

N431 Care Plan #

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N431: Adult Health II

Professor Unrein

09-28-2023

Demographics (3 points)

Date of Admission 09-16-2023	Client Initials J.K	Age 71 years-old	Gender Female
Race/Ethnicity White	Occupation Retired	Marital Status Divorced	Allergies No Known Allergies
Code Status Full Status	Height 5'4	Weight 128 lbs.	

Medical History (5 Points)

Past Medical History: hyponatremia, hyperlipidemia, osteoporosis, breast cancer.

Past Surgical History: patient has no known surgical history.

Family History: patient has no known family history.

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

The patient reported the use of smokeless tobacco. Patient report drinking in the past but doesn't drink now. Patient reports never using drugs.

Assistive Devices: Patient uses a walker.

Living Situation: Patient is waiting on placement at a nursing facility.

Education Level: patient graduated high school and never attended college.

Admission Assessment

Chief Complaint (2 points): Patient presented with slurred speech and altered mental status.

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

A female patient, 71, was admitted from Lincoln Memorial Hospital after complaining of mental instability and presenting with a medical history of hyponatremia, hyperlipidemia, osteoporosis, and breast cancer. According to reports, the woman said she was not feeling well and throwing up. The patient awoke this morning at 7:00 a.m. and could speak properly. She took her pills.

She dialed EMS because she had slurred speech. The patient had tremors in both upper extremities and was confused. The person was last known on September 16, 2023, at 7:00 a.m. When the patient arrived at the Lincoln Memorial, she had hypoglycemia; her blood sugar was 53. She was given D50. According to the notes, the patient had an NIHSS of 3 when they arrived, but after administering dextrose, all of their symptoms except for disorientation improved. At 92% on room air, the patient's blood pressure was 144/72. Magnesium 1.3, chloride 79, and sodium 115 were found in the lab work, but urine sodium studies did not return results after being provided. The patient had a 1 L bolus of IVF, and a negative brain scan using 2 G of magnesium sulfate. On D10, the patient was transported to Carle Foundation Hospital at a rate of 75 mL/hour. The patient now denies experiencing any nausea, diarrhea, fever, stomach pain, or chest pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Symptomatic hyponatremia.

Secondary Diagnosis (if applicable): Patient has no known secondary diagnosis.

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

The primary diagnosis of patient J.K., is symptomatic hyponatremia. (Cleveland Clinic, 2022) states that hyponatremia is a condition in which the sodium level in the blood is lower than usual. The leading cause of this illness is an excessive amount of water in the body, which dilutes the sodium level and causes the water to flow into body cells, causing them to enlarge. A mental shift could result from the swelling. In addition to a mental state shift, the patient currently suffers from low sodium levels. Kidney failure, congestive heart failure, and liver, brain, or lung ailments, among other conditions, are risk factors for hyponatremia. Cleveland Clinic; the year 2022. (Cleveland Clinic, 2022) lists headache, nausea, vomiting, weakness or

cramping in the muscles, low energy, and changes in mental status as signs and symptoms of hyponatremia. Hyponatremia is the cause of the patient's altered mental state and low energy. Medical professionals can rule out hyponatremia by requesting a complete blood count and urine tests. They may also inquire about the patient's use of prescribed medications and alcohol (Mayo Clinic, 2022). Her sodium levels were exceedingly low, along with those of many other electrolytes, and the patient also underwent a chest x-ray to rule out a chest infection, as hyponatremia can be connected to chest infections. Additionally, the patient had a urinalysis, and the results revealed abnormal levels suggesting hyponatremia. According to (Mayo Clinic, 2022), the treatment for hyponatremia includes reducing fluid intake, giving intravenous fluids to the patient so that the sodium levels in the blood slowly rise, routine monitoring to ensure that the sodium levels are not rising quickly, and giving medications to help with the relief of signs and symptoms of hyponatremia, such as nausea, headaches, and potential seizures. The patient receives IV fluids to boost her sodium levels gradually, undergoes daily lab checks to check sodium levels, and receives medicine to treat her nauseous symptoms. To determine whether the patient's mental status is improving, her neurologic condition is also being assessed. The patient should continue to follow up with primary care provider if she is having any more symptoms of hyponatremia.

