N441 Care Plan

Lakeview College of Nursing

Name

Shivani Patel

Your Name Here

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
2/2/23	T.M.M	53 yrs. old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Disability	Single	None
Code Status	**Height**	**Weight**	
Full code	172.7 cm	73.8 kg	

Medical History (5 Points)

Past Medical History: ESRD, anemia of CKD, insulin-dependent diabetes mellitus, hypertension, bilateral foot drops, right heel ulcer

Past Surgical History: C-section, laser surgery to the eye, EGD, insertion hemodialysis catheter, wound debridement of right heel, AV fistula placement of right

Family History: Hypertension in mother

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Cigarette use: quarter pack of cigarettes per day. The patient did not remember the duration of cigarette use.

Assistive Devices: Wheelchair

Living Situation: Lives at home

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): The patient came into the ED with pain and swelling of the right foot

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

The patient stated their pain on the right foot began last week. The pain was mainly located on the right heel of her foot. The pain lasted for about a week and is constant. The patient describes

the pain as “sharp and stabbing”. The pain does not radiate anywhere else to the body. The right heel has become darker, and the area is foul smelling. The patient stated that she is also experiencing swelling and fever along with pain. The pain increases when she moves around too much, and the pain is relieved with bedrest. In the ED, she was given IV vancomycin, cefepime, and flagyl to lessen the symptoms. The patient has a history of end stage renal disease. She did not seek treatment for her right foot pain prior to admission to the ED. Upon further examination, a Ct scan of the right lower extremity reveals evidence of necrotizing fasciitis of the lower leg. Currently, the patient states their pain is a 9 on a scale of 1 to 10.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Necrotizing fasciitis of the lower leg

Secondary Diagnosis (if applicable): N/A

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

Necrotizing fasciitis is classified as the rapid spread of infection in the subcutaneous tissue. IT commonly affects the lower extremities. The overlying skin will initially appear unaffected, but it will transition to a reddish-purple or bluish-gray color. The texture of the skin becomes swollen and warm to touch (Desta & Yee, 2020). Skin breakdowns begin in 3 to 5 days and is accompanied by severe pain (Capriotti, 2020). Anaerobic bacteria is spread with subcutaneous tissues and deep fascial planes that cause tissue necrosis. Necrotizing fasciitis is accompanied by fever, tachycardia, sepsis, swollen area, and severe pain. Lab findings include positive blood culture, elevated inflammatory markers, elevated serum creatinine, and leukocytosis (Capriotti, 2020). Diagnostic tests for necrotic fasciitis include performing a biopsy, looking at bloodwork for signs of infection, CT scans, and MRI. A CT scan of the right lower extremity was performed

on the patient to reveal evidence of necrotic fasciitis (Desta & Yee, 2020). The patient's high WBC and neutrophil count indicated they have an infection from necrotic fasciitis. Antibiotic therapy helps to stop the spread of infection. Examples of antibiotics include vancomycin and clindamycin. Also, penicillin's help stop the growth of bacteria. The primary treatment for necrotic fasciitis includes surgery (Capriotti, 2020). Surgery options include amputation of skin grafting. The patient was taken to surgery for the debridement of the right heel. They needed to do an amputation on the patient to prevent further spread of infection.

Pathophysiology References (2) (APA):

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

Desta, R., & Yee, J. (2020). Necrotizing fasciitis. *Journal of Education and Teaching in Emergency Medicine*, *5*(2), 1-10.

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	3.80-5.30	2.21	3.52	Low RBC indicate kidney problems. The patient has a history of end stage renal disease (Pagana et al., 2019).
Hgb	12.0-15.8	6.3	9.7	Low Hgb indicates a low red blood cell count which indicates kidney problems (Pagana et al., 2019).
Hct	36.0-47.0%	19.5	30.1	Low Hct indicates an insufficient supply of red blood cells (Pagana et al., 2019).

