

N431 Care Plan 2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 3-31-2024	Client Initials DB	Age 91	Gender Female
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Widowed	Allergies Pollen Extracts, potassium chloride, Vioxx
Code Status No CPR	Height 149cm	Weight 41.6kg	

Medical History (5 Points)

Past Medical History: Asthma, Fracture of distal radius, macular degeneration, osteoporosis

Past Surgical History: Cataract removal, hysterectomy, total knee replacement

Family History: Mother-Hypertension, diabetes. Sister- hypertension, stroke. Son- diabetes, COPD

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

1-2 drinks (wine) every few weeks. Denies other social history

Assistive Devices: A walker

Living Situation: Lives alone at home

Education Level: Unable to determine because of patient not being able to answer. Not in history

Admission Assessment

Chief Complaint (2 points): Presents with fall

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

Patient fell on 3-30-2024 at home when she was alone. The location that she hurt was her lower back. The duration was 1 day of her in pain. The pain was sharp and come and goes. The patient

tried to take Tylenol for the pain but did not help. She tried to sit on heating pad and that helped a little bit. The intended treatment is to potentially be giving her a brace with pain medication.

The severity was moderate.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Encephalopathy

Secondary Diagnosis (if applicable): N/A

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

Encephalopathy is an alteration in your brain function (Cleveland Clinic Staff, 2023). The cause of encephalopathy can be a head injury, stroke, an infection, malnutrition, or a brain tumor. It is not a single disease. It is a collection of disorders that have several causes (Sood, 2019). Encephalopathy can have a reduced or over production metabolism of different neurotoxins (Cleveland Clinic Staff, 2023). There is also a deficient in thiamine that can cause brain damage (Cleveland Clinic Staff, 2023).

Signs and symptoms of encephalopathy can be different for each person. The most common signs and symptom that patients present with are sleepiness, loss of motivation, memory loss, disorientation, confusion, poor attention span, behavioral changes, difficulty breathing, loss of consciousness, and hallucination (Cleveland Clinic Staff, 2023). My patient did not come for encephalopathy, but came for a fall. She soon became confused and did not know why or where she was at. She did not know her birthday or the current year. She was only able to mutter her name She was arousable for a few seconds if you said her name loudly. The patient's healthcare provider will order tests to help rule out other conditions.

The test that could be ran is CT scan, MRI, lumbar puncture, blood tests, or an electroencephalogram (Cleveland Clinic Staff, 2023). My patient had a CT scan and an MRI that

was completed. The results came back that nothing was abnormal. The lab values that may be abnormal with encephalopathy are serum ammonia levels, ALT, AST serum bilirubin, electrolytes, and a urine screen (Sood, 2019). My patient has an abnormal troponin due to the patient being dehydrated. She had all these labs completed. They checked the patient for a UTI to rule out that for a cause of her confusion. She was taking thiamine before she was admitted to the hospital.

The treatment and management are determined by how severe that case is and what caused the encephalopathy (Cleveland Clinic Staff, 2023). Some treatments include surgery, life support measure, organ transplant, managing the health condition, taking medication, and taking supplement that the body may be lacking (Cleveland Clinic Staff, 2023). My patient's treatment was yet to decide as she was a new admit during my clinical rotation.

Pathophysiology References (2) (APA):

Cleveland Clinic Staff. (October, 2 2024). Encephalopathy. *Cleveland Clinic*.

<https://my.clevelandclinic.org/health/diseases/encephalopathy>

Sood, G. (2019). Portosystemic Encephalopathy Workup. *MedScape*.

<https://emedicine.medscape.com/article/182208-workup?form=fpf#c4>

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	3.8-5.3 10(6)mcl	3.62	N/A	N/A
Hgb	12.0-15.8 g/dL	11.4	N/A	N/A
Hct	36.0-47.0%	32.5%	N/A	Patient has an increase of Hct from

