N431 Care Plan #1

Lakeview College of Nursing

Name: Lindsey Burnett

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
2/4/23	WB	74	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Single	Lidocaine
Code Status	**Height**	**Weight**	
Full	6'0"	214lb	

Medical History (5 Points)

Past Medical History: A-Fib, HTN, congestive cardiac failure, glaucoma, hyperlipidemia

Past Surgical History: Right clavicle surgery, cardiac Cath (2/10/16), left heart Cath (1/28/18), upper GI endoscopy (11/13/19), colonoscopy (11/15/19), cataract removal (7/8/19), left foot fifth digit toe amputation (1/23/23).

Family History: Mother-diabetes, glaucoma, and macular degeneration; brother-diabetes.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Quit smoking 9 years ago, 30 pack year smoking history, never used smokeless tobacco, current alcohol drinker 10 cans of beer per week, does not use drugs.

Assistive Devices: Patient currently using a wheelchair to get around due to recent surgery.

Living Situation: Patient lies in an extended rehab facility

Education Level: Highschool

Admission Assessment

Chief Complaint (2 points): Malaise

History of Present Illness – OLD CARTS (10 points): Patient is a 74 y/o male who arrives in the ED via EMS from rehab facility. On arrival patient presents with weakness with blood pressures in the 90's/60's. Patient had a recent amputation on the left foot to the fifth digit and is currently taking antibiotics. Patient has an extensive past medical history related to cardiac.

Patient is working with physical therapy and has medications under control and is being discharged back to rehab facility.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Hypotension

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): Hypotension is the decrease in systemic blood pressure below accepted low values. Hypotension is a benign condition as it is under-recognized mainly due to it being asymptomatic (Sharma et al., 2022). This only becomes a concern once pumping pressure is insufficient to perfuse key organs with oxygenated blood (Sharma et al., 2022). Although there is no accepted standard for hypotensive pressures, less than 90/60 are recognized as hypotensive (Sharma et al., 2022). This patient presented to the emergency department with blood pressure less than 90/60. This patient has a history of hypertension and arrived with a blood pressure of 90s/60s and blood pressure continued to be in the 90s/60s for the beginning of treatment in the emergency department. Blood pressure is continuously regulated via the autonomic nervous system as a balance of the sympathetic nervous system and the parasympathetic nervous system (Sharma et al., 2022). The sympathetic nervous system acts to raise blood pressure by increasing heart rate and constricting arterioles; the parasympathetic nervous system lowers blood pressure by decreasing heart rate and relaxing arterioles to increase vessel diameter (Sharma et al., 2022). This patient was put on a bunch of new medicines and antibiotics that caused his blood pressure to become very low resulting in

hypotension. Hypotension can cause a lot of problems and damage to multiple organs if not controlled immediately. Reduced cardiac output that cannot be compensated by neuro-reflexes can cause hypotension, which can lead to shock Klabunde, 2022). Therefore, it's important to monitor blood pressure closely, especially after this patient was put on new medicines with an already extensive heart history, as the new medicines that were prescribed have the ability to lead to hypotension, which in this case this patient presented to the hospital with hypotension due to recent changes in medicine.

Pathophysiology References (2) (APA):

Klabunde, R. (2022). Cardiovascular Physiology Concepts.

https://www.cvphysiology.com/Blood%20Pressure/BP030

Sharma S, Hashmi MF, Bhattacharya PT. Hypotension. Treasure Island (FL): Stat Pearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK499961/

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	4.10-5.70	4.42	4.00	The decrease in RBC could be caused by blood loss due to recent surgery

				(Pagana 2019).
Hgb	12-18	13.6	12.2	Lab is within normal limits
Hct	37-51	41.7	37	Lab is within normal limits
Platelets	14-400	271	221	Lab is within normal limits
WBC	4-11	11.95	9.95	The increase in WBC is related to an infection and the WBC are fighting to destroy the infection (Pagana 2019).
Neutrophils	1.60-7.70	10.29	7.61	This is due to bacteria and virus, patient does have norovirus and had a recent surgery (Pagana 2019).
Lymphocytes	1.00-4.90	0.85	1.07	This would be related to possible inflammation.
Monocytes	0.00-1.10	0.62	1.03	Lab is within normal limits
Eosinophils	0.00-0.50	0.10	0.14	Lab is within normal limits
Bands	N/A	N/A	N/A	*No lab completed for this pt.*