Platelets	140-440	294	381	
WBC	4.00-12.00	13.00	20.40	High WBC can indicate an infection. Necrotic fasciitis is an infection that caused the patient to get a fever (Pagana et al., 2019).
Neutrophils	47.0-73.0%	92.7	86.9	High levels indicate an infection from necrotic fasciitis (Pagana et al., 2019).
Lymphocytes	18.0-42.0%	4.7	5.7	Low levels indicate a high risk for infection from the necrotic fasciitis (Pagana et al., 2019).
Monocytes	4.0-12.0%	2.1	5.0	Low levels the body is more susceptible to infection (Pagana et al., 2019).
Eosinophils	0.0-5.0%	0.1	1.3	
Bands	Less than or equal to 10%	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-	136-145	129	135	Low levels indicate kidneys are not functioning normally. The cause of this is because the patient has end stage renal disease (Pagana et al., 2019).
K+	3.5-5.1	4.0	4.6	
Cl-	98-107	94	97	Low levels indicate kidney disease. Kidneys maintain the body's total chloride levels (Pagana et al., 2019).
CO2	22-30	22	23	
Glucose	70-99	565	394	The patient has hyperglycemia. The patient is an insulin-dependent diabetic (Pagana et al., 2019).
BUN	10-20	33	29	High levels of BUN indicate the kidneys aren't working well due to renal disease (Pagana et al., 2019).
Creatinine	0.60-1.00	4.04	4.23	The patient has poor kidney function due to renal disease (Pagana et al., 2019).

Albumin	3.4-4.8	N/A	2.8	Low albumin levels are a sign of kidney disease (Pagana et al., 2019).
Calcium	8.9-10.6	N/A	8.5	Indicates that vitamin D is low because the patient has kidney failure (Pagana et al., 2019).
Mag	1.6-2.6	N/A	N/A	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0.2-1.2	0.5	0.3	
Alk Phos	40-150	237	239	Levels are high in patients with chronic kidney disease (Pagana et al., 2019).
AST	5-34	N/A	15	
ALT	0-55	N/A	15	
Amylase	40-140	N/A	N/A	
Lipase	8-78	N/A	N/A	
Lactic Acid	0.7-2.0	1.0	N/A	
Troponin	0-0.04	N/A	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	0.9-1.1	N/A	N/A	
PT	11.7-13.8	N/A	N/A	
PTT	22.4-35.9	N/A	N/A	

D-Dimer	Less than 0.5	N/A	N/A	
BNP	Less than 100	N/A	N/A	
HDL	45-70	N/A	N/A	
LDL	Less than 100	N/A	N/A	
Cholesterol	Less than 200	N/A	N/A	
Triglycerides	Less than 150	N/A	N/A	
Hgb A1c	Less than 5.7%	N/A	N/A	
TSH	0.5-5.0	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-yellow	Dark yellow/cloudy	N/A	The patient is experiencing dehydration (Pagana et al., 2019).
pH	5.0-9.0	7.5	N/A	
Specific Gravity	1.003-1.030	1.019	N/A	
Glucose	Neg	Neg	N/A	
Protein	Neg	4+	N/A	The kidneys are damaged due to end-stage renal disease (Pagana et al., 2019).
Ketones	Neg	Trace	N/A	Can indicate diabetic ketoacidosis (Pagana et al., 2019).
WBC	0-25	11-20	N/A	
RBC	0-20	3-5	N/A	
Leukoesterase	Neg	N/A	N/A	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	N/A	N/A	
PaO2	80-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22.0-26.0	N/A	N/A	
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	Neg	>100,000	N/A	The patient has staphylococcus epidermidis caused by necrotic fasciitis (Pagana et al., 2019).
Blood Culture	No growth	No growth	N/A	
Sputum Culture	Neg	N/A	N/A	
Stool Culture	Neg	N/A	N/A	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana T. N. (2019). *Mosby's diagnostic and laboratory desk reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT of the right lower leg without contrast was performed on the patient. A CT of the lower legs is a diagnostic imaging test that shows an abscess or infection. The CT helps to explain the cause of pain of other problems in the foot. The CT is an exam that takes 2-5mm images of a specific portion of the leg.

Diagnostic Test Correlation (5 points): The CT indicated a soft tissue infection of the lower leg on the right side. There was evidence of necrotic fasciitis of the lower right leg.

Diagnostic Test Reference (1) (APA):

Lahham, S., Shniter, I., Desai, M., Andary, R., Saadat, S., Fox, J. C., & Pierce, S. (2022). Point of care ultrasound in the diagnosis of necrotizing fasciitis. *The American Journal of Emergency Medicine*, *51*(1), 397-400.

