptying adjunct, peristalsis stimulant, antiemetic	Gastrointest inal agent/Antiu lcer	Hydrox ymethy lglutary l CoA (HMG-CoA) reducta se inhibito r/Anti-hyperli pidemi c
Mechanism of Action	Inhibits sodium reabsorption in distal renal tubules, causing excretion of water, potassium, sodium, and hydrogen ions. Promotes diuresis; reduces blood pressure (Hodgson & Kizior, 2019).	Inhibits calcium movement across cardiac and vascular smooth muscle cell membranes. Dilates coronary arteries, peripheral arterioles/arteries. Decreases total peripheral vascular resistance and blood pressure by vasodilation (Hodgson & Kizior, 2019).	Stimulates motility of upper GI tract. Blocks dopamine/ser otonin receptors in chemorecepto r trigger zone. Enhances acetylcholine response in upper GI tract; increases lower esophageal sphincter tone (Hodgson & Kizior, 2019).	Forms ulcer-adherent complex with proteinaceo us exudate at ulcer site. Forms viscous, adhesive barrier on surface of intact mucosa of stomach, duodenum. Protects damaged mucosa from further destruction by absorbing gastric acid, pepsin, bile salts (Hodgson & Kizior, 2019).	Interfer es with cholest erol biosynt hesis by prevent ing convers ion of HMG-CoA reducta se to mevalo nate, a precurs or to cholest erol. Lowers LDL, VLDL cholest erol, plasma triglyce rides; increas es HDL (Hodgs on & Kizior,

Medications Reference (1) (APA):

Hodgson, B., & Kizior, R. (2019). *Saunders Nursing Drug Handbook 2019* (1st ed.). Elsevier.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Patient is Alert and Oriented x 2. Person and Place No acute distress Well-groomed
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Dark Brown Dry Warm Normal Mobility No R upper extremity, L forearm L Brachium from IV tape 18 N/A
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Symmetrical No visible trauma or deformities Sclera-white. No lesion, discharge, or drainage. No visible bleeding. Septum is midline. No teeth, no available denture at the moment
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. No gallops, murmur or rubs. 2+ throughout bilaterally Less than 3 seconds 1+ on lower extremities and ankles bilaterally

RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 Diminished anterior and posterior Lung sounds bilaterally
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:** N/A **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** N/A	 Regular Regular 170.2 cm 112.6 kg Normoactive in all four quadrants 01/30/23 No pain, no masses noted upon palpation. No Horizontal incision from C-Section C-section Scar No drains, No wounds
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	 Yellow Normal 1 occurrence N/A N/A N/A
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** 2+ **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐	No clubbing and cyanosis on fingers, cap refill less than 3 secs Upper: Full, Lower: Limited Bed Rail, Gait Bel & walker Poor 97 Two persons assist. Yes

Needs support to stand and walk☐	Yes
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. Person and Self Lethargic Clear, slowed. Senses normal and intact A+Ox2
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):**	Patients identify as Christian but have not been in church for a long time. Full developmental level. Patient lives alone and have children as support system.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0715	93	125/95	16	97.2	96%
1100	83	96/68	18	97.6	97%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0720	0	N/A	N/A	N/A	N/A
1105	0	N/A	N/A	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 G
Location of IV:	L Hand
Date on IV:	1/28
Patency of IV:	Patent
Signs of erythema, drainage, etc.:	No
IV dressing assessment:	Clean, dry, intact. Saline Lock in place.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
946 mL	1 occurrence

Nursing Care

Summary of Care (2 points)

Overview of care: Patient is waiting for placement for rehabilitation therapy. Receives Physical and Occupational therapy at OSF Danville. Plan of discharge to follow.

Procedures/testing done: N/A

Complaints/Issues: N/A

Vital signs (stable/unstable): N/A

Tolerating diet, activity, etc.: Yes

Physician notifications: N/A

Future plans for client: No referral appointments.

Discharge Planning (2 points)

Discharge location: Rehabilitation Center/SNF.

Home health needs (if applicable): Grab handles, Ramp, walk in shower.

Equipment needs (if applicable): Gait belt, walker, wheelchair.

Follow up plan: No referral or follow-up appointment at this time.

