N321 Care Plan 1

Tyranny Davis

Lakeview College of Nursing

N321 Adult Health 1

Professor Kristal Henry

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Demographics (3 points)

Date of Admission 02/09/2024	**Client Initials** N. D.	**Age** 68	**Gender** Female
Race/Ethnicity White/Caucasian	**Occupation** Retired cafeteria worker	**Marital Status** Divorced	**Allergies** amoxicillin, moxifloxacin, clarithromycin, carbamazepine, oxaprozin, erythromycin, levofloxacin, penicillin, and sulfa antibiotics
Code Status FULL code	**Height** 5’ 8” (172.7 cm.)	**Weight** 284 lbs (128.8 kg)	

Medical History (5 Points)

Past Medical History: Abdominal aortic aneurysm, Parkinson’s, chronic obstructive pulmonary disease (COPD), seizure disorder, morbid obesity, obstructive sleep apnea, dyslipidemia, gastroesophageal reflux disease (GERD), hematuria, non-melanoma skin cancer, malignant melanoma, hypertension, migraines, restless leg syndrome, inguinal hernia (right side), neoplasm or ureter, uterine mass, and ventral hernia.

Past Surgical History: The client has a history of right total knee arthroplasty, upper gastrointestinal endoscopy (2018), skin biopsy, hysterectomy (2019), carpal tunnel right hand (2021), right wrist ganglion cyst removal (2021), hernia repair, tunneled venous port placement, tonsillectomy (1968), cholecystectomy, appendectomy, and dilation & curettage.

Family History: Arthritis and breast cancer (mother). Dementia (father). Heart disease (mother, father, brother, paternal grandmother, paternal grandfather, maternal grandmother, maternal grandfather). Hypertension (mother and father). Stroke (brother). Diabetes mellitus (paternal grandmother).

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The client reports she quit smoking 7 years ago after 9 years of smoking about 50 packs a year. She denies any current or prior use of smokeless tobacco. The client denies any current use of drugs or alcohol.

Assistive Devices: The client uses a walker and bilateral hearing aids.

Living Situation: The client lives in a senior living apartment complex, alone in her own unit, with a partner living in the next building.

Education Level: The client reports the highest level of education completed as 11th grade.

Admission Assessment

Chief Complaint (2 points): The client's admission complaint is a seizure and accompanied fall.

History of Present Illness – OLD CARTS (10 points): The client reports having had a seizure at home in the afternoon 3 days prior (02/09/2024). She reports having fallen from the seizure and said "I couldn't get up and laid there for like 30 minutes to an hour yelling for help," before a neighbor heard her and called an ambulance. The client was transported to the emergency department by ambulance and was admitted to the intensive care unit. She reports initially feeling dull pain on her left elbow and "general soreness" throughout her body. The client describes movement and "brushing the elbow scrape into things" as aggravating factors, and rest and immobility as alleviating factors. The client has been diagnosed with seizures in the past and is currently prescribed an anticonvulsant medication to prevent them. The client reports the pain having subsided since admission at the hospital and the elbow is only painful when bumped into something. She reports this pain as minimal and not severe.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Seizure

Secondary Diagnosis (if applicable): Acute on chronic respiratory failure

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

A seizure occurs when nerve cells in the brain become electrically active and transmit signals throughout the body without a targeted purpose (Capriotti, 2020). Electric signals, or impulses, are firing all over the body at all times. This is how the cells of the body communicate and coordinate bodily processes. However, during a seizure, this communication becomes disordered. There are neurotransmitters that promote the propagation of the nerve impulse, and there are neurotransmitters that impede these signals (Capriotti, 2020). Seizures occur when these the excitable impulses suddenly outnumber the ones who hinder the signal, and because the excited signal is sent out, other nerve cells suddenly experience the excitatory phase, too (Capriotti, 2020).

Seizures are categorized in several ways and one of them is whether or not the impulse travels from one half of the brain to the other (Capriotti, 2020). When the hyper excitable impulse stays on the side of the brain it originated, it is called a focal seizure (Capriotti, 2020). A generalized seizure is one that travels to and impacts the other side of the brain (Capriotti, 2020). The onset of focal seizures happens when many impulses begin firing in one area and are moving at the same rate, which causes cell membranes to move calcium ions inward (Capriotti, 2020). Sodium then moves into the cells and causes the cells to respond to the stimulus and polarize, which is visualized on an electroencephalography (EEG) (Capriotti, 2020). The rapid firing of signals within the brain can then send uncoordinated movement signals to various parts of the

musculoskeletal system causing the signs and symptoms that can be seen such as muscle spasms, jerking movements, rigidity, altered mental status, rapid eye movements, and others, depending on the area of the brain affected, and where the impulses send signals to (Capriotti, 2020).

