N441 Care Plan

Lakeview College of Nursing

Name: Lauren McClain

Demographics (3 points)

Date of Admission 1/28/2023	**Client Initials** P.Y.	**Age** 58	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Disabled	**Marital Status** Widower	**Allergies** Ibuprofen: Not specified Penicillin: SOB, rash Cat hair: Swelling of eyes
Code Status DNR	**Height** 156 cm	**Weight** 72.8 kg	

Medical History (5 Points)

Past Medical History: COPD; Type II diabetes; GERD; HTN; hyperlipidemia; hypertensive cardiovascular disease; ischemic myocardial dysfunction; MI; PAD; Vitamin D deficiency

Past Surgical History: CTR (2017); Elbow (2017); Back; Cardiac catherization; cataract; fusion of joint

Family History: Father: Diabetes mellitus, HTN; Mother: COPD, liver damage

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Tobacco: smokes 3-4 packs a day, does not specific how long the patient has been smoking, but the patient does not plan on stopping; Alcohol: Does not drink anymore; Drugs: Marijuana, does not specific how long or how often the patient has been using.

Assistive Devices: None

Living Situation: Lives with nephew and is independent

Education Level: High school/ disabled

Admission Assessment

Chief Complaint (2 points): Left foot pain

History of Present Illness – OLD CARTS (10 points): A 58-year-old female presents to the ED due to left foot pain. The patient stated that she began problems in December after finishing up her antibiotics. For the past month the pain and a putrid smell has progressively gotten worse. She also stated that the color and pain was significantly wore two days prior to coming in. She stated that walking made the pain worse and keeping the foot elevated helps decrease the pain. The patient denied any other symptoms such as shortness of breath, chest pain, and nausea.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Ischemic left lower extremity

Secondary Diagnosis (if applicable): Diabetes type 2

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

Ischemic necrosis is tissue death due to prolonged ischemia (Capriotti, 2020). This patient also has uncontrolled type two diabetes related to insulin resistance and impaired insulin secretion (Overbaugh et al., 2021). Since insulin cannot bind to the receptors, it becomes less effective, causing glucose uptake. Risk factors that contribute to ischemia are poor glycemic control and smoking. This patient was not controlling her diabetes and smoked 3-4 packs a day, which led to a common complication of diabetes, necrosis of the foot.

Symptoms of diabetes include polyuria, polydipsia, polyphagia, fatigue, irritability, and poorly healing wounds (Overbaugh et al., 2021). Symptoms of an ischemic foot include numbness, paresthesia, and a burning sensation. This patient experienced high blood glucose levels upon admission, 198; she also stated that she did not realize when she first injured her foot which gave her an infection. She said her foot was in intense pain while walking and had a putrid smell from the skin dying. The patient also had increased WBC and neutrophils, indicating

inflammation and infection. When diagnosing an ischemic limb, there is no diagnostic test but looking at clinical findings such as dry shiny hairless skin on the affected area, brittle nails, and cool skin to the touch. Ordering labs such as a CBC, CMP, PT, aPTT, blood cultures, and lactic acid can help rule out sepsis which is common in necrosis (Capriotti, 2020). The client received a blood culture that returned negative, showing no signs of sepsis. Standard imaging includes x-rays, a CT scan, and an ultrasound (Overbaugh et al., 2021). This client received an x-ray of the left foot showing mild degenerative changes, diffuse soft tissue edema, and extensive soft tissue air consistent with necrotizing infection.

Treatment includes antibiotics, surgical debridement, fluid resuscitation, and in some cases, amputation (Capriotti, 2020). Previously this patient received antibiotics in December for a previous foot infection. Since the patient waited so long for treatment, the antibiotics did not work, causing the infection to move up her leg and need an above-the-knee amputation.

Pathophysiology References (2) (APA):

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

Overbaugh, J. L., Hinkle, K. H., & Cheever, K. (2021). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed). Wolters Kluwer Health.