Pathophysiology References (2) (APA):

Hyponatremia: Causes, symptoms, diagnosis & treatment. (2022). Cleveland Clinic. Retrieved September 28, 2023, from <https://my.clevelandclinic.org/health/diseases/17762-hyponatremia>

Hyponatremia - Symptoms and causes. (2022). Mayo Clinic. Retrieved September 28, 2023, from <https://www.mayoclinic.org/diseases-conditions/hyponatremia/symptoms-causes/syc-20373711>

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	4.40 – 5.80 mcl	3.49	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
Hgb	13.0 – 16.5 g/dL	10.6	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
Hct	38.0 – 50.0 %	29.6	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
Platelets	140 – 440 mcl	187	N/A	
WBC	4.00 – 12.00 mcl	6.86	N/A	
Neutrophils	1.40 – 5.30 mcl	4.92	N/A	
Lymphocytes	19.0 – 49.0 %	10.1	N/A	
Monocytes	3.0 – 13.0 %	16.6	N/A	
Eosinophils	0.0 – 8.0 %	1.0	N/A	
Bands	0 - 5	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 mmol/L	120	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
K+	3.5 – 5.1 mmol/L	3.9	N/A	
Cl-	98 – 107	84	N/A	RBC are low due to the patient

	mmol/L			having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
CO2	22 – 30 mmol/L	27.0	N/A	
Glucose	74 – 100 mg/dL	105	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
BUN	8 -26 mg/dL	11	N/A	
Creatinine	0.70 – 1.30 mg/dL	0.73	N/A	
Albumin	3.5 – 5.0 g/dL	3.0	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
Calcium	8.9 – 10.6 mg/dL	8.6	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
Mag	1.6 – 2.6 md/dL	1.7	N/A	
Phosphate	3.0 – 4.5 mg/dL	1.9	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
Bilirubin	0.2 – 1.2 mg/dL	0.7	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
Alk Phos	40 – 150 u/L	91	N/A	
AST	5 – 34 u/L	27	N/A	
ALT	0 – 55 u/L	6	N/A	
Amylase	60 – 120 u/L	N/A	N/A	
Lipase	8 – 78 u/L	17	N/A	
Lactic Acid	0.50 – 2.20 mmol/L	N/A	N/A	

Troponin	0.00 – 0.03 ng/L	N/A	N/A	
CK-MB	0.5 – 3.6 ng/mL	N/A	N/A	
Total CK	30 – 200 u/L	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	0.8 – 1.1	N/A	N/A	
PT	10.1 – 13.1 sec	N/A	N/A	
PTT	25 – 36 sec	N/A	N/A	
D-Dimer	0 – 622 ng/mL	N/A	N/A	
BNP	0 – 100 pg/mL	N/A	N/A	
HDL	➤ 60	N/A	N/A	
LDL	< 130	N/A	N/A	
Cholesterol	< 200	N/A	N/A	
Triglycerides	40 – 180 mmpl/L	N/A	N/A	
Hgb A1c	4.0 – 6.0 %	N/A	N/A	
TSH	0.300 – 5.000 mlu/L	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	Yellow & Clear	Clear	N/A	
pH	5.0 – 9.0	6.0	N/A	

Specific Gravity	1.003 – 1.030	1.018	N/A	
Glucose	Negative	Negative	N/A	
Protein	Negative mg/dL	Negative	N/A	
Ketones	Negative mg/dL	40	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
WBC	Negative 0 – 5/hpf	N/A	N/A	
RBC	Negative 0 – 2/ hpf	26	N/A	RBC are low due to the patient having a primary diagnosis of symptomatic hyponatremia (Pagana, 2019).
Leukoesterase	Negative	Negative	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 mm Hg	N/A	N/A	
PaCO2	35 – 45 mm Hg	N/A	N/A	
HCO3	22 – 26 mEq/L	N/A	N/A	

SaO2	95%–100%	N/A	N/A	
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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 < 10,000 Positive > 100,000	N/A	N/A	
Blood Culture	Negative	No growth	N/A	
Sputum Culture	Normal upper respiratory tract	N/A	N/A	
Stool Culture	Normal intestinal flora	N/A	N/A	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): X-ray chest

Diagnostic Test Correlation (5 points): zero results shown.

Diagnostic Test Reference (1) (APA): N/A

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

Home Medications (5 required) Patient didn't have any other home medications!!!