Seizures are not as well understood as other disorders, but can be caused by a variety of things such as head injuries or tumors, in utero injury, developmental disorders, genetics, and other medical disorders (Capriotti, 2020). Diagnosing a seizure disorder can be a lengthy process that involves a detailed health history and description of that client's specific seizures and symptoms (Capriotti, 2020). This history includes any injuries, personal and familial health history, and social history (Capriotti, 2020). Another factor included in the diagnosing of seizures is extensive labs to rule out other explanations for the symptoms, brain scans, and eventually an EEG to determine the areas in the brain that are affected (Capriotti, 2020). An EEG depicts waves stimulated by the brain and are electrical impulses tracked by electrodes on the head (Pagana et al., 2022). The waves can tell us where in the brain the seizure originated from and can aid in diagnosing the type of seizure (Pagana et al., 2022). In a client having a seizure, we would expect to see unexplained changes in rate and rhythm on the EEG beginning in one area and potentially traveling to others (Pagana et al., 2022).

During a seizure, expected findings would be abnormal heart rate, rhythm, and respirations, altered state of consciousness, potentially repetitive movements and/or loss of musculoskeletal control. We did not visualize any acute seizure activity while I was working with this client. However, she had a complete blood count (CBC), complete metabolic panel (CMP), and urinalysis to rule out potential underlying causes of the seizure and fall. She also underwent an EEG to monitor for seizure activity to help localize the portion of the brain affected by her seizures. During this admission, the client's urinalysis, CBC, and CMP ruled out

other potential causes of the seizure. She underwent another diagnostic EEG to try to localize the affected areas and specify the types of seizures she is having, and the EEG results were still pending.

Treatment for seizures varies based on the suspected cause of the seizures. One common treatment method for seizures is the administration of anticonvulsant medication. This is the treatment method being utilized by this client as she has been prescribed levetiracetam. If the seizure has a treatable underlying cause such as fever, injury, or chemical imbalance, treatment involves healing and correcting the issue (Capriotti, 2020). The type of this client's seizures has not been solidified, so she takes anticonvulsants and undergoes routine EEGs to trace seizure activity.

Pathophysiology References (2) (APA):

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

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2022). *Mosby's Manual of Diagnostic and Laboratory tests* (16th ed.). Elsevier.

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	3.8-5.30 10(6)/mcL	3.25 10(6)/mcL	N/A	An excessive fluid level and chronic illness can cause decreased RBCs and potential anemia (Pagana et al., 2022).
Hgb	12.0-15.8 g/dL	10.5 g/dL	N/A	The accompanying low RBC and low hematocrit, in adjunction with the low hemoglobin, are the results of suspected low iron level (Pagana et al., 2022).

Hct	36.0-47.0%	32.3%	N/A	The client's RBC values and potentially iron, have contributed to a low hematocrit (Pagana et al., 2022).
Platelets	140-440 10(3)/mcL	210 10(3)/mcL	N/A	
WBC	4.0-12.0 10(3)/mcL	8.70 10(3)/mcL	N/A	
Neutrophils	47-73%	74.2%	N/A	This slight increase in neutrophil count is likely due to inflammation and stress as a result of the seizure and fall that brought her to the hospital.
Lymphocytes	18.0-42.0%	16.9%	N/A	A low lymphocyte level in this client is likely caused by underlying infection or as an acute injury response (Pagana et al., 2022).
Monocytes	4.0-12.0%	8.6%	N/A	
Eosinophils	0-5%	0.0%	N/A	
Bands	0.0-3.0%	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 mmol/L	142 mmol/L	144 mmol/L	
K+	3.5-5.1 mmol/L	4.1 mmol/L	3.8 mmol/L	
Cl-	98-107 mmol/L	103 mmol/L	104 mmol/L	
CO2	22-30 mmol/L	27 mmol/L	28 mmol/L	
Glucose	70-99 mg/dL	87 mg/dL	90 mg/dL	
BUN	10-20 mg/dL	35 mg/dL	27 mg/dL	An elevated BUN is a side effect of treatment with furosemide (Pagana et al., 2022).
Creatinine	0.6-1.0 mg/dL	2.18 mg/dL	1.5 mg/dL	A combination of this client's heart failure, and use of nephrotoxic medications such as ibuprofen, and potentially the diuretic use has raised her serum creatinine (Pagana