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.8-5.41**	**4.10**	**3.38**	Low RBCs are due to renal disease

				(Pagana et al., 202). This patient was recently diagnosed with AKI.
Hgb	**11.3-15.2**	**10.8**	**9.2**	Decreased levels are due to kidney disease (Pagana et al., 2021). This patient was diagnosed with AKI.
Hct	**33.2-45.3**	**33.7**	**27.5**	Low levels are due to renal disease and dietary deficiency (Pagana et al., 2021). This patient was diagnosed with AKI and recently went from a regular diet at home to enteral feedings.
Platelets	**149-393**	**385**	**216**	
WBC	**4-11.7**	**31.6**	**163**	WBCs are increased in cases of infection and inflammation (Pagana et al., 2021). This client has an infection in her left leg which was partially removed.
Neutrophils	**45.3-79**	**86.5**	**77.8**	Increased in cases of infection and inflammation (Pagana et al., 2021). This client has an infection in her left leg which was partially removed.
Lymphocytes	**11.8-45.9**	**6.9**	**11.5**	Low levels due to sepsis and certain drug therapies (Pagana et al., 2021). This patient was ruled out for sepsis.
Monocytes	**4.4-12**	**5.2**	**8.4**	
Eosinophils	**0-6.3**	**0.1**	**1.5**	
Bands	**0.2-1.6**	**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**	**131**	**136**	Decreased levels are due to deficient dietary intake, diarrhea, and edema (Pagana et al., 2021). This patient has diarrhea from lactulose, edema in her right foot and has been NPO taking enteral feedings for a few days now.

K+	**3.5-5.1**	**3.7**	**3.0**	Low level due to medications such as insulin, certain antibiotics, and corticosteroids (Pagana et al., 2021). This patient is a diabetic, has recently been taking antibiotics, and is currently taking Budesonide a corticosteroid.
Cl-	**98-107**	**101**	**102**	
CO2	**21-31**	**29**	**21**	
Glucose	**74-109**	**198**	**93**	Patient was not controlling her diabetes and due to stress, which increases glucose (Pagana et al., 2021).
BUN	**7-25**	**13**	**58**	High levels indicate hypovolemia, dehydration, shock, renal problems (Pagana et al., 2021). This client was recently diagnosed with acute kidney injury and is receiving dialysis.
Creatinine	**0.6-1.2**	**0.60**	**2.82**	Increased due to CHF (Pagana et al., 2021). This patient has a recent diagnosis of CHF.
Albumin	**3.5-5.2**	**3.0**	**2.0**	Decreased due to infection and kidney disease (Pagana et al, 2021). This patient has a new onset of AKI and is being treated for a infection.
Calcium	**8.6-10.3**	**0.60**	**7.3**	Decreased due to renal failure and vitamin D deficiency (Pagana et al., 2021). This patient has a new diagnosis of AKI and a history of vitamin D deficiency.
Mag	**1.8-2.6**	**N/A**	**2.0**	
Phosphate	**2.7-4.6**	**N/A**	**N/A**	
Bilirubin	**0.3-1**	**0.5**	**0.9**	
Alk Phos	**34-104**	**259**	**432**	Increased due to healing fracture (Pagana et al., 2021). This patient recently had an amputation which is currently healing.
AST	**13-39**	**9**	**61**	Abnormal levels are due to renal issues (Pagana et al., 2021). This

				patient was diagnosed with AKI.
ALT	**7-54**	**10**	**116**	Increased due to trauma of straited muscle (Pagana et al., 2021). This patient recently had an amputation.
Amylase	**0-90**	**N/A**	**N/A**	
Lipase	**0-70**	**N/A**	**N/A**	
Lactic Acid	**4.5-19.8**	**2.9**	**N/A**	Increased due to tissue ischemia and diabetes mellitus (Pagana et al., 2021). This patient has tissue ischemia beneath her amputated limb and has a history of uncontrolled diabetes.
Troponin	**0-0.04**	**0.162**	**N/A**	
CK-MB	**3-5**	**N/A**	**N/A**	
Total CK	**22-198**	**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	**1-2**	**1.01**	**1.22**	
PT	**10-12**	**13.8**	**15.6**	High PT indicates abnormal clotting time (Pagana et al., 2021).
PTT	**30-45**	**N/A**	**60.2**	Increased due to heparin administration (Pagana et al., 2021). This patient is receiving a heparin drip.
D-Dimer	**Less than 0.5**	**N/A**	**N/A**	
BNP	**Less than 100**	**N/A**	**N/A**	
HDL	**60 and greater**	**N/A**	**N/A**	
LDL	**Less than 100**	**N/A**	**N/A**	
Cholesterol	**Less than**	**N/A**	**N/A**	