Education needs: Patient needs education and information about the risk of falling, how to prevent falls, mobilization and muscle strengthening exercises.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for Fall related to general weakness as evidence by decrease in lower extremity strength and inability to stand.	The patient is non weight bearing and unable to stand with the help of gait belt and walker.	1.Observe client for signs of anemia such as fatigue and weakness. 2. Refer to physical therapy for strength training, using free weights or machines, and suggest participation in exercise program (Ackley et al., 2021).	1. The client will be free of fall in the next 12 hours.	Client agrees to the intervention and prevention from injury and fall.
2. Impaired physical	The client is having	**1.** Perform passive ROM	The client will mobilize as	The client will have less

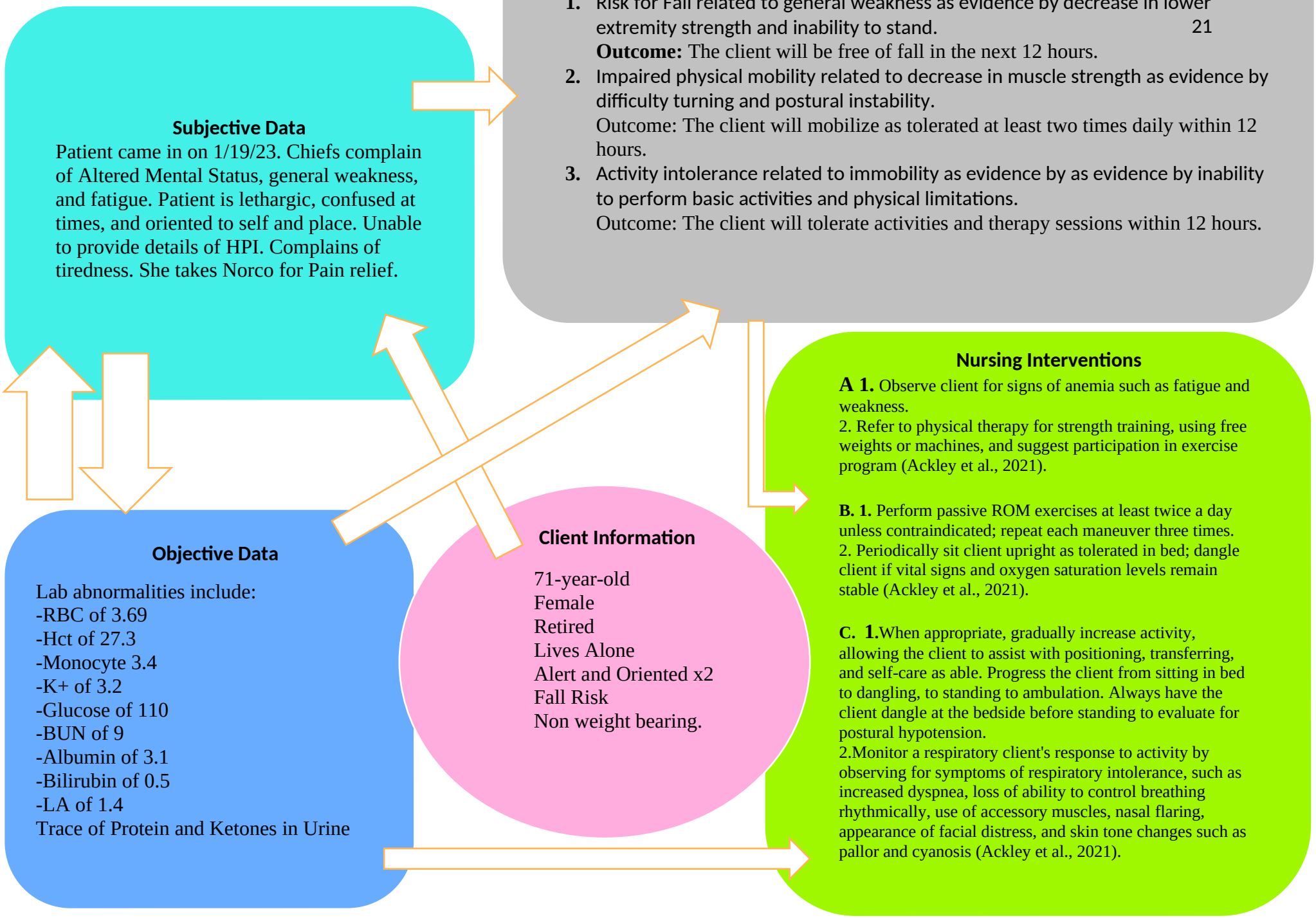
mobility related to decrease in muscle strength as evidence by difficulty turning and postural instability.	difficulty turning in bed without support, and weakness hinder with ADL.	exercises at least twice a day unless contraindicated; repeat each maneuver three times. 2. Periodically sit client upright as tolerated in bed; dangle client if vital signs and oxygen saturation levels remain stable (Ackley et al., 2021).	tolerated at least two times daily within 12 hours.	weakness and fatigue. Physical mobility will improve.
3. Activity intolerance related to immobility as evidence by as evidence by inability to perform basic activities and physical limitations.	The patient is unable to tolerate exercises instructed by physical and occupational therapist.	1.When appropriate, gradually increase activity, allowing the client to assist with positioning, transferring, and self-care as able. Progress the client from sitting in bed to dangling, to standing, to ambulation. Always have the client dangle at the bedside before standing to evaluate for postural hypotension.	The client will tolerate activities and therapy sessions within 12 hours.	The client will report improvement after therapy sessions.