				et al., 2022).
Albumin	3.5-5.0 g/dL	3.8 g/dL	3.5 g/dL	
Calcium	8.7-10.5 mg/dL	8.2 mg/dL	8.5 mg/dL	This client's use of anticonvulsants and diuretics, which can be calcium wasting, lead to these low calcium levels (Pagana et al., 2022).
Mag	1.6-2.6 mg/dL	1.9 mg/dL	N/A	
Phosphate	2.5-4.5 mg/dL	4.9 mg/dL	N/A	Phosphate and calcium have an inverse relationship, so her raised phosphate level is likely a result of the low calcium (Pagana et al., 2022).
Bilirubin	0.2-1.2 mg/dL	0.4 mg/dL	0.3 mg/dL	
Alk Phos	40-150 U/L	239 U/L	197 U/L	The elevated alkaline phosphatase likely indicates liver dysfunction, I would suspect as a result of a hepatotoxic medication (Pagana et al., 2022).
AST	5-34 U/L	73 U/L	27 U/L	A raised AST level is a result of the client's recent seizure as convulsions can temporarily increase AST levels (Pagana et al., 2022).
ALT	0-55 U/L	33 U/L	25 U/L	
Amylase	52-123 U/L	N/A	N/A	
Lipase	8-78 U/L	N/A	N/A	
Lactic Acid	0.7-2.0 mmol/L	1.5 mmol/L	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 (this**	1.0	N/A	

	is a ratio)			
PT	**10.1-13.1 seconds**	11.8 seconds	N/A	
PTT	**25-36 seconds**	22 seconds	N/A	This low PTT could be an initial sign of disseminated intravascular coagulation (DIC), potentially related to inflammation from the fall, or her cancer history (Pagana et al., 2022).
D-Dimer	**0-622 ng/mL**	N/A	N/A	
BNP	**<100 pg/mL**	40 pg/mL	N/A	
HDL	**>40 mg/dL**	56 mg/dL	N/A	
LDL	**<130 mg/dL**	92 mg/dL	N/A	
Cholesterol	**<200 mg/dL**	155 mg/dL	N/A	
Triglycerides	**<150 mg/dL**	33 mg/dL	N/A	
Hgb A1c	**4.0-6.0%**	N/A	N/A	
TSH	**0.270-4.2 MIU/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 and clear**	Clear, yellow	N/A	
pH	**5.0-9.0**	5.5	N/A	
Specific Gravity	**1.005-1.020**	1.017	N/A	
Glucose	**Negative**	Negative	N/A	
Protein	**Negative**	2+	N/A	The client reported urine retention upon admission and likely had highly concentrated urine given the specific gravity is on the higher end, as well (Pagana et al., 2022). Highly concentrated urine can include protein excretion (Pagana et al.,

				2022).
Ketones	**Negative**	Negative	N/A	
WBC	**0-5 hpf**	0.5 hpf	N/A	
RBC	**0-2 hfp**	3-5 hpf	N/A	The client was catheterized upon admission and experienced bleeding as a result, so the RBCs in her urine are likely related to the catheterization (Pagana et al., 2022).
Leukoesterase	**Negative**	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	**No growth**	No growth	N/A	
Blood Culture	**No growth**	No growth	N/A	
Sputum Culture	**No growth**	N/A	N/A	
Stool Culture	**No growth**	N/A	N/A	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2022). *Mosby's Manual of Diagnostic and Laboratory tests* (16th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT Head on Brain w/o contrast. Impression: No acute infarction, masses, or hemorrhaging present, indications for prior pathology. CT Abdomen/Pelvis w/o contrast. Impression: No significant findings. CT Chest w/o contrast. Impression: Atelectasis of lower lobes of lungs bilaterally, possible aspiration pneumonia, some opacity in right lower lobe. X-Ray Chest Single view (portable). Impression: Port-a-cath tip appropriate placed, low

respiratory effectiveness, enlarged heart and congestion of lungs. X-Ray Shoulder complete left. Impression: No injury evident, positive for degeneration from prior injury. EEG (pending).