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-	136-145	134	133	The decrease in sodium may be caused by heart failure, cirrhosis, and use of diuretics (Pagan 2019).
K+	3.5-5.1	4.3	3.5	Lab is within normal limits
Cl-	98-107	98	104	Lab is within normal limits
CO2	22-29	27	23	Lab is within normal limits
Glucose	74-100	82	84	Lab is within normal limits
BUN	8-26	17	13	Lab is within normal limits
Creatinine	0.55-1.30	0.77	0.62	Lab is within normal limits
Albumin	3.4-4.8	3.4	4.8	This low number can be due to malnutrition, patient is on a cardiac diet but may not be getting all of his adequate nutrition needed, can also be kidney disease (Pagana 2019).

Calcium	8.9-10.6	8.2	8.0	This is due to vitamin deficiency, patient is on a lot of different medicines, and isn't always hungry so he wouldn't be getting all the vitamins and nutrient he needs everyday. (Pagana 2019).
Mag	1.6-2.6	N/A	1.4	This is due to vitamin deficiency due to certain medicines patient is taking (Pagana 2019).
Phosphate	N/A	N/A	N/A	*No lab completed for this pt.*
Bilirubin	0.2-1.2	0.2	1.2	Lab is within normal limits
Alk Phos	40-150	61	65	Lab is within normal limits
AST	5-34	42	35	This is due to heart problems, patient does have an extensive history of cardiac (Pagana 2019).
ALT	0-55	34	29	Lab is within normal limits
Amylase	N/A	N/A	N/A	*No lab completed for this pt.*
Lipase	N/A	N/A	N/A	*No lab completed for this pt.*
Lactic Acid	0.50-2.20	N/A	N/A	*No lab completed for this pt.*
Troponin	N/A	N/A	N/A	*No lab completed for this pt.*
CK-MB	N/A	N/A	N/A	*No lab completed for this pt.*
Total CK	N/A	N/A	N/A	*No lab completed for this pt.*

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	0.9-1.1	2.9	N/A	This could be do to patient being on recent antibiotics (Pagana 2019).
PT	11.7-13.8	29.8	N/A	This could be do to patient being on recent antibiotics (Pagana 2019).

PTT	22.4-35.9	37.6	N/A	This could be related to vitamin deficiency and liver problems (Pagana 2019).
D-Dimer	N/A	N/A	N/A	*No lab completed for this pt.*
BNP	0.0-100	490	N/A	This is elevated related to cardiac dysfunctions (Pagana 2019).
HDL	60	N/A	N/A	*No lab completed for this pt.*
LDL	60-130	N/A	N/A	*No lab completed for this pt.*
Cholesterol	<200	N/A	N/A	*No lab completed for this pt.*
Triglycerides	<150	N/A	N/A	*No lab completed for this pt.*
Hgb A1c	N/A	N/A	N/A	*No lab completed for this pt.*
TSH	0.350-4.940	N/A	N/A	*No lab completed for this pt.*

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	Colorless Yellow	Dark Yellow Clear	N/A	Urine color could be do to patient being dehydrated (Pagana 2019).
pH	n/a	N/A	N/A	*No labs completed for this pt.*
Specific Gravity	1.000-1.030	1.025	N/A	Lab is within normal limits
Glucose	Negative	Negative	N/A	Lab is within normal limits
Protein	Negative	Negative	N/A	Lab is within normal limits
Ketones	Negative	Negative	N/A	Lab is within normal limits
WBC	0-25	14	N/A	Lab is within normal limits
RBC	0-20	3	N/A	Lab is within normal limits
Leukoesterase	Negative	Negative	N/A	Lab is within normal limits

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	N/A	N/A	N/A	*No lab completed for this pt.*
PaO2	N/A	N/A	N/A	*No lab completed for this pt.*
PaCO2	N/A	N/A	N/A	*No lab completed for this pt.*
HCO3	N/A	N/A	N/A	*No lab completed for this pt.*
SaO2	N/A	N/A	N/A	*No lab completed for this pt.*

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	N/A	N/A	N/A	*No lab completed for this pt.*
Blood Culture	N/A	N/A	N/A	*No lab completed for this pt.*
Sputum Culture	N/A	N/A	N/A	*No lab completed for this pt.*
Stool Culture	N/A	N/A	N/A	*No lab completed for this pt.*

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T. J., & Pagana, T. N., (2019). Mosby's diagnostic and laboratory test reference. St. Louis, MO-Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): XR Chest AP/PA

Diagnostic Test Correlation (5 points): Mildly enlarged cardio mediastinal, slightly increased appearance, stable, no left pleural effusion or pneumothorax.