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

Home Medications (5 required)

Brand/ Generic	Eliquis/ Apixaban	Carvedilol/ Coreg	Amlodipine/ Norvasc	Acetaminophen/ Tylenol	Atorvastatin/ Lipitor
Dose	5 mg	6.25 mg	5 mg	325 mg	10 mg
Frequency	Twice daily	Twice daily	Once daily	Every 4 hrs. PRN	Once daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacologic class: Factor Xa inhibitor Therapeutic class: Anticoagulant	Pharmacologic class: Nonselective beta blocker and alpha-1 blocker Therapeutic class: Antihypertensive, heart failure treatment adjunct	Pharmacologic class: Calcium channel blocker Therapeutic class: Antianginal, antihypertensive	Pharmacologic class: Nonsalicylate, para-aminophenol derivative Therapeutic class: Antipyretic, nonopioid analgesic	Pharmacologic class: HMG-CoA reductase inhibitor Therapeutic class: Antihyperlipidemic
Mechanism of Action	Inhibits free and clot-bound factor Xa and prothrombinase activity. Although apixaban has no direct effect on platelet aggregation, it does indirectly inhibit platelet	Reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload.	It binds to dihydropyridine and nondihy-dropyridine cell membrane receptor sites on myocardial and vascular smooth-muscle cells and inhibits influx of extracellular calcium ions across slow calcium	It inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus.	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors.

	aggregation induced by thrombin.		channels. This decreases intracellular calcium level, inhibiting smooth-muscle cell contractions and relaxing coronary and vascular smooth muscles, decreasing peripheral vascular resistance, and reducing systolic and diastolic blood pressure.		
Reason Client Taking	Prevents DVT	Controls hypertension	Controls hypertension	Relieves mild to moderate pain	It helps to control lipid levels
Contraindications (2)	-Active pathological bleeding -Severe hypersensitivity to apixaban or its components	-Bronchial asthma or related bronchospastic conditions - Cardiogenic shock	- Hypersensitivity to amlodipine or its components - Cardiogenic shock	- Hypersensitivity to acetaminophen or its components -Severe hepatic impairment	-Active hepatic disease - Hypersensitivity to atorvastatin or its components
Side Effects/Adverse Reactions (2)	- Hemorrhagic stroke - Hypotension	-Aplastic anemia -Dyspnea	-Anxiety -Weight loss	-Hypotension -Fatigue	-Arrhythmias - Hyperglycemia
Nursing Considerations (2)	-Crush tablet and mix with	-Use carvedilol cautiously	-Use amlodipine cautiously in	- Use acetaminophen cautiously in	-Be aware that atorvastatin

	apple juice or water or put in applesauce and administer immediately for patient unable to swallow whole tablets. -Know that apixaban should not be given to patients with severe hepatic dysfunction. Drug should also not be given to patient with triple positive antiphospholipid syndrome.	in patients with peripheral vascular disease because it may aggravate symptoms of arterial insufficiency. -Monitor patient's blood glucose level, as ordered, during carvedilol therapy because drug may alter blood glucose level.	patients with heart block, heart failure, impaired renal function, hepatic disorder, or severe aortic stenosis. -Monitor blood pressure while adjusting dosage, especially in patients with heart failure or severe aortic stenosis because symptomatic hypotension may occur.	patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment. - Monitor renal function in patient on long-term therapy. Keep in mind that blood or albumin in urine may indicate nephritis.	may be used with colestipol or cholestyramine for additive antihyperlipidemic effects. -Use atorvastatin cautiously in patients who consume substantial quantities of alcohol or have a history of liver disease because atorvastatin use increases risk of liver dysfunction.
Key Nursing Assessment(s) /Lab(s) Prior to Administration	-Assess patient for symptoms of stroke	-Assess patient for dyspnea	-Assess blood pressure prior to administration	-Assess for any allergies to acetaminophen	-Monitor liver function tests
Client Teaching needs (2)	-Tell patient unable to swallow whole tablets to crush tablet and mix with apple	-Alert patient with diabetes to monitor his glycemic control closely because drug may	-Tell patient to take missed dose as soon as remembered and next dose in 24 hours. -Tell patient to	- Tell patient that tablets may be crushed or swallowed whole. - Inform patient that acetaminophen may cause	-Tell patient to take drug at the same time each day to maintain its effects. -Instruct patient to