	200			
Triglycerides	**Less than 150**	**N/A**	**N/A**	
Hgb A1c	**Less than 5.7%**	**N/A**	**N/A**	
TSH	**0.5-5**	**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	**Clear to yellow**	**N/A**	**N/A**	
pH	**5-8**	**N/A**	**N/A**	
Specific Gravity	**1.005-1.034**	**N/A**	**N/A**	
Glucose	**Negative**	**N/A**	**N/A**	
Protein	**Negative**	**N/A**	**N/A**	
Ketones	**Negative**	**N/A**	**N/A**	
WBC	**0-5**	**N/A**	**N/A**	
RBC	**0-5**	**N/A**	**N/A**	
Leukoesterase	**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 - 7.45a**	**N/A**	**7.40**	
PaO2	**75-100**	**N/A**	**74.1**	Decreased due to hypoxemia and

				pain (Pagana et al., 2021). This patient is taking Fentanyl for pain management.
PaCO2	**35-45**	**N/A**	**35.7**	
HCO3	**22-26**	**N/A**	**22.2**	
SaO2	**92-100%**	**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**	**N/A**	**N/A**	**In progress**
Blood Culture	**Negative**	**Negative**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). *Mosby's diagnostic & laboratory test reference* (15th ed.) Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- **X-ray foot (left):** mild degenerative changes; diffuse soft tissue edema; extensive soft tissue air consistent with necrotizing infection.

- **CT angio abdomen aorta with contrast:** due to left foot pain, swelling, and no pulse. Showed fatty liver; soft tissue edema distal right lower w/o soft tissue air; intra-arterial air in the left posterior tibial artery due to extensive necrotizing infection.
- **Electrocardiogram:** showed sinus tachycardia; inferior infarct; QRS duration decreased.
- **X-ray chest:** showed progressive hypoxia and pulmonary. Congestion; pulmonary vascular opacities which are seen with infection or edema. Another one was also done to check NG tube placement.
- **CV echo complete without contrast:** Due to abnormal ECG showing coronary artery disease, NSTEMI, and an ejection fraction of 39.7%.
- **US renal complete with bladder:** Showed acute kidney infection and ascites.
- **US abdomen limited (single organ or quad):** Showed increased trans aminases and trace periostitis ascites

Diagnostic Test Correlation (5 points):

A chest x-ray can show cardiac enlargement, pericardial effusion, inflammation, lung tumors, and pulmonary edema (Pagana et al., 2021). The results showed progressive hypoxia and pulmonary. Congestion; pulmonary vascular opacities which are seen with infection or edema. Another one was also done to check NG tube placement. An x-ray of the foot was also done showing extensive soft tissue air consistent with necrotizing infection. A CT is used to visualize and assess internal organs for anatomical features, abscesses, aneurysms, cancer, other masses, infection, or the presence of disease (Pagana et al., 2021). The client received a CT angio abdomen aorta with contrast. The test was ordered due to left foot pain, swelling, and no pulse, showing fatty liver; soft tissue edema distal right lower w/o soft tissue air; intra-arterial air in the left posterior tibial artery due to extensive necrotizing infection. Ultra sound is an imaging

method that uses sound waves to produce images of structures within your body (Pagana et al., 2021). The client received a renal complete with bladder ultra sound and a limited abdomen ultra sound both showing acute kidney infection and ascites.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). *Mosby's diagnostic & laboratory test reference* (15th ed.) Elsevier.