Diagnostic Test Reference (1) (APA): Pagana, K.D., Pagana, T. J., & Pagana, T. N., (2019). Mosby's diagnostic and laboratory test reference. St. Louis, MO-Elsevier.

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

Home Medications (5 required)

Brand/Generic	Atorvastatin Lipitor	Carvedilol Coreg	Furosemide Lasix	Acetaminophen	Levofloxacin Levaquin
Dose	40 mg	6.25 mg	20 mg	500 mg	750 mg
Frequency	1x daily	2x daily	1x daily	PRN	1x daily
Route	PO	PO	PO	PO	PO
Classification	Statins	Alpha Beta Adrenergic	Loop diuretics	Analgesic Antipyretics No salicylate	Antibiotic
Mechanism of Action	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver	Reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular tissue, which reduces blood pressure and cardiac workload.	Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation.	Inhibits the enzyme cyclooxygenase , blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Binds to central and peripheral H1 receptors, competing with histamine for these sites an preventing it from reaching its site of action.
Reason Client	Lower	Treat heart	Get rid of extra	Pain when it's	Wound

Taking	cholesterol	failure	fluid	1-3	infection
Contraindications (2)	Active hepatic disease Hypersensitivity to atorvastatin	Bronchial asthma Decompensated heart failure	Anuria Hypersensitivity to furosemide or its components	Hypersensitivity to acetaminophen or its components. Severe hepatic impairment, severe active liver disease	Creatinine clearance less than 10 ml/min hemodialysis
Side Effects/Adverse Reactions (2)	Diarrhea Nausea	Hypotension Diarrhea	Thrombophlebitis Diarrhea	Nausea Pulmonary Edema	Edema dizziness
Nursing Considerations (2)	Use cautiously in patients who consume substantial quantities of alcohol or have a history of liver disease, this medicine increases risk of liver dysfunction. Expect medicine to be used in patients without obvious coronary artery disease, but with multiple risk factors.	Know that if patient has heart failure, expect to also give digoxin, a diuretic, and an ACE inhibitor. Avoid stopping drug abruptly in patients with hyperthyroidism because thyroid storm may occur.	Use cautiously in patients with advanced hepatic cirrhosis. Notify prescriber if patient experiences hearing loss, vertigo, or ringing, buzzing, or sense of fullness in their ears.	Use cautiously in patient wit hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment. Make sure dose is based on patient weight and infusion pumps are properly programmed.	Monitor patient for abnormal thinking, such as desire to harm oneself. Use cautiously in patients with predisposing risk factors for urinary retention.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Lipids	Blood glucose	Obtain weight, blood pressure, hepatic and renal function, BUN, blood glucose, serum creatinine, electrolyte, and uric acid levels	AST ALT Bilirubin creatinine	Creatinine
Client Teaching Needs (2)	Emphasize medicine is an adjunct to not a	Warn patient drug may cause dizziness, light-headedness, and	Instruct patient to take medicine at the same time each day. Advise patient to	Tell patient tablets may be crushed or swallowed	Instruct patient to take drug exactly as

	substitute for a low cholesterol diet. Tell patient to take drug at the. Same time each day.	orthostatic hypotension. Tell patient with heart failure to notify prescriber if they gain 5 lb or mor in 2 days or if shortness of breath increases.	change positions slowly to minimize effects of orthostatic hypotension.	whole. Teach patient to recognize signs of hepatoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic overdose.	prescribed. Advise patient to avoid hazardous activities until drug's CNS effects are known.

Hospital Medications (5 required)

Brand/Generic	Hydrocodone Norco	Doxycycline Vibramycin	Loperamide	Calcium carbonate Tums	Guaifenesin Oral liquid
Dose	5-325 mg	100 mg	2mg	500 mg	200 mg
Frequency	1 tablet PRN	2x daily	PRN, after each loose stool	PRN	PRN
Route	PO	PO	PO	PO	PO
Classification	Opioid analgesic	Antibiotic	Antidiarrheal	Antacid	Expectorant
Mechanism of Action	Binds to and activates opioid receptors at sites in the periaqueductal matter, the medulla, and the spinal cord to produce pain relief.	Exerts a bacteriostatic effect against a wide variety of gram positive and gram-negative organisms.	Binds to opiate receptors in the gut wall.	Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal system.	Loosens and things phlegm and bronchial secretions to ease expectoration.
Reason Client Taking	Pain	Prevent infection	Diarrhea	Reflux symptoms	Cough, chest congestion
Contraindications (2)	Acute or severe bronchial asthma, known or	Hypersensitivity to doxycycline, other tetracyclines, or	Infectious diarrhea Abnormal EKG	Cardiac resuscitation with risk existing digitalis	Should not be used for persistent or chronic cough.