Brand/Generic	Cholecalciferol/ Vitamin D	N/A	N/A	N/A	N/A
Dose	0.25 mcg				
Frequency	Daily				
Route	Oral				
Classification	Vitamin D analogs				
Mechanism of Action	Increase calcium uptake by the intestines (Jones & Bartlett Learning, 2021)				
Reason Client Taking	Vitamin D deficiency.				
Contraindications (2)	Hypersensitivity to cholecalciferol or its components, Vitamin D toxicity (Jones & Bartlett Learning, 2021)				
Side Effects/Adverse Reactions (2)	Erythema multiforme, anaphylaxis (Jones & Bartlett Learning, 2021)				
Nursing Considerations (2)	Check to be sure the patient receives enough calcium and monitor closely for vitamin D toxicity (Jones				

	& Bartlett Learning, 2021)				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess the client for signs of hypercalcemia (Jones & Bartlett Learning, 2021)				
Client Teaching Needs (2)	Store the medication away from light, heat, and moisture, and warn the patient not to take other forms of vitamin D while taking cholecalciferol (Jones & Bartlett Learning, 2021).				

Hospital Medications (5 required)

Brand/Generic	Acetaminophen / Tylenol	Dextrose 40%/ Glucose	Bisacodyl/ Dulcolax	Enoxaparin /Lovenox	Sodium chloride soluble tablets
Dose	500 mg	15 grams	10 mg	40 mg	2000 mg
Frequency	Every 4 hours/ PRN	As needed	As needed	Once a day	BID
Route	Oral	Oral	Rectal	Subcutaneous injections	Oral
Classification	Non-salicylate	Glucose elevating agent	Stimulant laxative	Low molecular-weight	Mineral and electrolytes

				heparin	
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system (Jones & Bartlett Learning, 2021).	Glucose undergoes oxidation into carbon dioxide, water, and yields energy molecules in the process of glycolysis and subsequent citric cycle and oxidative phosphorylation (Jones & Bartlett Learning, 2021).	Enhancing the mobility, reducing transit time, and increasing the water content of the stool (Jones & Bartlett Learning, 2021).	Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors. Without thrombin, fibrinogen can't convert to fibrin and thrombus can't form (Jones & Bartlett Learning, 2021).	Inducing diuresis depending on the clinical condition of the patient. Sodium and chloride-major electrolytes of fluid compartment outside of cells- work together to control extracellular volume and blood pressure (Jones & Bartlett Learning, 2021).
Reason Client Taking	To relieve mild to moderate pain.	Hypoglycemia	For constipation	To prevent clots.	Treat low levels of sodium in the body
Contraindications (2)	Hypersensitivity to acetaminophen or its components, severe hepatic impairment (Jones & Bartlett Learning, 2021).	Hypersensitivity to the active substance, hyperglycemia (Jones & Bartlett Learning, 2021).	Hypersensitivity to bisacodyl, obstruction or severe impaction, rectal bleeding (Jones & Bartlett Learning, 2021).	Active major bleeding; history of immune-mediated heparin-induced thrombocytopenia within past	Fluid retention, hypersensitivity to oral medication (Jones & Bartlett Learning, 2021).

			Learning, 2021).	100 days or in the presence of circulating antibodies. Hypersensitivity to benzyl alcohol, enoxaparin, heparin (Jones & Bartlett Learning, 2021).	
Side Effects/Adverse Reactions (2)	Hypotension, abdominal pain (Jones & Bartlett Learning, 2021).	Wheezing, tightness in chest, peeling skin with or without fever (Jones & Bartlett Learning, 2021).	Cramping, nausea, diarrhea, rectal burning (Jones & Bartlett Learning, 2021).	Confusion, thrombosis (Jones & Bartlett Learning, 2021).	Nausea vomiting, stomach pain, swelling in the hands, ankles, or feet (Jones & Bartlett Learning, 2021).
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment and monitor renal function in patients on long-term therapy (Jones & Bartlett Learning, 2021).	Use cautiously in patients with hepatic dysfunction and pregnancy to avoid adverse effects (Jones & Bartlett Learning, 2021).	Long term use of Dulcolax is not recommended. Use cautiously in patients who are breastfeeding (Jones & Bartlett Learning, 2021).	Be aware that drug isn't recommended for patients with prosthetic heart valves, especially pregnant women, because of risk of prosthetic valve thrombosis. If enoxaparin	Caution in patient with heart failure and severe renal insufficiency. Monitor for rash/itching/swelling (especially in the face/tongue/throat), severe dizziness, trouble breathing, these are signs that