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

Home Medications (5 required)

Brand/Generic	**Albuterol (ProAir HFA)**	**Amlodipine (Norvasc)**	**Atorvastatin (Liptor)**	**Famotidine (Pepcid)**	**Cephalexin (Keflax)**
Dose	90 mcg	5 mg	80 mg	20 mg	500 mg
Frequency	q4h, PRN	Daily	Daily	BID	BID
Route	Inhale	PO	PO	PO	PO
Classification	Adrenergic; Bronchodilator	Antihypertensive; calcium channel blocker	HMG – CoA reductase inhibitor; Antihyper-lipidemic	Histamine receptor antagonist; Gastrointestinal agent	Anti-infectives; first gen cephalosporins
Mechanism of Action	Albuterol attaches to the receptors to stimulate the adenylate cyclase into ATP/CAMP. This will relax the bronchial	Inhibits the transport of calcium into myocardial and vascular smooth muscle cells.	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA to enhance LDL and	Blocks histamine receptors on parietal cells of the stomach to decrease production of gastric acid.	Bind to bacterial cell wall membrane causing cell death.

	smooth muscles		LDL breakdown.		
Reason Client Taking	Wheezing due to allergic reactions	HTN	Hyper-lipidemia	GERD	Left foot infection
Contraindications (2)	Hypersensitivity to albuterol or its components.	Hypersensitivity to amlodipine and hepatic impairment	Active hepatic disease and unexplained increase in transaminase levels.	Hypersensitivity to and should be reduced in patients with renal impairment.	Hypersensitivity to cephalosporins; severe hypersensitivity to penicillins
Side Effects/Adverse Reactions (2)	Bronchospasms and pulmonary edema	Headache; edema	Hypo-glycemia; hepatic failure	Diarrhea; thrombocytopenia	Seizures; vomiting
Nursing Considerations (2)	Administer medication in the second half of inhalation when the airways open wider. Use cautiously in patient with cardiac disorders and diabetes mellitus because albuterol can worsen these symptoms.	Monitor patient carefully; use caution in CHF (this patient was recently diagnosed with CHF).	Monitor liver function tests before and after the start of atorvastatin for liver dysfunction. Expect to hold atorvastatin of the client experienced myopathy or risk for predisposing renal failure.	Monitor for signs of improvement and monitor for signs of GI bleeding.	Monitor for signs of anaphylaxis; monitor bowel function
Key Nursing Assessment(s)/Lab(s) Prior to	Baseline lung assessment	Assess the patients BP and pulse.	Monitoring lipid panel	Assess for potential drug interaction.	History of penicillin allergy;

Administration	before and after administration to monitor for therapeutic effects.	Never should be given if the patient has low blood pressure.	before and after administering for therapeutic effects.		Renal function tests
Client Teaching needs (2)	Teach the client to shake the inhaler first prior to administration. Advise the client to wait at least 1 full minute before the next inhalation of the medication.	Avoid large amounts of grape juice. Change positions slowly to minimize orthostatic hypotension.	Advise the client that this medications of not a replacement and still should monitor diet (cholesterol). Teach the client that taking the drug at the same time each day will maintain its effects.	Take 15-30 minutes before meals; Encourage client to quit smoking as it interferes with the action of the medication.	Take with food if GI upset occurs; notify healthcare provider of diarrhea.

Hospital Medications (5 required)

Brand/Generic	**Vasopressin**	**Budesonide (Entocort)**	**Propofol (Diprovan)**	**Fentanyl (Sublimaze)**	**Lactulose (Enulose)**
Dose	20 units Premix: 100mL	0.5mg=2mL	6.4 mL/hr; 15mcg/kg/min	2.5mL/hr 50 mcg/hr	20g=30 mL
Frequency	Continuous	BID	Continuous	Continuous	Daily
Route	IV	Neb solution	IV	IV	NG tube
Classification	Hormones; antidiuretic hormone	Anti-inflammatories; corticosteroids	Sedative hypnotic; general anesthetic	Narcotic Analgesic; opioid	Laxatives; Osmotics