				dehydration (Martin, 2023)
Platelets	140-440 10(3)mcl	133 10(3)mcl	N/A	Patient has a decrease in platelets from possible infection (Martin, 2023).
WBC	4-12 10(3)mcl	6.49	N/A	N/A
Neutrophils	47-73%	3.90	N/A	N/A
Lymphocytes	18-42%	1.29	N/A	N/A
Monocytes	4-12%	0.95	N/A	N/A
Eosinophils	0.0-1.0%	0.31	N/A	N/A
Bands	0.0-10.0%		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-	136-145 mmol/L	138	N/A	N/A
K+	3.5-5.1 mmol/L	3.5	N/A	N/A
Cl-	98-107 mmol/L	104	N/A	N/A
CO2	22-30 mmol/L	24.0	N/A	N/A
Glucose	70-99 mg/dL	122 mg/dL	N/A	Patient has an increase due to acute stress response (Martin, 2023).
BUN	10-20 mg/dL	19	N/A	N/A
Creatinine	0.6-1 mg/dL	0.70	N/A	N/A
Albumin	3.5-5 g/dL		N/A	N/A
Calcium	8.7-10.5 mg/dL	8.7	N/A	N/A
Mag	1.6-2.6 mg/dL	N/A	N/A	N/A
Phosphate	2.8-4.5 mg/dL	N/A	N/A	N/A

Bilirubin	0.3-1.0 mg/dL	N/A	N/A	N/A
Alk Phos	34-104 u/L	N/A	N/A	N/A
AST	8-33 u/L	21	N/A	N/A
ALT	4-36 u/L	9	N/A	N/A
Amylase	29-103 u/L	N/A	N/A	N/A
Lipase	8-78 u/L	N/A	N/A	N/A
Lactic Acid	0.7-2.0 mmol/L	1.5	N/A	N/A
Troponin	0.5-2.0mmol/L	22 mmol/L	N/A	Patient has increase of troponin due to stress and dehydration (Martin, 2023).
CK-MB	0-4mg/L	N/A	N/A	N/A
Total CK	29-168 u/L	157	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	08-1.1	N/A	N/A	N/A
PT	10.1-13.1 sec	N/A	N/A	N/A
PTT	25-36 sec	N/A	N/A	N/A
D-Dimer	0.0-0.5	N/A	N/A	N/A
BNP	>100pg/ml	N/A	N/A	N/A
HDL	>40mg/dL	N/A	N/A	N/A
LDL	<130 mg/dL	N/A	N/A	N/A
Cholesterol	<200 mg d/L	N/A	N/A	N/A

Triglycerides	<150 mg d/L	N/A	N/A	N/A
Hgb A1c	4.0-6.0%	N/A	N/A	N/A
TSH	0.300-5.000 ml U/L	2.090 ml U/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/ Yellow	N/A	N/A
pH	4.5-8	5.5	N/A	N/A
Specific Gravity	1.005-1.025	1.024	N/A	N/A
Glucose	≤ 130 mg/d	Neg	N/A	N/A
Protein	≤ 150 mg/d	30	N/A	N/A
Ketones	None	80	N/A	Patient presence of ketones could be from not adequate nutrition (Martin, 2023).
WBC	≤ 2-5 WBCs/hpf	3	N/A	N/A
RBC	≤ 150 RBCs/hpf	13	N/A	N/A
Leukoesterase	Negative	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	7.34-7.45	N/A	N/A	N/A

PaO2	35-45	N/A	N/A	N/A
PaCO2	40-50	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A
SaO2	>95%	N/A	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	10,000-1,000,000 bacteria/mL	N/A	N/A	N/A
Blood Culture	10-20 mL	N/A	N/A	N/A
Sputum Culture	>25 leukocytes	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Martin, P. (2023). *Complete normal lab values reference guide cheat sheet*. Nurselabs.

<https://nurseslabs.com/normal-lab-values-nclex-nursing/#h-total-calcium-ca-ionized-calcium>

Diagnostic Imaging

All Other Diagnostic Tests (5 points): XR Chest AP and CT Brain W/O Contrast

Diagnostic Test Correlation (5 points):

XR Chest AP – The doctor wrote “cardiac silhouette and pulmonary vasculature appear stable from the prior study. Slight increase of interstitial markings in both lungs and appears

unchanged.” A chest X-ray will give the doctors an image of blood vessels, lungs, heart, airways, and bones of the spine and chest (Mayo Clinic Staff, 2023). The patient had an X-Ray to help visual any fractures that she may have sustained during her fall.

CT Brain W/O Contrast- The doctor wrote, “there is no evidence of acute intracranial hemorrhage, edema, or hydrocephalus. No mass effect or midline shift is seen.” A head CT scan can identify problems around or in your brain (Mayo Clinic Staff, 2023). My patient was confused and had a fall so they doctors wanted to rule out any damage to the brain that could have happened during her fall.