Diagnostic Test Correlation (5 points): The client's present admission required the CT scans of her head, abdomen, and pelvis to rule out and injury from the fall. The client fell as a result of her seizure, was unable to get up, and experiencing generalized pain when brought to the hospital. These factors, along with her age, warranted the CT scans to rule out internal injuries from the fall, and the impressions from the brain, abdomen, and pelvis did not indicate an acute injury. The CT and X-ray of the chest were necessary for this client not only to rule out acute injury, but to evaluate her respiratory status as she has COPD, was using accessory muscles for breathing, and to see if there was a respiratory cause contributing to the fall, such as poor oxygenation leading to a loss of consciousness. The CT of the chest confirmed collapsing of the alveoli in the lower lungs, and potential signs of pneumonia which could contribute to the onset of the seizure. The chest x-ray confirmed placement of the previously placed port-a-cath in the superior vena cava, inefficient respiratory effectiveness related to congestion in the lungs, which can be related to the possible pneumonia and the COPD. The x-ray also indicated an enlarged heart which is not surprising given the respiratory failure. The heart would be working harder to adequately pump enough to distribute oxygenated blood to the rest of the body, and would experience hypertrophy as a result. The client also underwent an EEG which was necessary to track electrical impulses in the brain and to try to map where they originated and where they traveled (Pagana et al., 2022). This diagnostic test was pending.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2022). *Mosby's Manual of Diagnostic and Laboratory tests* (16th 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	Keppra/ levetiracetam	Paxil/ PARoxetine chloride	Gocovri/ amantadine hydrochloride	Zanaflex/ tizanadine hydrochloride	Myrbetriq/ mirabegron
Dose	500 mg	20 mg	100 mg	2 mg	50 mg SR
Frequency	TID	Once daily	BID	TID PRN	Once daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pyrrolidine derivative, Anticonvulsant (*NDH*, 2023)	Selective serotonin reuptake inhibitor (SSRI), antidepressant (*NDH*, 2023)	Dopamine agonist, antidyskinetic (*NDH*, 2023)	Alpha 2 adrenergic agonist, antispasmodic (*NDH*, 2023)	Beta-3 adrenergic agonist, bladder antispasmodic (*NDH*, 2023)
Mechanism of Action	Stops nerve cells in the brain from rapid misfiring (*NDH*, 2023).	Increases serotonin levels by hindering its uptake at the presynapse, leaving it at receptor sites for longer (*NDH*, 2023).	Enhance the sensitivity of post-synaptic dopamine receptors to minimize loss of smooth motor control (*NDH*, 2023).	Inhibits spinal motor neurons before the synapse thereby inhibiting full release of amino acids that lead to spasm-like movements (*NDH*, 2023).	This medication activates the beta-3 adrenergic receptors to relax the detrusor and prevent premature voiding of the bladder (*NDH*, 2023).

Reason Client Taking	This client has a history of seizures.	Stabilize mood and alleviate depression symptoms.	The client has a history of Parkinson's.	The client has a history of muscle spasms and spastic movements secondary to Parkinson's.	The client has a history of bladder over activity.
Contra-indications (2)	Contraindicated in clients with suicidal ideation and/or people operating heavy machinery (*NDH*, 2023).	Contraindicated within 2 weeks of MAO inhibitors and clients taking warfarin ((*NDH*, 2023).	Contraindicated in clients receiving live virus vaccines and those with kidney disease (*NDH*, 2023).	This medication should not be used with ciprofloxacin or by clients with severe low blood pressure (*NDH*, 2023).	Contraindicated within 2 week of MAO inhibitor use and while taking CNS depressants (*NDH*, 2023).
Side Effects/ Adverse Reactions (2)	Thrombocytopenia and hypotension are adverse effects of Keppra (*NDH*, 2023).	Seizures and hyponatremia are adverse effects of Paxil (*NDH*, 2023).	Pulmonary edema and seizures are adverse effects of Gocovri (*NDH*, 2023).	Urinary frequency and urinary tract infections are adverse effects of Zanaflex (*NDH*, 2023).	Dyspnea and angioedema are adverse effects of Myrbetriq (*NDH*, 2023).
Nursing Consider-ations (2)	Assess suicide risk/ideation and implement seizure precautions (*NDH*, 2023).	Monitor regularly for suicide risk and monitor electrolytes as prescribed (*NDH*, 2023).	Monitor respiratory status including auscultation of lung fields and monitor for changes in skin (*NDH*, 2023).	Monitor liver and kidney function and educate client ways to minimize orthostatic hypotension (*NDH*, 2023).	Monitor electrolytes, specifically sodium, and encourage the client to take this medication at bedtime (*NDH*, 2023).