Mechanism of Action	Alters the permeability of the renal collecting ducts, allowing reabsorption of water. Directly stimulates musculature of GI tract.	Potent, locally acting anti-inflammatory and immune modifier. Decreases frequency/severity of asthma attacks.	Makes the space b/w the cells with chemicals that determines whether or not the message gets to the next nerve cell.	Binds with stereospecific receptors at many sites within the CNS	Lowers pH of the colon, which inhibits the diffusion of ammonia from the colon into the blood.
Reason Client Taking	Diabetes	Asthma	Mechanically ventilated	Pain relief	High ammonia levels
Contraindications (2)	Renal failure; hypersensitivity to pork	Hypersensitivity to budesonide; renal failure	Hypovolemia; allergy to soybeans, peanuts, eggs	Respiratory depression; renal impairment	Diabetes mellitus; prolonged use
Side Effects/Adverse Reactions (2)	Dizziness; paleness	Otitis media; abdominal pain	Seizures; dysrhythmias	Dehydration constipation	Diarrhea; Hyperglycemia
Nursing Considerations (2)	Weigh patient assess for edema; monitor for signs of MI	Assess muscle strength; observe for paradoxical bronchospasm.	Needs to be given continuously to maintain sedation; maintain patent airway	Monitor labs such ad AST and AL; monitor renal function	Assess for abdominal distention; Assess blood glucose
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess drug history	Assess pulmonary function	Assess heart rate, ECG, and heart sounds	Assess baseline pain and function.	Assess bowel sounds and function.
Client Teaching needs (2)	Report severe or prolonged fever; report GI problems	Advise patient not to exceed the recommended does; Teach how to properly use	Educate patient that this med will decrease mental	Educate that they may experience a dry	Don't take with other laxatives; Notify

	such as heartburn or diarrhea	inhaler techniques.	recall; may cause drowsiness	mouth; Report swelling of the limbs.	provider if diarrhea occurs

Medications Reference (1) (APA):

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

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is A&Ox1. Oriented to name. Patient shows no signs of distress. Patient seen in hospital gown with an overall good appearance.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 11 **Drains present:** **Y☐** **N ☒** **Type:**	Pink Dry, intact, and no moisture present. Warm to the touch on the clients anterior and posterior extremities bilaterally. Turgor less than three seconds and elastic. No rashes or bruises present. Left leg surgical incision presented with a dry dressing. Posterior showed little necrosis of the skin. There was pressure ulcers and necrosis of the skin on the patients gluteal.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical with no abnormalities and within normal range of motion. The thyroid was able to rise and fall when swallowing. No inflammation or drainage noted in the ears. Both left and right eyes were equal, round, and reactive to light. 3mm when comparing to the penlight. The sclera was white, and conjunctive was pink with no drainage noted. The nose was midline and symmetrical, with no drainage. Patient has all of her teeth

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	Patients heart sounds are normal. S1 and S2 noted. Patients heart rate is 91 bpm. Radial 2+ bilaterally and pedal pulses 1+ with doppler unilaterally. Capillary refill less than 3 seconds in the upper and lower extremities. Patient has no neck vein distention. 2+ pitting edema in right lower extremity.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** 7.5 mm **Placement (cm to lip):** 3.7 cm **Respiration rate:** 25 **FiO2:** 35 **Total volume (TV):** 360 **PEEP:** 8 **VAP prevention measures:**	The client had course crackles in the anterior and posterior upper and lower lobes bilaterally. Respirations were 25 bpm, nonlabored, and were equal. The client was not using accessory muscles when breathing. The client was mechanically ventilated. VAP prevention were oral care with hydrogen peroxide solution, head of bed was at 45 degrees, and oral suctioning every 2 hours.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** 156 cm **Weight:** 72.8 kg **Auscultation Bowel sounds:** **Last BM:** 2/7/23 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☒ N ☐** **Size:** 18 gauge **Feeding tubes/PEG tube Y ☒ N ☐** **Type:** Nepro 40mL/hr star: 10mL/hr q4h	Patient is on a regular diet at home. While at the hospital patient was NPO and receiving Nepro feedings 40mL/hr. The patient is 1565 cm tall and weighs 72.8kg. Bowel sounds were active and heard in all 4 quadrants. Patient had a fecal collection system in place. No pain, tenderness upon palpation. No distention, incisions, scars, drains, or wounds were noted.
GENITOURINARY: **Color:** **Character:**	Patient's urine is yellow with no foul odor. There is no pain upon urination. The patient has