	juice or water or mix with applesauce and take immediately. -Tell patient not to stop taking apixaban without first consulting prescriber.	increase blood glucose level or mask symptoms of hypoglycemia. -Warn patient that drug may cause dizziness, light-headedness, and orthostatic hypotension; advise him to take precautions.	immediately notify prescriber of dizziness, arm or leg swelling, difficulty breathing, hives, or rash.	reduced fertility in both females and males.	take a missed dose as soon as possible. If it's almost time for his next dose, he should skip the missed dose. Instruct not to double the dose.

Hospital Medications (5 required)

Brand/Generic	Ceftriaxone/ Rocephin	Metronidazole / Flagyl	Pantoprazole/ Protonix	Heparin/Hep-Lock	
Dose	2 g	500 mg	40 mg	5000 u	
Frequency	Once daily	Every 8 hours	Once daily	Every 8 hours	
Route	IV	Oral	Oral	Subcutaneous	
Classification	Pharmacologic class: Third-generation cephalosporin Therapeutic	Pharmacologic class: Nitroimidazole Therapeutic class:	Pharmacologic class: Proton pump inhibitor Therapeutic class: Antiulcer	Pharmacological class: Anticoagulant Therapeutic class:	

	class: Antibiotic	Antiprotozoal		Anticoagulant	
Mechanism of Action	Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan strands. Peptidoglycan makes the cell membrane rigid and protective.	Undergoes intracellular chemical reduction during anaerobic metabolism. After metronidazole is reduced, it damages DNA's helical structure and breaks its strands	It irreversibly inhibits the final step in gastric acid production by blocking the exchange of intracellular H+ and extracellular K+, thus preventing H+ from entering the stomach and additional HCl from forming.	Heparin binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin. At high doses, heparin inactivates thrombin, and prevents fibrin formation and existing clot extension	
Reason Client Taking	Helps treat bacterial infections	Treats skin infections and pelvic inflammatory disease	Treats heartburn	It prevents blood clotting	
Contraindications (2)	- Hypersensitivity to ceftriaxone - Hypersensitivity to penicillin	- Hypersensitivity to metronidazole - Hypersensitvity nitroimidazole derivatives, or their components	- Concurrent therapy with rilpivirine-containing products - Hypersensitivity to pantoprazole	-Heparin-induced thrombocytopenia - Hypersensitivity to heparin	
Side Effects/Adverse Reactions (2)	-Chills -Fever	-Use of disulfiram within past two weeks	-Chest pain -Abdominal pain	-Chest pain -Epistaxis	
Nursing Considerations (2)	-Obtain culture and sensitivity results, if possible and as ordered,	-Monitor patient with severe liver disease because	- Administer delayed-release oral suspension 30 minutes before a meal	-Use heparin cautiously in alcoholics; menstruating women; patients	

	before giving drug. -Assess for arthralgia, bleeding, ecchymosis, and pharyngitis; they may indicate a blood dyscrasia.	slowed metronidazole metabolism may cause drug to accumulate in body and increase the risk of adverse effects. -Use cautiously in patients with blood dyscrasias or a history of such because metronidazole therapy has caused agranulocytosis, leukopenia, and neutropenia in some patients.	mixed in apple juice or applesauce. - Be aware that if therapy lasts more than 3 years, patient may not be able to absorb vitamin B12 because of achlorhydria or hypochlorhydria.	over age 60 and patients with conditions that increase risk of hemorrhage. -Read heparin label carefully. Revision has been made to state the strength of the entire container of heparin.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Monitor respiratory status	-Monitor liver enzymes	-Assess respiratory status	-Assess the patient's hemoglobin, hematocrit, platelet count, aPTT, and PT levels	
Client Teaching needs (2)	-Tell patient to report evidence of blood dyscrasia or superinfection to prescriber immediately. -Advise patient to report any hypersensitivity reactions, such as a rash,	-Caution patient to avoid alcohol during therapy and for at least 3 days. afterward. -Urge patient to follow up with prescriber to make sure infection is gone.	- Advise the patient who takes warfarin to follow bleeding precautions and to notify prescriber immediately if bleeding occurs. - Instruct patient to notify	-Advise patient to avoid drugs that interact with heparin, such as aspirin and ibuprofen. -Inform patient about increased risk of bleeding; urge her to avoid injuries and use a soft-bristled toothbrush and	

	itching skin, or hives, to prescriber immediately and to stop taking the drug.		prescriber if diarrhea occurs and becomes prolonged or severe.	an electric razor.	