Diagnostic Test Reference (1) (APA):

Mayo Clinic Staff. (2023). Chest X-rays. *Mayo Clinic*. <https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494>

Mayo Clinic Staff. (20230). Brain tumor. *Mayo Clinic*. <https://www.mayoclinic.org/diseases-conditions/brain-tumor/diagnosis-treatment/drc-20350088>

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

Home Medications (5 required)

Brand/ Generic	heparin (Lovenox)	Mirtazapine (Remeron)	Thiamine (Vit B1)	Calcium carbonat e (Tums)	Ondansetro n (Zofran)
Dose	5,000 Units	15mg	100mg	500mg	4mg
Frequency	BID	Bedtime	Daily	PRN	PRN
Route	Sub Q	Oral	Oral	Oral	Sublingual

Classification	Pharmacologic: Anticoagulant Therapeutic: Anticoagulant (NDH, 2023).	Pharmacologic: Tetracycline Therapeutic: Antidepressant (NDH, 2023).	Pharmacologic: Vitamin Therapeutic: Supplement (NDH, 2023).	Pharmacologic: Calcium Salts Therapeutic: Antacid (NDH, 2023).	Pharmacologic: Selective Serotonin Therapeutic: Antiemetic (NDH, 2023).
Mechanism of Action	According to <i>Nursing Drug Handbook</i> , “binds with antithrombin III.” (2023).	According to <i>Nursing Drug Handbook</i> , “inhibits neural reuptake of norepinephrine” (2023).	According to <i>Nursing Drug Handbook</i> , “Binds with adenosine triphosphate” (2023).	According to <i>Nursing Drug Handbook</i> , “increases the levels of intracellular and extracellular calcium” (2023).	According to <i>Nursing Drug Handbook</i> , “blocks serotonin receptors centrally in the trigger zone” (2023).
Reason Client Taking	To prevent blood clots	To help treat major depression	To help with B1 levels	To help settle her stomach	To help prevent nausea
Contraindications (2)	Uncontrolled active bleeding, and alcohol Anticoagulant	Hypersensitive to mirtazapine or its component (NDH, 2023).	If you have a high B1 level and vitamin toxicity (NDH, 2023).	Cardiac resuscitation, and hypercalcemia (NDH, 2023).	Hypersensitive to ondansetron and concomitant use of apomorphine (NDH, 2023).
Side Effects/Adverse Reactions (2)	Dizziness and headache (NDH, 2023).	Anxiety and depression (NDH, 2023).	May cause an upset stomach and wheezing (NDH, 2023).	Hypotension and vomiting (NDH, 2023).	Fever and chest pain (NDH, 2023).
Nursing	Use cautiously in	Monitor	Make sure the	Make	Monitor

Considerations (2)	alcoholics and avoid injecting drug by IM (NDH, 2023).	closely for the first few weeks, and monitor for infection (NDH, 2023).	patient has had reaction to he medication, and it can raise the blood pressure when overused (NDH, 2023).	sure the patient is able to chew and that they have teeth to do so	patient’s electrocardio gram and monitor and serotonin syndrome (NDH, 2023).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check their platelet count and assess if there is any active bleeding.	Assess patient’s mental status and check WBC to see if there is an active infection	Check the dosage of the medication and to see if she is showing signs of adverse effect	Check the patient calcium levels and make sure they do not have an upset stomach before administering	Assess if the patient if vomiting and check levels of magnesium (NDH, 2023).
Client Teaching Needs (2)	Tell client not to use razors but use an electric razor. BE more careful that they do not fall	Tell patient may take up to 14 days to start working and that it may cause mild pupil dilation (NDH, 2023).	That it can raise her blood pressure if it is overused and not to drink while taking vitamin. (NDH, 2023).	Urge patient to chew tablets all the way and take 1-2 hours after meals (NDH, 2023).	Tell patient to report signs of hypersensitive and to place tablet under their tongue (NDH, 2023).