		2.Monitor a respiratory client's response to activity by observing for symptoms of respiratory intolerance, such as increased dyspnea, loss of ability to control breathing rhythmically, use of accessory muscles, nasal flaring, appearance of facial distress, and skin tone changes such as pallor and cyanosis (Ackley et al., 2021).		

Other References (APA):

Ackley, B., Ladwig, G., Makic, M., Kratz, M., Zanotti, M. (2021). *Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care*. (12th ed.) Elsevier.

Concept Map (20 Points):


Nursing Diagnosis/Outcomes
1. Risk for Fall related to general weakness as evidence by decrease in lower extremity strength and inability to stand. 21
Outcome: The client will be free of fall in the next 12 hours.
2. Impaired physical mobility related to decrease in muscle strength as evidence by difficulty turning and postural instability.
Outcome: The client will mobilize as tolerated at least two times daily within 12 hours.
3. Activity intolerance related to immobility as evidence by as evidence by inability to perform basic activities and physical limitations.
Outcome: The client will tolerate activities and therapy sessions within 12 hours.
Subjective Data
Patient came in on 1/19/23. Chiefs complain of Altered Mental Status, general weakness, and fatigue. Patient is lethargic, confused at times, and oriented to self and place. Unable to provide details of HPI. Complains of tiredness. She takes Norco for Pain relief.
Nursing Interventions
A 1. Observe client for signs of anemia such as fatigue and weakness.
2. Refer to physical therapy for strength training, using free weights or machines, and suggest participation in exercise program (Ackley et al., 2021).
B. 1. Perform passive ROM exercises at least twice a day unless contraindicated; repeat each maneuver three times.
2. Periodically sit client upright as tolerated in bed; dangle client if vital signs and oxygen saturation levels remain stable (Ackley et al., 2021).
C. 1.When appropriate, gradually increase activity, allowing the client to assist with positioning, transferring, and self-care as able. Progress the client from sitting in bed to dangling, to standing to ambulation. Always have the client dangle at the bedside before standing to evaluate for postural hypotension.
2.Monitor a respiratory client's response to activity by observing for symptoms of respiratory intolerance, such as increased dyspnea, loss of ability to control breathing rhythmically, use of accessory muscles, nasal flaring, appearance of facial distress, and skin tone changes such as pallor and cyanosis (Ackley et al., 2021).
Client Information
71-year-old
Female
Retired
Lives Alone
Alert and Oriented x2
Fall Risk
Non weight bearing.
Objective Data
Lab abnormalities include:
-RBC of 3.69
-Hct of 27.3
-Monocyte 3.4
-K+ of 3.2
-Glucose of 110
-BUN of 9
-Albumin of 3.1
-Bilirubin of 0.5
-LA of 1.4
Trace of Protein and Ketones in Urine