	suspected GI obstruction	their components.		toxicity or presence of ventricular fibrillation.	Avoid taking MAO inhibitors while using this medicine.
Side Effects/Adverse Reactions (2)	Bradycardia Dyspnea	Abdominal pain diarrhea	Dizziness Nausea	Hypotension Hypercalcemia	Dizziness Vomiting
Nursing Considerations (2)	Be aware that it increases the risk of abuse, addiction and misuse. Should not be given to a patient with impaired consciousness .	Don't give by IM or subcutaneous route. Use oral suspension cautiously in patient allergic to sulfites because it contains sodium metabisulfite.	Discontinue if there is no improvemen t within 48 hours. Monitor fluid and electrolyte balance.	Store at room temperature and protect from heat, moisture, and direct light. Keep patient in recumbent position for 30 minutes after administration.	Medicine may cause drowsiness. Monitor reaction to drug: persistent cough for more than one week, rash, or persistent headache.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Make sure patient doesn't have a fentanyl patch on.	BUN	CMP Magnesium	Calcium	Uric acid levels
Client Teaching Needs (2)	Instruct patient to take drug exactly as ordered and not to adjust dosage without speaking to prescriber first. Instruct patient to take capsules and tablets whole and never chewed, crushed, or dissolved.	Instruct patient not to take just before bed because it may not dissolve properly and may cause esophageal burning and ulceration. Advise patient to avoid antacids containing aluminum, calcium, or magnesium.	Take with a full glass of water. Drink plenty of fluids to prevent becoming dehydrated.	Urge patient to chew chewable tablets thoroughly before swallowing and to drink a glass of water afterward. Instruct patient to take tablets 1-2 hours after meals and other forms with meals.	Do not break, crush, or chew. If symptoms do not improve after seven days, have a high fever, rash, or headache, contact provider right away.

Medications Reference (1) (APA):

Jones & Bartlett Learning (2021). 2021 Nurses' Drug Handbook. Burlington, MA

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Alert and oriented to situation, time, place, and person** **X4** **No distress** **Hair is well groomed, clean shaven, and bathed for the day**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 19** **Drains present: Y☐ N ☒** **Type:**	**Skin is warm to the touch, lower extremities red and warm. Overall appearance is good, skin turgor is good, the capillary refill is good at less than 3 seconds in the upper extremities, there is a wound vac to the left foot due to the fifth digit recently being amputated, there is pitting edema to the feet.** **Braden score is 19**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck symmetrical **No discharge from ears, patient was able to hear clearly and responded appropriately, eyes symmetrical, nose symmetrical, no deviation, patient has all teeth, and they are in good condition.**
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: Bilateral feet**	**Heart sounds are abnormal, there was an extra beat, as well as the radial pulses were faint and skipped a beat. Capillary refill less than 3 seconds in the upper extremeties. No neck vein distention. Pitting edema in the feet.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular, nonlabored, no wheezing. Lung sounds are clear in all quadrants.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height: 6'0**	Patient is on a low sodium diet at home, due to having an extensive history with heart. **6'0"** **214lb**

Weight:214 **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:**	**Last bowel movement was this AM (2/6/23)** **Bowel sounds are heard and active in all four quadrants** **There is distension on the right side with tenderness** **No incisions, scars, drains, or wounds present, there is a wound present on the left foot.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Patient is taking diuretics and is going to the bathroom frequently.** **Patient states no pain or troubles with urinating.** **Urine is yellow, clear, and odorless.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 15** **Activity/Mobility Status:** **Independent (up ad lib) ☐X** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Normal ROM **Strength in both upper and lower extremities** **Patient is able to get around on his own, but needs assistance getting up out of the chair.** **Fall risk score of 15**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:**	Bilateral arms and legs are strong **PERLA is present bilaterally** **Cognitive to time, place, situation, and person** **Speech patient is able to speak clearly and respond appropriately to questions** **Cognitive and Alert** **No LOC**

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 is not religious and only family living is his sister in law. Patient lives in an extended care facility, he uses his cell phone as a means of coping as well as watching TV.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	**89**	**102/62**	**18**	**97.6**	**97% on Room Air**
1115	**92**	**104/60**	**20**	**97.5**	**96% on Room Air**

Vital Sign Trends: Vital signs are stable and within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	**Numeric 0-10**	**N/A**	**0**	**N/A**	**Patient states he is not in any pain at this time.**
1100	**Numeric 0-10**	**N/A**	**0**	**N/A**	**Patient states he is not in any**

					pain at this time.