Hospital Medications (5 required)

Brand/Generic	Prochlorper (Compazine)	Acetaminophen (Tylenol)	Albuterol HFA (Ventolin HFA)	Diclofenac (VOLTaren)	Lactated Ringers (LR)
Dose	10mg	500mg	18g	3g	75ml/hr
Frequency	PRN	PRN	PRN	BID PRN	Continuous
Route	Oral	Oral	Inhaler	Topically	IV
Classification	Pharmacologic:	Pharmacologic:	Pharmacologic:	Pharmacologic: NSAID	Pharmacologic: Isotonic

	Piperzine Therapeutic: Antiemetic (<i>NDH</i> , 2023).	Nonsalicylat w Therapeutic: antipyretic (<i>NDH</i> , 2023).	adrenergic Therapeutic: bronchodilat ar (<i>NDH</i> , 2023).	Therapeutic: Analgesic (<i>NDH</i> , 2023).	Fluids Therapeutic: Isotonic Fluids
Mechanism of Action	According to <i>Nursing Drug Handbook</i> , “blocks dopamine receptors, depressing release of hormones” (2023).	According to <i>Nursing Drug Handbook</i> , “inhibits the enzyme cyclooxygenase blocking prostaglandin” (2023).	According to <i>Nursing Drug Handbook</i> , “attaches to beta 2 that stimulate the enzyme ATP to covert to cAMP” (2023).	According to <i>Nursing Drug Handbook</i> , “blocks the activity of cyclooxygenase” (2023).	According to <i>Nursing Drug Handbook</i> , “the production of lactate takes hydrogen forming acids” (2023).
Reason Client Taking	To help with nausea	To treat mil pain	To prevent bronchospas ms (<i>NDH</i> , 2023).	To help signs and symptoms of arthritis	To help patient replace electrolytes
Contraindications (2)	Weight loss and severe CNS depression (<i>NDH</i> , 2023).	Hepatic impairment and hypersensitive to acetaminophen (<i>NDH</i> , 2023).	Hypersensitive to albuterol or its components (<i>NDH</i> , 2023).	Hypoglycemia and thiazides (<i>NDH</i> , 2023).	The patient can become over hydrated and if the patient has liver disease (<i>NDH</i> , 2023).
Side Effects/Adverse Reactions (2)	Drowsiness and hypotension (<i>NDH</i> , 2023).	Fatigue and muscle spasms (<i>NDH</i> , 2023).	Hyperglycemia and diaphoresis (<i>NDH</i> , 2023).	Dizziness, euphoria (<i>NDH</i> , 2023).	Liver cirrhosis and swelling (<i>NDH</i> , 2023).
Nursing Considerations (2)	Monitor closely for adverse reactions and should not be used in dementia patients	Use cautiously in patient with hepatic impairment and monitor renal function	Use cautiously in patients with cardiac disorders and hypertension (<i>NDH</i> , 2023).	Adjust dose between type and monitor blood glucose (<i>NDH</i> , 2023).	To monitor for a brain bleed and to look for edema (<i>NDH</i> , 2023).
Key Nursing	Assess if the	Check the	Check	Assess the	Assess

Assessment(s)/Lab(s) Prior to Administration	patient has an upset stomach and check for allergies (NDH, 2023).	output of urine in the patient and liver function	potassium levels (NDH, 2023). and assess breathing rate	pan level and blood sugar (NDH, 2023).	electrolyte imbalance
Client Teaching Needs (2)	Tell patient to avoid the use of alcohol and notify doctor if medication makes you restless (NDH, 2023).	Tell patient not to exceed the recommended amount and stop taking if you are showing signs of hepatic toxicity (NDH, 2023).	Tell patient to wash mouth after administration and wait 1 minute between inhalations (NDH, 2023).	Take on a regular schedule and notify provided if show signs of hyperglycemia (NDH, 2023).	That the medication will go through the IV. The medication will be continuous

Medications Reference (1) (APA):

Nurse’s drug handbook. (2023). Jones & Barlett Learning

Assessment

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

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Patient was AxAx1. She was not alert. She only knew her name. She was 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:	She was pale and warm and dry upon palpation. She was no rashes, bruises, wounds. Her Braden score was 13. Her skin turgor was tenting.