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:**	The patient is alert and oriented The patient seems mildly distressed Pt well dressed in clean gown Pt's skin, hair, nails clean and well maintained
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 14** **Drains present: Y☐ N ☒** **Type: Closed-suction drain**	Skin color: White Character: Skin is warm and dry upon palpation Temperature: Taken orally and was 97.9 F Turgor: Skin has normal turgor Pt has visible bruising on right leg Normal quantity, distribution, and texture of hair Braden score: 14 There is a drain present
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head/Neck: Head and neck are symmetrical. Normocephalic and atraumatic. Oropharynx clear, mucosa moist. No cervical lymphadenopathy, normal range of motion, no rigidity. Ears: Left/right external ear normal. No loss of hearing, grossly intact. Eyes: No visible drainage from eyes, the bilateral sclera is white, the bilateral cornea is clear, bilateral conjunctiva is pink. Bilateral lids are moist and pink without any discharge -Eyes are symmetrical in appearance Extraocular movements: Extraocular movements intact Conjunctiva/sclera: conjunctivae normal Pupils: pupils are equal, round, reactive to light Nose: Septum is midline and no visible bleeding from nose Teeth: Did not notice plaque or tartar. Teeth are white and somewhat aligned with gums. The mucous membrane is moist .

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:**	Regular tachycardic rate/rhythm, normal heart sounds, no murmur Clear S1 and S2 without any murmurs Peripheral pulse: 3+ Capillary refill: 2 seconds No edema or neck vein distention
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	No accessory muscle use Breath sounds: normal breath sounds. Equal and clear bilaterally Effort: pulmonary effort is normal. No respiratory distress Regular depth and pattern; nonlabored breathing; expansion symmetrical; no retractions No cough, rhonchi, crackles, or wheezing The patient is not receiving oxygen The patient does not have an ET tube in place
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:**	Diet at home: diabetic Current diet: diabetic Height: 172.7 cm Weight: 73.8 kg Bowel sounds: normoactive Last BM: 2/1/23 Upon palpation there is no pain and no abdominal mass present. The abdomen is soft Tenderness: There is no abdominal tenderness. There is no guarding or rebound tenderness Inspection: Distention- none Incisions- the patient has an incision from the amputation of the right leg Scars- the patient has slight scarring from the incision on the right leg Drains: yes Wounds: small wound on right leg There are staples on the right leg There is swelling and sanguineous drainage with clots on the amputated leg No ostomy, nasogastric, or feeding tubes

GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type: External** **Size: 12F** **CAUTI prevention measures:**	Color: Dark yellow Character: Cloudy Quantity of urine: 500 mL No pain with urination The patient gets hemodialysis done 3 days a week Genitals appear to be normal The patient has a catheter CAUTI prevention measures: handwashing, catheter care, keeping drain clean
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) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Neurovascular status: abnormal Swelling on right leg. Limited range of motion (left knee range of motion decreased. No CVA tenderness Cervical back- limited range of motion Strength: Patient noticeably weak Supportive devices: wheelchair ADL assistance: yes (bathing) Fall risk: yes Fall risk score: 15 Mobility status: patient not able to move freely without equipment. Pt dependent. Needs assistance when standing or walking. Patient restricted from ambulating. Currently on bedrest
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is alert and oriented x4. Orientation, mental status, speech, sensory are all within normal limits. Strength is not equal in all extremities. Does not move all extremities well. Patient has weak left/right dorsiflexion and weak left/right plantar flexion. Weakness in arms and legs Cranial nerves grossly intact, speech clear PERRLA: yes, normal pupil accommodation Sensory: normal sensation
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):**	Coping method: resting, smartphone, television Developmental level: developmental status appropriate for age Patient is calm and cooperative. The patient is also accepting and participates in care. Behavior is appropriate to the situation. The patient does not state that they are religious. The patient has minimal family support and lives by herself at home.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
9:00	79	163/59	14	97.9F(oral)	99%
12:01	71	145/66	14	98.7F(oral)	100%