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:**	Peripheral IV on 2/6/23, 20 G, Left Antecubital and Right hand, appears comfortable, no pain, erythema, drainage at the site of IV. IV dressing is clean, intact, and dry.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
470mL: water, coffee, juice, milk, pudding, **yogurt**	**400mL**

Nursing Care

Summary of Care (2 points)

Overview of care: MRSA (-), Norovirus (+)

Procedures/testing done: Chest XR

Complaints/Issues: Patient has not complaints, pain is under control

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Tolerates diet well and activity when able.

Physician notifications: To continue antibiotics and resume activity as tolerated

Future plans for client: Reduce risk of infection, get blood pressure under control

Discharge Planning (2 points)

Discharge location: Patient being discharged back to extended rehab facility.

Home health needs (if applicable): Needs assistance getting up, but able to get around on his own.

Equipment needs (if applicable): No equipment needs

Follow up plan: Patient needs to attend follow up doctor's appointments and go to PT and OT.

Education needs: Education on signs and symptoms of infection to the wound vac and the importance of attending follow up appointments.

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	**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

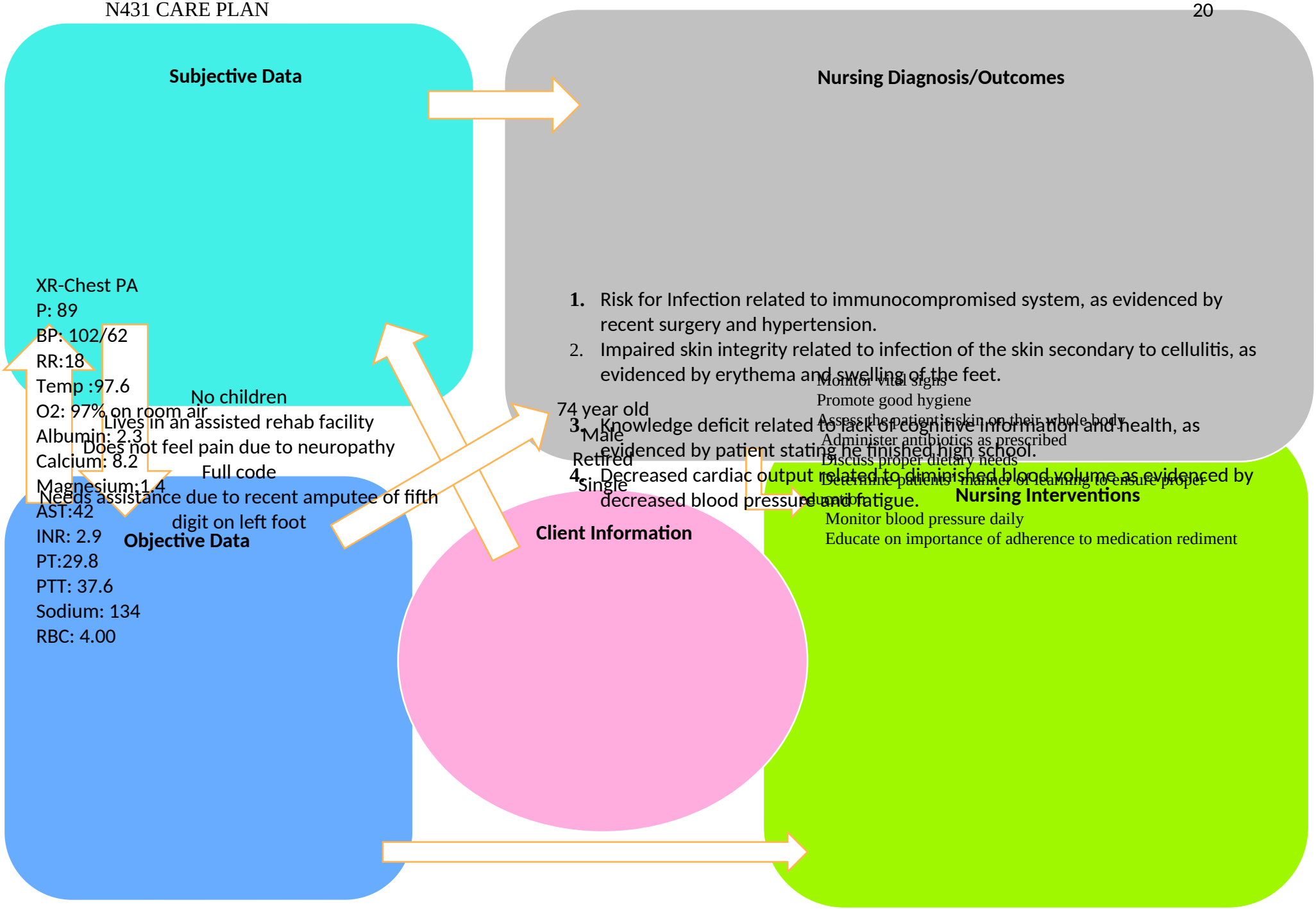
priority to lowest priority pertinent to this client				response, status of goals and outcomes, modifications to plan.
1. Risk for Infection related to immunocompromised system, as evidenced by recent surgery and hypertension.	Patient recently had surgery with removal of fifth digit on left foot with an open wound vac, was put on antibiotics and now has hypotension and weakness	**1.**Monitor vital signs 2.Promote good hygiene	**1.** To reduce the risk of infection, and help stop the spread if infection early	Vitals signs were monitored every 2 hours, to make sure they are staying stable and patient was placed on antibiotics for infection. This client responded very well to this and remained compliant and was ready to go home.
2. Impaired skin integrity related to infection of the skin secondary to cellulitis, as evidenced by erythema and swelling of the feet.	The patient had noticeable swelling and warmth to the lower extremities.	**1.** Assess the patients' skin on their whole body. **2.**Administer antibiotics as prescribed.	**1.** To determine the severity of the cellulitis.	The patient was very receptive to the interventions put into place, he was accepting of the assessment of skin.
3. Knowledge deficit related to lack of cognitive information and health, as evidenced by patient stating he finished high school.	Patient states they finished high school and admits they don't have the proper resources at their current living facility to help with their health	**1.** Discuss proper dietary needs. **2.**Determine patients' manner of learning to ensure proper education.	**1.** To make sure patient is aware and knowledgeable of his diagnosis, and what he needs to do to ensure proper recovery.	Client is very well goal oriented, accepting, and willing to learn interventions being put into place.