Hospital Medications (5 required)

Brand/ Generic	LASIX/ furosemide	COZAAR/ losartan potassium	DILANTIN/ phenoytoin	Stiolto respimat/ tiotropium olodaterol	Neurontin/ gabapentin
Dose	40 mg	25 mg	200 mg	2.5 mcg/ACT	300 mg
Frequency	BID w/ meals	Once daily	Once daily morning	2 puffs once daily	TID
Route	Oral	Oral	Oral	Inhalation	oral
Classification	Loop diuretic, antihypertensive (*NDH*, 2023)	Angiotensin II receptor blocker, antihypertensive (*NDH*, 2023)	Hydantoin derivative, anticonvulsant (*NDH*, 2023)	Long-acting beta2-adrenergic agonist, bronchodilator (*NDH*, 2023)	1-amino-methyl-cyclohexaneacetic acid, anticonvulsant (*NDH*, 2023)
Mechanism of Action	Encourages excretion of sodium and water by blocking the reabsorption and excreting them through urination (*NDH*, 2023).	Inhibits binding of angiotensin II to receptor sites so vasoconstriction cannot occur, lowering blood pressure (*NDH*, 2023).	Stabilizes neurons to minimize seizure activity by altering calcium movement across membranes (*NDH*, 2023).	Activation of beta2-adrenoreceptors signals the release of enzyme that increases cAMP levels, causing relaxation of bronchus muscles (*NDH*, 2023).	Slows burst-like firing of neurons in the brain that cause seizures (*NDH*, 2023).
Reason Client Taking	The client has a history of hypertension and heart failure.	The client has a history of hypertension and pitting edema of the lower	The client has a history of seizure activity.	This client has a history of chronic obstructive pulmonary disease and current	The client has a history of seizure activity and restless leg syndrome.

		extremities.		atelectasis of the lower lobes.	
Contraindications (2)	Lasix is contraindicated in clients with severe hyponatremia or hypotension (*NDH*, 2023).	Losartan is contraindicated for clients with poor kidney functioning and taking NSAIDs, as well as high potassium diets as losartan is potassium-sparing (*NDH*, 2023).	This medication is contraindicated in clients who have experienced hepatotoxicity related to this drug and should not be administered while also prescribed nonnucleoside reverse transcriptase inhibitors (*NDH*, 2023).	Contraindicated with other highly potassium-wasting drugs and clients in acute COPD deterioration (*NDH*, 2023).	This is contraindicated in clients receiving morphine and those taking central nervous system depressants (*NDH*, 2023).
Side Effects/Adverse Reactions (2)	Hypokalemia and cardiac arrhythmias are adverse effects of LASIX (*NDH*, 2023).	Hyperkalemia and persistent coughing are adverse effects of Cozaar (*NDH*, 2023).	Hypotension and hypoxia are adverse effects of Dilantin (*NDH*, 2023).	Atrial fibrillation and hypokalemia are adverse effects of this medication (*NDH*, 2023).	Respiratory depression and hyponatremia are adverse effects of gabapentin (*NDH*, 2023).
Nursing Considerations (2)	Monitor electrolytes and monitor client's hearing (*NDH*, 2023).	Monitor blood pressure and educate client on avoiding salt substitutes due to risk for hyperkalemia (*NDH*,	Monitor client's ECG for signs of cardiac depression and monitor for therapeutic level of phenytoin	Monitor client's ECG for alterations and monitor serum potassium regularly (*NDH*, 2023).	Monitor for enlarged lymph nodes and educate client on avoiding antacids within 2 hours of taking gabapentin (*NDH*, 2023).

		2023).	(typically 10-20 mcg/L) (*NDH*, 2023).		

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2023). 2021 *Nurse's drug handbook* (22nd ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness: Conscious and alert** **Orientation: Oriented to person, place, time, situation.** **Distress: No acute distress noted.** **Overall appearance: Well-groomed, stated age, positive affect.**	Client is alert and oriented to person, place, time, and situation. She appears well groomed and showing no signs of acute distress. Client is laying in her bed in the room with her fiancé, watching television and is positive in affect.
INTEGUMENTARY: **Skin color: Fair** **Character: Dry, intact** **Temperature: Warm** **Turgor: Normal, no tenting** **Rashes: None** **Bruises: Two purple contusions on left forearm.** **Wounds: Approximately 1 inch long abrasion on left elbow, bandage to left calf wound is clean, dry, and intact.** **Braden Score: 18** **Drains present: Y☐ N ☒** **Type:**	Client's skin is fair, dry and warm, has some hair thinly distributed on all extremities. Client's skin had normal turgor with no signs of tenting. No rashes were visualized on the client's skin. The client has 2 purple bruises on her left forearm, and a 1-inch scabbed abrasion on her left elbow. The client reports these are from her seizure-related fall on 02/09/2024. The client has a small wound on her left calf that is bandaged and the bandage is clean, dry, and intact. The client has a Braden score of 18.
HEENT: **Head/Neck: Round, symmetrical,**	Head is round, symmetrical, atraumatic, and had