Vital Sign Trends/Correlation:

The patients' blood pressure and pulse have decreased. Though, the blood pressure continues to remain elevated.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:00	1-10	Right heel	0	N/A	N/A
12:01	1-10	Right heel	9	"Sharp and stabbing"	Acetaminophen

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:**	Size of IV: 20 G Location of IV: Right middle arm Date on IV: 2/3/23 Patency of IV: open Signs of erythema, drainage, etc.: no signs IV dressing assessment: dry and intact
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:**	Type: Arteriovenous graft Size: 6 mm Location: Right upper arm Date of insertion: 11/29/2022

Patency: **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☒ N ☐** **CLABSI prevention measures:**	Patency: Bruit and thrill present Signs of erythema, drainage, etc.: no signs IV dressing assessment: dry and intact Date on dressing: 2/6/23 CLABSI prevention measures: -Changing dressing every 2 days -Using chlorhexidine for skin prepping -Hand hygiene -Using sterile technique

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
Oral liquids: 120 mL (water)	Urine: 500 mL Drain: 100 mL

Nursing Care

Summary of Care (2 points)

Overview of care: The patient is diagnosed with necrotic fasciitis. The patient is calm and cooperative. The patient's labs are monitored daily.

Procedures/testing done: CT of right lower leg

Complaints/Issues: There are no complaints or issues

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Patient noticeably weak. Unable to tolerate activity

Physician notifications: N/A

Future plans for client: Continue treating renal disease and glucose levels

Discharge Planning (2 points)

Discharge location: Undetermined

Home health needs (if applicable): N/A

Equipment needs (if applicable): Wheelchair

Follow up plan: There is currently no follow-up plan in place

Education needs: Signs and symptoms to look out for including fever, rapid pulse, nausea, and increased pain. Notify the provider if glucose levels don't stabilize. Along with that, educate the patient on the important of receiving adequate fluid and food intake to minimize fatigue and weakness. It is important to educate to the patient on ways to manage their renal disease. Most importantly, the patient should monitor for swelling or excessive drainage from their incision site.

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 infection related to a WBC count of 20.40 as evidenced by necrotic fasciitis	The patient's WBC count is significantly high. A high WBC can put the patient at risk for infection. The normal range	1.Educate the patient on the importance of hand hygiene. Educate the patient to limit touching multiple surfaces.	1. The client will remain free of infection, as evidenced by normal vital signs and a normal WBC count. Ensure the patient is washing their	The client was understanding when they were instructed to consume protein-rich foods. They also knew to maintain proper hand hygiene

	for WBC count is 4.00-12.00.	2. Encourage the intake of protein-rich and calorie-rich foods and encourage a balanced diet when off liquid diet. Encourage the patient to drink more fluids.	hands after going to the bathroom. Continue to encourage intake or protein and calorie-rich foods when off liquid diet.	while at the hospital. They were aware that their vital signs will be checked frequently to assess for any changes.
2. Risk for decreased cardiac output related to a high BUN evidenced by a blood pressure reading of 163/59	The patient's blood pressure levels remained high throughout the hospitalization which can affect the patient's cardiac output.	1. Auscultate the patient's heart tones and breath sounds frequently. 2. Monitor the patient's vital signs every hour to assess if treatment is working to control blood pressure levels.	1. Continue to give the patient their blood pressure medications in the correct dose and frequency. The patient's cardiovascular status will continue to be monitored.	The patient was aware of all the blood pressure medications he was given. The patient agreed to do continuous monitoring of their blood pressure at home. They were instructed to take their medications in a timely manner and notify the provider if there is a drastic increase in blood pressure.
3. Risk for ineffective tissue perfusion related to right leg amputation as evidenced by necrotic fasciitis	The patient had an amputation of the right leg. This can cause ineffective tissue perfusion due to inadequate circulation of blood.	1. It is important to perform periodic neurovascular assessments. 2 The nurse should inspect dressings and drainage devices,	1. The goal is to prevent the risk for ineffective tissue perfusion. Monitoring drainage and doing regular neurovascular assessments can help to act in a timely manner and improve circulation. The	The client was cooperative and understanding they will need to get frequent neurovascular checks done. The patient was also aware that they need to inform the nurse if they experience severe pain, excessive