	diagnosis.			
4. Decreased cardiac output related to diminished blood volume as evidenced by decreased blood pressure and fatigue.	Patient has a history of hypertension and comes in with hypotension possibly related to new antibiotics and medications patient has started.	**1.** Monitor blood pressure daily **2.** Educate on importance of adherence to medication regiment	**1.** Patient will maintain blood pressure within normal limits	Patient verbalizes understanding of the plan of care and verbalizes the signs and symptoms of when they need to seek help with there blood pressure.

Other References (APA):

Swearingen, Pamela L. And Wright, Jacqueline D. All – in – One Nursing Care Planning Resource (2019). St. Louis, MO.

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
XR-Chest PA
P: 89
BP: 102/62
RR:18
Temp :97.6
O2: 97% on room air
Albumin: 2.3
Calcium: 8.2
Magnesium:1.4
AST:42
INR: 2.9
PT:29.8
PTT: 37.6
Sodium: 134
RBC: 4.00
No children
Lives in an assisted rehab facility
Does not feel pain due to neuropathy
Full code
Needs assistance due to recent amputee of fifth digit on left foot
Objective Data
74 year old
Male
Retired
Single
Client Information
1. Risk for Infection related to immunocompromised system, as evidenced by recent surgery and hypertension.
2. Impaired skin integrity related to infection of the skin secondary to cellulitis, as evidenced by erythema and swelling of the feet.
3. Knowledge deficit related to lack of cognitive information and health, as evidenced by patient stating he finished high school.
4. Decreased cardiac output related to diminished blood volume as evidenced by decreased blood pressure and fatigue.
Monitor vital signs
Promote good hygiene
Assess the patient's skin on their whole body
Administer antibiotics as prescribed
Discuss proper dietary needs
Determine patients' manner of learning to ensure proper education
Monitor blood pressure daily
Educate on importance of adherence to medication rediment
Nursing Interventions