atraumatic. **Ears: Symmetrical, free of excessive cerumen.** **Eyes: Symmetrical, free of drainage, pupils 3 mm bilaterally** **Nose: Septum appears slightly deviated to clients right.** **Teeth: The client has no teeth.**	one pink lesion, approximately ½ cm in size on the crown, and no deformities. No lymph nodes were palpable and trachea is midline. Eyes are symmetrical, free of drainage, and pupils were 3mm bilaterally and round. Eyes satisfied PERRLA. Ears are symmetrical and showed no break down under nasal cannula. Nose was appropriate in size, septum was slightly deviated to the client's right, and nasal mucosa was dark pink with minimal hair present. Oral mucosa pink and moist, tongue and uvula midline, bilateral tonsils +1. Client has no teeth.
CARDIOVASCULAR: **Heart sounds: Clear** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): Regular** **Peripheral Pulses: 2+ bilaterally on upper and lower extremities** **Capillary refill: Less than 3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema: Lower bilateral extremities**	Heart sounds are clear with no murmurs or gallops auscultated. S1 and S2 were clearly auscultated. Rhythm is regular and peripheral pulses were palpated as 2+ bilaterally. Capillary refill is less than 3 seconds bilaterally on upper and lower extremities. No signs of jugular vein distension. 1+ pitting edema present on bilateral lower extremities.
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Breath sounds auscultated bilaterally on anterior and posterior with crackles in the bases and bilateral wheezing in upper lobes. Chest is appropriate shape with signs of accessory muscle use upon inspiration.
GASTROINTESTINAL: **Diet at home: Cardiac** **Current Diet: Cardiac** **Height: 5' 8"** **Weight: 284 lbs** **Auscultation Bowel sounds: present, normoactive in all quadrants.** **Last BM: 02/11 PM** **Palpation: Pain, Mass etc.:** **Inspection: protuberant** **Distention: none.** **Incisions:** **Scars: 1 healed, about 6-inches, diagonal on right side.** **Drains: None**	Client following cardiac diet both at home and in the hospital. Bowel sounds were auscultated in all four quadrants to be normoactive. Client reports passing gas and passed a large bowel movement on 02/11 in the evening. Abdomen is protuberant, non-tender and free of masses and tenderness. No wounds or drains present. Client is free of ostomy and any feeding tubes. There is a 6-inch surgical scar that is pink and healed on the right side of the client's abdomen.

Wounds: None **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY: **Color: Yellow** **Character: Clear** **Quantity of urine: 700 mL** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: Redness in hip folds, sparse hair, no lesions** **Catheter: Y ☒ N ☐** **Type: Foley catheter** **Size: 16 Fr.**	Client's genitals are free of rashes, lesions, or discoloration. Client has sparse hair on genitals, and erythema bilaterally on hip folds (groin). Upon assessment, client has voided 700 mL of yellow, clear urine via catheter at 1320. The catheter is a 16 Fr. Foley. Client denies any urgency or pain with urination.
MUSCULOSKELETAL: **Neurovascular status: No pain, pallor, or paresthesia.** **ROM: Full ROM** **Supportive devices: Walker, gait belt** **Strength: 4/5 bilaterally on upper and lower extremities.** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 75** **Activity/Mobility Status: Up as tolerated with 1 assist.** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☒**	Client is free of pain, pallor, and paresthesia of extremities. Client demonstrated full ROM in all extremities and was able to lift them all and hold them there. Client is ambulating well with a walker and gait belt assist. Grip strength was 5/5 bilaterally. Pushes and pulls on upper and lower extremities is 4/5 strength. Client requires assistance with toileting hygiene. Client is at risk for falls and uses one assist for ambulation, as well as a gait belt and walker but moves independently. The client's fall score is 75, deeming her a high fall risk
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation: Ox4** **Mental Status: Intact, no confusion** **Speech: Clear, appropriate, loud.** **Sensory: Appropriate** **LOC: Conscious, responds appropriately and spontaneously.**	Client eyes satisfy PERRLA and she moves all extremities well. Client is oriented to person, place, time, and situation. Client's mental status is clear and free of confusion. Speech is clear, well-articulated, and loud in volume. Client's senses are intact and appropriate and client is conscious and responds to questions and commands.
PSYCHOSOCIAL/CULTURAL:	Client uses coping strategies of prayer, talking