				is needed, monitor peak and trough antifactory Xa levels often and adjust dosage as needed. Use cautiously in those with bleeding diathesis, diabetic retinopathy , hepatic or renal impairment (Jones & Bartlett Learning, 2021).	indicate allergic reactions (Jones & Bartlett Learning, 2021).
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess the patient's pain level (Jones & Bartlett Learning, 2021).	access history of allergy to medication. Assess orientation and reflexes and baseline pulse, blood pressure, and adventitious sounds (Jones & Bartlett Learning, 2021).	Assess patients for abdominal distention and cramping (Jones & Bartlett Learning, 2021).	Monitor the patient's vital signs, including blood pressure, pulse, and oxygen saturation (Jones & Bartlett Learning, 2021).	Assess the patient's vital signs, edema status, lung sounds and heart sounds (Jones & Bartlett Learning, 2021).
Client Teaching Needs (2)	Teach the patient that tablets may be crushed or swallowed whole but that extended-	Teach patients to check blood sugar level 10 to 15 minutes after taking this product. Make sure to	Teach patients to not crush, chew, or break the tablet or take it	Advise patients to notify prescriber about adverse reactions,	Take medication exactly as prescribed. Take sodium chloride

	release forms should not be broken, chewed, crushed, or split (Jones & Bartlett Learning, 2021).	swallow dextrose gel (Jones & Bartlett Learning, 2021).	within 1 hour of antacids, milk, or milk products. do not take bisacodyl more than once a day or for more than 1 week without talking to the healthcare provider (Jones & Bartlett Learning, 2021).	especially bleeding. Inform patients that taking aspirin or other NSAIDs may increase risk for bleeding. teach patient how to administer medication at home if needed (Jones & Bartlett Learning, 2021).	with a full glass of water (8 oz) (Jones & Bartlett Learning, 2021).
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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:	Alert and oriented to person, place, time, but not situation . Well-groomed and in no acute distress.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	SKIN COLOR: Skin is usual for ethnicity, fair color. CHARACTER: Skin is dry and intact, with no rashes, lesions, or bruising. TEMPERATURE: Skin is warm and dry upon palpation. TURGOR: Skin has normal elasticity. WOUNDS: The patient does not have any wounds CAPILLARY REFILL: Capillary refills on the fingers & toes are less than 3 seconds bilaterally. BRADEN SCORE: 17
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	HEAD: Head is normocephalic and atraumatic. NECK: Neck is symmetrical. Bilateral carotid pulses are palpable and 2+. EYES: Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge. PERRLA bilaterally. EOMs intact bilaterally. EARS: No drainage or ear wax, hearing intact, bilateral auricles, no visible or palpable deformities, lumps, or lesions. NOSE: Nose has no drainage, lumps, rashes, lesions, or deformities. Septum is midline. TEETH: Oral mucosa pink and moist with good dentition.
CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	HEART SOUNDS: S1 and S2 heard, no murmur or extra heart sounds. Regular rate and rhythm. PERIPHERAL PULSES: Peripheral pulses 2+, bilaterally, and symmetrical. CAPILLARY REFILL: Capillary refill less than 3 seconds on fingers and toes. Patient has no edema.

RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	RESPIRATIONS: Normal rate and pattern of respirations. Symmetrical and non-labored. BREATH SOUNDS: Breath sounds, clear throughout. No wheezes or crackles noted.
GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Diet at home: regular diet Current Diet: regular diet Height: 5'4 Weight: 128 lbs. AUCULTATION BOWEL SOUNDS: Bowel sounds within defined limits, normoactive in all four quadrants. No organomegaly found. No rashes, lesions, lumps, or deformities. Last BM: last bowel movement was 09-16-2023. PALPATION: Abdomen is soft, no tenderness, and no masses. INSPECTION: No distention. No incisions. No drains. No wounds.
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:	COLOR: Yellow CHARACTERISTIC: Clear QUANTITY: Within defined limits, adequate output. INSPECTION: Genitals are of standard appearance
MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input checked="" type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/>	NEUROVASCULAR: Within normal limits. ROM: All extremities have full range of motion. SUPPORTIVE DEVICES: Patient does use a walker at home and at the hospital. STRENGTH: Hand grips, pedal pushes, and pulls demonstrate normal and equal strength. Fall Score: 60 ACTIVITY/MOBILITY STATUS: Patient does use a walker at home and used one in the hospital.