Quantity of urine: **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** indwelling catheter **Size:** 14g French **CAUTI prevention measures:**	received one session of dialysis and does have a catheter inserted. Patient's genitalia show no sign of irritation.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 50 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	The client had normal strength (5/5) in her right extremities but cannot grasp things in her left hand. The client does not have active range of motion due to being ventilated. The client does not use any assistive / supportive devices. Client scored a 50 which is a severe fall risk.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient was alert and oriented x1. Unable to tell if patients thinking process fully intact. Unable to determine speech. Sensations was equal in all extremities bilaterally, lacks grip in hand on left side The client's LOC 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 watched TV to help cope and had frequent interactions with staff and occasional visitors. Religion is not known. Lives with nephew and is independent at home.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	91 bpm	135/76	24 rpm	36.7 C	98%

					ventilator
1200	97 bpm	109/73	30 rpm	36.4 C	98% ventilator

Vital Sign Trends/Correlation: The client's vital signs are stable and within normal ranges, except the patient's respirations. This is due to the patient being mechanically ventilated. The client should continue to be monitored for changes.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	FLACC	N/A	0	N/A	Patient is receiving continuous fentanyl for pain management.
1200	FLACC	N/A	0	N/A	Patient is receiving continuous fentanyl for pain management.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18g and 20 g **Location of IV:** Midline right upper arm and left peripheral **Date on IV**: Both dated 2/6/23 **Patency of IV:** No complications, flushes easily. **Signs of erythema, drainage, etc.:** There are no signs of erythema or drainage. **IV dressing assessment:** Dry, clean, and intact.	No fluids running. Both saline locked.
Other Lines (PICC, Port, central line, etc.)	

Type: Central line IV hemodialysis double catheter; Triple PICC **Size:** 16 cm; 20 cm **Location:** Right subclavian vein; left upper forearm **Date of insertion:** 1/31/23 for both **Patency:** No complications, flushes easily. **Signs of erythema, drainage, etc.:** There are no signs of erythema or drainage. **Dressing assessment:** Dry, clean, and intact. **Date on dressing: 1/31/23; 2/6/23** **CUROS caps in place: Y ☒ N ☐** **CLABSI prevention measures:**	Central line for hemodialysis: locked PICC line: Antibiotic therapy, hydration, lab draws, and other medications. CLABSI prevention measures consisted of dressing changes, caps were in place, and hand hygiene was performed before administering new meds.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
184 mL Nepro feeding **60 mL water** **30 mL lansoprazole** **10 mL lactate**	**1 loose stool by fecal collection system** **550 urine output**

Nursing Care

Summary of Care (2 points)

Overview of care: During my time with the patient, I was able to perform a head-tp-toe assessment and a bed change with my nurse.

Procedures/testing done: The patient has continuous EKG monitoring due to having previous arrhythmias. She also received a US of the abdomen and renal complete with bladder.

Complaints/Issues: Patient had no complaints.

Vital signs (stable/unstable): The clients vitals for the most part was stable and should be continuously be monitored. However, the client's respiration rate was increased but she showed no other signs of distress.

Tolerating diet, activity, etc.: The client seems to be tolerating her enteral feedings well, showing no signs or discomfort. Every two hours the nurse will come in the room to assess her wrist, remove restraints and perform arm exercises which she seemed to tolerate well.

Physician notifications: N/A

Future plans for client: Friday February 10th the patient are planning on going to surgery to remove the remaining left tibia and complete an above the knee amputation.

Discharge Planning (2 points)

Discharge location: Discharge planning has not been discussed at this time.

Home health needs (if applicable): Whenever the patient is discharged, she will need a home health nurse if she is not admitted to a rehabilitation center.

Equipment needs (if applicable): She will need a wheelchair, walker, and later down the road a prothesis.

Follow up plan: As of right now there is no follow up plan, just continuously monitoring the patient, preparing her for surgery.

Education needs: Whenever the patient is not sedated and is able to follow commands and verbalizes that she is ready to be taught, the patient should be taught about medication compliance, diabetes management, was to cope with an amputated limb, and ways to manage pain properly after a major surgery.