Coping method(s): Support system of family, fiancé, friends. **Developmental level: Integrity v. Despair** **Religion & what it means to pt.: Methodist, prays, source of hope.** **Personal/Family Data (Think about home environment, family structure, and available family support): Well supported, feels safe.**	with friends and family, and distractions through movies. Client operates appropriately at the level of someone in late adulthood. Client reports being a Methodist and reports religion as a source of hope. Client reports having a good support system of children, extended family, her fiancé, and friends within her community. The client reports feeling safe at home.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1500	80	95/69	19	98.9 temporal	100% 3L NC
1714	77	107/69	18	98.7 temporal	100% 3L NC

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1505	0-10	N/A	0	N/A	N/A
1715	0-10	N/A	0	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: ¾ inch **Location of IV: Right side of chest** **Date on IV: 11/01/2023** **Patency of IV: Flushed 2/12 with good blood return** **Signs of erythema, drainage, etc.: None**	The client has a port-a-cath on the right side of her chest that was placed 11/01/2023. The port has a ¾ inch IV and a saline lock. She is not currently receiving fluid. The site shows no signs of erythema or drainage and the dressing is clean, dry, and intact. The line is

IV dressing assessment: Clean, dry, intact	patent and was flushed on 2/12/24 with good blood return.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1170 mL (oral- water, soda)	2600 mL (urine)

Nursing Care

Summary of Care (2 points)

Overview of care: I arrived in the client's room at 1310 and introduced myself to the client. I accompanied the client with the transporter to the lower level where the client underwent an EEG for about an hour. I accompanied the client back to the unit where I removed beverage trash and assessed the client's vitals around 1510. I obtained a shampoo cap and performed hair washing and combing to clean out paste from the EEG. The student nurse helped the client order dinner from dietary. I retrieved the client a cup of ice prior to the arrival of dinner. Per provider orders, I removed the client's Foley catheter, provided perineal care, and helped the client redress in undergarments. With the nurse's guidance, I flushed the client's port-a-cath with 0.9% normal saline to check patency and obtained good blood flow upon aspiration. I debriefed the client's care with the nurse before exiting the floor for post conference.

Procedures/testing done: The client underwent an EEG around 1345 before being transferred back to the floor. The nurse guided the student nurse through flushing the client's port-a-cath at approximately 1715.

Complaints/Issues: The client complained that her catheter was pulling down on her and causing pain. The client also complained about sticky hair.

Vital signs (stable/unstable): During my care of the client, her vitals remained stable.

Tolerating diet, activity, etc.: The client tolerated her cardiac diet and activity well. She moved independently from the chair to the transporting bed prior to her EEG.

Physician notifications: There was nothing to notify the provider about during my time with client.

Future plans for client: The future plans for the client include discharging to home and following up with her primary care physician.

Discharge Planning (2 points)

Discharge location: The client will be discharging home likely tomorrow (02/13/2024), and resume in home caregiving services. The client will be transported home by her fiancé.

Home health needs (if applicable): The client does not currently require help at home regarding health.

Equipment needs (if applicable): The client needs to continue to use her walker.

Follow up plan: The client's plan of care involves a follow-up appointment with their primary care physician in the next week and increasing activity as tolerated.

Education needs: The client could use education on the benefits of an emergency home response button (Life Alert) and appropriate use of anticonvulsants and diuretics.