<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>ORIENTATION: The patient is alert and oriented to person, place, and time, but not situation. COGNITION/MENTAL: The patient's cognition status was assessed at times, but the patient was confused about answering some questions and took longer than normal pauses when thinking of something. SPEECH: The patient's speech is adequate. SENSORY: The patient has adequate sensory, was tested on the legs and arms. LOC: The client is alert and awake, answers questions that are asked appropriately.</p>
<p>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):</p>	<p>COPING METHODS: The patient stated, "I am not sure how I cope; I just deal with things and hope they get better. I don't have the best coping skills." The patient is waiting for placement of a nursing home.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	87	145/68	42	98.0	93
1500	77	128/72	29	97.3	94

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
No Pain	No Pain	No Pain	No Pain	No Pain	No Pain
No Pain	No Pain	No Pain	No Pain	No Pain	No Pain

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G Location of IV: Right forearm Date on IV: 09-21-2023 Patency of IV: patent Signs of erythema, drainage, etc.: none IV dressing assessment: occlusive dressing	Saline lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
480 mL	Patient was up 1 assist to the toilet/ sometimes incontinent

Nursing Care**Summary of Care (2 points)**

Overview of care: The patient was in a happy mood; this nursing student came to do frequent checks to make sure the patient was comfortable or needed anything. This student nurse ordered a meal for the patient at 2:40 p.m. and did a head-to-toe assessment. The patient stated, “she wanted to go live with her son” and was confused about going to a nursing home.

Procedures/testing done: There were no procedures or tests done while this student nurse was there.

Complaints/Issues: Patient wanted to see her son.

Vital signs (stable/unstable): The patient’s vital signs were regular and stable.

Tolerating diet, activity, etc.: The patient tolerated her diet well and had no issue eating, swallowing, or drinking.

Physician notifications: None

Future plans for client: Patient knows she needs more help than her son can give her, but the long term goal is to live with her son.

Discharge Planning (2 points)

Discharge location: case management reached out to the nursing home, and now the patient is waiting placement.

Home health needs (if applicable): The patient would benefit from extensive monitoring; nursing facility.

Equipment needs (if applicable): The patient uses a walker.

Follow up plan: The patient needs to follow up with the help of a caregiver or her son to talk with primary care provider and be evaluated for maintenance of health and any other concerns.

Education needs: The patient needs educated on fall risks, such as getting rid of throw rugs in the home, making sure areas that are being used in the home are well lit so patient is able to see sufficiently, and installing grab bars in the shower or around toilet to assist patient in standing up until fully healed. The patient also needs education on medications and teach back method needs to be used so that it is ensured that the patient understands how to execute medication administration. The patient also needs education on seizure precautions and safety measures.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis <ul style="list-style-type: none"> Include full nursing diagnosis with 	Rationale <ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation <ul style="list-style-type: none"> How did the client/family respond to the nurse's
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<p>“related to” and “as evidenced by” components</p> <ul style="list-style-type: none"> Listed in order by priority – highest priority to lowest priority pertinent to this client 				<p>actions?</p> <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
<p>1. Risk for acute confusion related to electrolyte imbalance as evidence by cognitive dysfunction (Phelps, 2020).</p>	<p>1. This nursing diagnosis was chosen due to the patient having low sodium, low calcium and phosphate.</p>	<p>2. Assess the patient’s mental status to establish base line cognitive function for patient (Phelps, 2020).</p> <p>3. Implement seizure precaution to prevent injury to the patient from a result in severely low sodium (Phelps, 2020).</p>	<p>1. patient will remain oriented to person, place, and time (Phelps, 2020).</p>	<p>This student nurse rounded on this patient every two hours and accessed the patient mental status by asking questions involving orientation to person, place, time, and situation. The patient was cooperative and showed know signs of cognitive dysfunction. The nurse explained to the patient that severely low sodium levels can cause seizure therefore we be implementing seizure precaution; patient was understanding of education</p>
<p>At risk for falls related to general weakness as</p>	<p>This nursing diagnosis was chosen due to the</p>	<p>1. make sure bed in low position (Phelps, 2020).</p>	<p>1. patient will demonstrate fall</p>	<p>The patient demonstrate understanding of</p>