		noting the amount and characteristics of the drainage.	nurse will perform neurovascular checks and assess the dressing every 2 hours.	drainage, and swelling from the incision site.
4. Risk for fatigue related to lower leg pain secondary to necrotizing fasciitis as evidenced by generalized weakness	The patient came into the ED with severe pain of the right leg. This causes the patient to experience weakness. After the amputation, the patient has been experiencing more weakness.	1.The patient will be recommended to maintain as much bed rest as possible. 2. The patient will be given their pain meds in a timely manner, and if the patient needs more, they will be informed to press the call light.	1. The goal is reduced fatigue by administering pain meds in a timely manner. Continue to assess the patient's pain throughout the day. Staff will ensure the call light is always placed next to the patient.	The patient did well with understanding that they will need to press the call light when they need something. They are also aware that they will need to report their pain level frequently throughout the day.
5. Risk for fluid volume deficit related to inadequate fluid intake as evidenced by high blood glucose level	After admission, the patient's lab indicated a blood glucose level of 565.	1. Assess the client's skin turgor and mucous membranes for signs of dehydration. **2.** Provide the client with adequate fluids throughout the day.	1. Continue to monitor the patient's fluid intake frequently. Continue to assess the patient's blood glucose levels to see any changes.	The patient is aware that they will have their blood glucose levels checked frequently. They will be expected to tell the nurse how much fluid they had throughout the day. The nurse will be expected to document the patient's fluid intake. They will monitor for any signs of hyperglycemia and notify the nurse immediately.

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Upon admission to the ED, the patient's pain level was a 9 on a scale of 1 to 10. The patient described the pain as "sharp and stabbing". The patient also experienced fever and swelling along with the pain.

Nursing Diagnosis/Outcomes

1. Risk for infection related to a WBC count of 20.40 as evidenced by necrotic fasciitis
   - The client will remain free of infection, as evidenced by normal vital signs and a normal WBC count. Ensure the patient is washing their hands after going to the bathroom. Continue to encourage intake or protein and calorie-rich foods when off liquid diet.
2. Risk for decreased cardiac output related to a high BUN evidenced by a blood pressure reading of 163/59
   - Continue to give the patient their blood pressure medications in the correct dose and frequency. The patient's cardiovascular status will continue to be monitored.
3. Risk for ineffective tissue perfusion related to right leg amputation as evidenced by necrotic fasciitis
   - The goal is to prevent the risk for ineffective tissue perfusion. Monitoring drainage and doing regular neurovascular assessments can help to act in a timely manner and improve circulation. The nurse will perform neurovascular checks and assess the dressing every 2 hours.
4. Fatigue related to lower leg pain secondary to necrotizing fasciitis as

Objective Data

The CT scan showed a soft tissue infection indicating necrotic fasciitis of the right lower leg.

Pulse: 79
Blood pressure: 163/59
Respiratory rate: 14
Temperature: 97.9F (oral)
Oxygen: 99%

Client Information

T.M.M
53 yrs. old
White
Disability
Single
Allergies: N/A
Full code
172.7 cm
73.9kg

Nursing Interventions

Risk for infection
1. Educate the patient on the importance of hand hygiene. Educate the patient to limit touching multiple surfaces.
2. Encourage the intake of protein-rich and calorie-rich foods and encourage a balanced diet when off liquid diet. Encourage the patient to drink more fluids.

Risk for decreased cardiac output
1. Auscultate the patient's heart tones and breath sounds frequently.
2. Monitor the patient's vital signs every hour to assess if treatment is working to control blood pressure levels.

Risk for ineffective tissue perfusion
1. It is important to perform periodic neurovascular assessments.
2 The nurse should inspect dressings and drainage devices, noting the amount and characteristics of the drainage.

Risk for fatigue
1.The patient will be recommended to maintain as much bed rest as possible.
2. The patient will be given their pain meds in a timely manner, and if the patient needs more, they will be informed to press the call light.

Risk for fluid volume deficit
1. Assess the client's skin turgor and mucous membranes for signs of dehydration.
2. Provide the client with adequate fluids throughout the day.