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

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client

priority – highest priority to lowest priority pertinent to this client				response, status of goals and outcomes, modifications to plan.
1. **Impaired physical mobility related to loss of limb as evidence by reluctant attempt to move.**	After the patient is able to move, she will be very weak	1. Provide stump care routinely. 2.Rewrap and elevate the stump.	1. Client will maintain a position of function.	These interventions cannot be meet as the patient is still is critical condition. Nurses will continue to monitor the site.
2. **Risk for infection related to broken skin as evidence by incomplete surgery.**	Surgeons were unable to complete surgery due to the patient crashing, leaving an open area at risk for infection.	1. Clean wounds daily, inspecting the dressing and open area. 2.Monitor vital signs.	1. Client will achieve timely wound healing.	Nurses are performing dressing changes daily and monitoring vitals continuously.
3. **Risk for disturbed sensory perception related to left foot infection as evidence by patient not realizing how she hurt her foot.**	The patient's family stated that she was unaware that hurt her foot which is why she waited so long to receive treatment.	1.Maintain blood glucose within normal range. 2.Monitor vital signs	1. Client will recognize and compensate for existing sensory impairments.	Since being admitted patient has maintained normal blood glucose levels and vitals are within normal limits.
4. **Risk for ineffective tissue perfusion related to reduced blood flow as evidence by necrosis of the skin.**	The skin around the bone is slowly starting to die due to lack of blood flow.	1. Evaluate the right side for inflammation and diabetic changes. 2. Monitor PT and a PTT.	1. The client will maintain adequate tissue perfusion keeping the skin warm and dry, promoting wound healing.	Patient will show decreased symptoms of necrosis and will maintain adequate perfusion in the right leg.
5. **Deficient**	Patient was	1.Assess	1. Before	Due to the

knowledge related to noncompliance as evidence by development of preventable complications.	not controlling her diabetes which lead to the infection and necrosis of her foot.	patients' readiness to learn. 2.Assess patients' fears and concerns of about diabetes.	discharge patient will demonstrate a knowledge of insulin injection, symptoms, and treatment of hypoglycemia.	severity of the patient's condition, the patient is not ready to learn but nurses will continue to monitor glucose levels.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient came in for left lower foot pain and bad smell.
Patient is a former smoker, does not drinker and uses marijuana.
The client has necrosis behind the incision site of the left knee.

Nursing Diagnosis/Outcomes

Impaired physical mobility related to loss of limb as evidence by reluctant attempt to move.

- These interventions cannot be meet as the patient is still is critical condition. Nurses will continue to monitor the site.

Risk for infection related to broken skin as evidence by incomplete surgery.

- Nurses are performing dressing changes daily and monitoring vitals continuously.

Risk for disturbed sensory perception related to left foot infection as evidence by patient not realizing how she hurt her foot.

- Since being admitted patient has maintained normal blood glucose levels and vitals are within normal limits.

Risk for ineffective tissue perfusion related to reduced blood flow as evidence by necrosis of the skin.

- Patient will show decreased symptoms of necrosis and will maintain adequate perfusion in the right leg.

Deficient knowledge related to noncompliance as evidence by development of preventable complications.

- Due to the severity of the patient's condition, the patient is not ready to learn but nurses will continue to monitor glucose levels.

Objective Data

- Electrocardiogram: showed sinus tachycardia; inferior infarct; QRS duration decreased.
- XR chest: showed progressive hypoxia and pulmonary. Congestion; pulmonary vascular opacities which are seen with infection or edema.
- Client is taking Lactulose for increased ammonia levels.

Client Information

Client is a 66-year-old Caucasian female with a history of hypertension, GERD, COPD, CAD, PAD, and hyperlipidemia. Admitted to care due to lower left extremity pain and smell. Denied SOB or nausea Client lives at home with nephew.

Nursing Interventions

1. Provide stump care routinely.
2. Rewrap and elevate the stump
3. Clean wounds daily, inspecting the dressing and open area.
4. Monitor vital signs
5. Maintain blood glucose within normal range.
6. Monitor vital signs
7. Evaluate the right side for inflammation and diabetic changes.
8. Monitor PT and a PTT.
9. Assess patients' readiness to learn.
10. Assess patients' fears and concerns of about diabetes.