evidence by needing ambulatory assistance via walker and morse score being 60 (Phelps, 2020).	patient having a high fall risk score of 60 and using an ambulatory assistive devise.	2. Make sure the call light is close for the patient to reach (Phelps, 2020).	prevention measure (Phelps, 2020).	the nursing diagnosis and understanding of the nursing action patient will the regiment.
Ineffective coping skills related to inadequate confidence in ability to deal with a situation as evidence by patient stating "I'm not sure how I cope, I just deal with things and hope they get better." (Phelps, 2020).	This nursing diagnosis was chosen due to patient stating "I'm not sure how I cope, I just deal with things and hope they get better."	1. Arrange to spend uninterrupted time with the patient to have a conversation (Phelps, 2020). 2. Negotiate with the patient to develop learning goals and have a sense of control with the situation (Phelps, 2020).	The patient will communicate feelings about present situations they are in (Phelps, 2020).	The student RN spoke with the patient and encouraged the patient to express her current feelings. The student RN validated the patient's feelings and encourage the patient in how she feels and consider other alternatives; like confiding in her son.
Risk for impaired skin integrity related to patient needing a gait belt with a walker with a 1 assist to ambulate to and from the restroom as evidence by	This nursing diagnosis was chosen due to the patient requiring the use of equipment, such as gait belt with a walker and one person assist to	Encourage ambulation getting out of bed with a gait belt, a walker and one person assist, every 2 hours to walk as far as patient can	1. The patient will achieve the highest mobility level possible (Phelps, 2020).	The student RN spoke with the patient and encouraged the patient to ambulate when she can. The patient was okay with following

Branden Scale being 17 (Phelps, 2020).	help the patient ambulate to and from the restroom.	walk (Phelps, 2020). Performing passive ROM exercises every 4 hours while patient is awake, as well as repositioning with pillows every 2 hours from left to right side to prevent skin breakdown (Phelps, 2020).		the treatment.
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Other References (APA): Phelps, L. L. (2020). *Sparks & Taylor's Nursing Diagnosis Reference Manual*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The patient stated she would rather live with her son rather than going into a nursing home. The patient's blood pressure was 145/68. The patient stated, "I am not sure how I cope; I just deal with things and hope things get better." The patient showed no signs of pain. The patient ate 75% of her meal and tolerated her regular food diet. Patient stated she does not talk to many people so its good to see faces in this hospital.

Objective Data

Client Information

Date of admission: 09-16-2023
 Clients Initials: J.K
 Age: 71 years of age
 Gender: Female
 Race: Non-Hispanic
 Occupation: Unemployed
 Marital Status: Divorced
 Allergies: No known allergies
 Code status: Full code
 Height: 5'4
 Weight: 128 lbs.

Nursing Diagnosis/Outcomes

Risk for acute confusion related to electrolyte imbalance as evidence by cognitive dysfunction.

- patient will remain oriented to person, place, and time.

At risk for falls related to general weakness as evidence by needing ambulatory assistance via walker and morse score being 60.

- patient will demonstrate fall prevention measure.

Ineffective coping skills related to inadequate confidence in ability to deal with a situation as evidence by patient stating, "I'm not sure how I cope, I just deal with things and hope things get better."

Nursing Interventions

1. Assess the patient's mental status to establish base line cognitive function for patient.
2. Implement seizure precaution to prevent injury to the patient from a result in severely low sodium.
3. Make sure bed in low position.
4. Make sure one can get to toilet for the patient to read.
5. Arrange to spend uninterrupted time with the patient to have a conversation.
6. Negotiate with the patient to develop learning goals and have a sense of control with the situation.
7. Encourage ambulation getting out of bed with a gait belt, a walker and one person assist, every 2 hours to walk as far as patient can walk.
8. Performing passive ROM exercises every 4 hours while patient is awake, as well as repositioning with pillows every 2 hours from left to right side to prevent skin breakdown.

The patient will communicate feelings about present situations they are in. The patient will achieve the highest mobility level possible.

Risk for impaired skin integrity related to patient needing a gait belt with a walker with a assist to ambulate to and from the restroom as evidence by Braden Scale being 17.

- The patient will achieve the highest mobility level possible.