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. Ineffective airway clearance related to retained secretions as evidenced by accessory muscle use and adventitious breath sounds (Phelps, 2023).	This is a pertinent nursing diagnosis because of the client's COPD diagnosis, potential pneumonia, atelectasis, and acute on chronic respiratory failure.	**1**. Provide the client supplemental oxygen therapy as prescribed (Phelps, 2023). **2**. Educate the client on coughing and deep breathing to promote optimal aeration of the lungs (Phelps, 2023).	**1.** The optimal outcome would be that the client's oxygen saturation will remain within provider's expected limits of 90-100% for the duration of her admission (Phelps, 2023).	The client is receptive to teaching on coughing and deep breathing and can demonstrate appropriate positioning and technique. The client also maintains oxygen saturation stays within range (Phelps, 2023).
2. Risk for decreased cardiac output related to elevated blood pressure, medication side effects, and impaired physical	This nursing diagnosis is important to the client's care because she has poor oxygenation so her heart is working extra to compensate for the decreased oxygenation	**1.** Monitor client's vital signs and level of consciousness every 4 hours paying specific attention to blood pressure and heart rate and contact provider with any unexpected findings	**1.** Patient's pulse will be between 60-100 bpm and blood pressure stay below 145/90 while in the hospital (Phelps, 2023).	The client's pitting edema will not worsen during her admission and her heart rate and blood pressure will be maintained within acceptable limits (Phelps, 2023).

mobility as evidenced by enlarged heart and pitting edema of the lower extremities (Phelps, 2023).	and she is showing signs of hypertrophy of the heart.	(Phelps, 2023). **2**. Track intake and output of client daily to track fluid retention (Phelps, 2023).		
3. Risk for adult falls related to impaired physical mobility and seizure disorder as evidenced by use of a walker and history of falls (Phelps, 2023).	The client's current admission is the result of a fall from a seizure, which places her at an increased risk for falls in the future.	**1**. Educate the client on environmental factors that place the client at an increased risk for falls and injury in a fall (Phelps, 2023). **2.** Provide the client with further education about proper use of the walker to minimize fall risks (Phelps, 2023).	**1.** The client will demonstrate appropriate use of the walker prior to discharge (Phelps, 2023).	The client can identify items in her home that pose a fall risk and she and her family are agreeable to making changes to these hazards to promote client safety (Phelps, 2023). The client can demonstrate the safe use of a walker (Phelps, 2023.

Other References (APA):

Phelps, L.L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The client was transported to the emergency department by EMS on 2/9/24 after a seizure and associated fall at home from which she couldn't get up. She states that she scraped her left elbow in the fall and bruised her left arm. She reported minor pain and soreness at the time, but states "I'm in no pain at all, now."

Nursing Diagnosis/Outcomes

1. Ineffective airway clearance related to retained secretions as evidenced by accessory muscle use and adventitious breath sounds (Phelps, 2023).
   - The optimal outcome would be that the client's oxygen saturation will remain within provider's expected limits of 90-100% for the duration of her admission (Phelps, 2023).
2. Risk for decreased cardiac output related to hypertension, medication side effects, and impaired physical mobility as evidenced by enlarged heart and pitting edema of the lower extremities (Phelps, 2023).
   - Patient's pulse will be between 60-100 bpm and blood pressure stay below 145/90 while in the hospital (Phelps, 2023).
3. Risk for adult falls related to impaired physical mobility and seizure disorder as evidenced by use of a walker and history of falls (Phelps, 2023).
   - The client will demonstrate appropriate use of the walker prior to discharge (Phelps, 2023).

Objective Data

The client's heart rate is 77 bpm, blood pressure is 107/69, respiratory rate is 18, temperature 98.7 F temporally, and O2 saturation is 100% on 3L nasal cannula. The client is positive in affect, appears stated age, appears well-groomed, and shows no signs of acute distress. Client's speech is clear and developmentally appropriate. Client is speaking loudly and is not wearing her hearing aids. The client has a medical history including GERD, COPD, Parkinson's, dyslipidemia, hypertension, and others.

Client Information

The client N. D., is a 68-year-old Caucasian female who is 5' 8" and 284 lbs. She is a retired cafeteria worker, divorced, and currently accompanied by her fiancé. The client is a FULL code and has allergies to amoxicillin, moxifloxacin, clarithromycin, carbamazepine, oxaprozin, erythromycin, levofloxacin, penicillin, and sulfa antibiotics.

Nursing Interventions

- Provide the client supplemental oxygen therapy as prescribed (Phelps, 2023).
- Educate the client on coughing and deep breathing to promote optimal aeration of the lungs (Phelps, 2023).
- Monitor client's vital signs and level of consciousness every 4 hours paying specific attention to blood pressure and heart rate and contact provider with any unexpected findings (Phelps, 2023).
- Track intake and output of client daily to track fluid retention (Phelps, 2023).
- Educate the client on environmental factors that place the client at an increased risk for falls and injury in a fall (Phelps, 2023).
- Provide the client with further education about proper use of the walker to minimize fall risks (Phelps, 2023).