<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck were symmetrical with no deviation. Ears has no drainage. EOMs were unable to do. Nose was clear and had no drain or polyps. She had teeth missing but had dentures. Mouth was dry and lips were cracked.</p>
<p>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:</p>	<p>Patient had an s1 and s2 noted. There were no murmurs, gallops, or rubs. Peripheral pulse was at 4 seconds.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Breaths had a normal rate and rhythm. No crackles, rhonchi, or wheezes.</p>
<p>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:</p>	<p>Diet was regular at home and hospital. The patient has difficulty swallowing. She is 150cm tall and 61.6 kg. All four quadrants had active bowel sounds. Last bowel movement was on 3-30-24. No masses or organomegaly noted upon palpation. No drains, scars, distention, or wounds.</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Patient urine was clear and yellow. No pain while urinating. She voided one time during my clinical rotation. There was very little urine when she voided. Unable to determine because she did not have a catheter in.</p>

<p>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:</p>	
<p>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 type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Patient was very weak. Her pedal pulls nad pushes were at 2/5. Her hand grasp was 2/5. She walks with a walker. Her fall risk score was 45. Patient was x2 assist when ambulating and needed assistance with walker.</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient was AxO x 1. She did not know the year, her birthday, or where she was at. she had equal strength in arms and legs. Her mental status was not determined because patient could not answer question. It was very hard to wake her up. She responded to verbal stimuli. Her speech was slurred</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>Unable to determine due to patient not responding to questions. She was a new admit and had little information on the patient.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0715	73	123/62	18	36.7 C	97
1113	71	118/60	18	36.6 C	96

Vital Sign Trends: The vitals are within normal limits and remained steady and stable through the clinical shift

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0715	Numerical	0	0	0	0
1113	Numerical	0	0	0	0

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G Location of IV: left wrist Date on IV: 3-31-24 Patency of IV: clear/patent Signs of erythema, drainage, etc.: no redness, swelling, drainage IV dressing assessment: dry and intact	Lactated Ringers 75mls/hour

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600ml LR 30ml Water 10ml of Apple Sauce	incontinent of urine x 1 void

Nursing Care

Summary of Care (2 points)

Overview of care: I did a head-to-toe assessment on the patient. I helped the nurse provide care by changing her solid diet. I administered medications and helped patient take sips of water.

Procedures/testing done: X-ray and CT scan

Complaints/Issues: The patient had no issues or complaints

Vital signs (stable/unstable): Stable except LOC

Tolerating diet, activity, etc.: Not tolerating normal diet because she is having difficulty swallowing

Physician notifications: She had encephalopathy

Future plans for client: The patient would be discharged to a nursing home because she is no longer able to live by herself

Discharge Planning (2 points)

Discharge location: A nursing home

Home health needs (if applicable): NA

Equipment needs (if applicable): Walker

Follow up plan: To continue to maintain a healthy diet and weight

Education needs: Would educate the patient on healthy options for food and fluids.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal	Evaluation
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<p>1. Risk for DVT related to sedentary lifestyle as evidence by her not being able to get out of bed</p>	<p>Patient was unable to walk with her walker or assistance (Phelps, 2021).</p>	<p>1. Observe patient for shortness of breath. 2. Encourage extensions and flexion of the legs</p>	<p>The patient remains free from developing a DVT</p>	<p>There was no family present. The patient had no shortness of breath and was able to flex of legs with assistance</p>
<p>2. Risk for electrolyte imbalance related to dehydration as evidence by the patient's poor skin turgor</p>	<p>The patient had a skin turgor that was tenting (Phelps, 2021).</p>	<p>1. assess patient's fluid status and labs 2. Offer patient sips of water</p>	<p>1. The patient would consume he daily recommended amount of water</p>	<p>There was no family present. The patient took 5 sips of water. The daily goal was not reached.</p>
<p>3. Risk for imbalanced nutrition related to patient's malnutrition as evidence by patient being underweight</p>	<p>The patient intake was 1 bite of apple sauce all clinical (Phelps, 2021).</p>	<p>1. Record patient's weight at the same time everyday 2. Assist with eating meals</p>	<p>1. Patient will show no evidence of further weight loss</p>	<p>There was no family present. The patient was not successful because she only ate one bite of applesauce</p>
<p>Risk for confusion disorientation as evidence by patient not knowing where she was</p>	<p>The patient was AxO x1 (Phelps, 2021).</p>	<p>Assess the patient's LOC 2. Talk slowly and clear and allow patient to respond</p>	<p>1. The patient would respond to questions and know where she was.</p>	<p>There was no family present. The client only was able to respond to one question</p>

Other References (APA):

Phelps, L. (2021). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer

Concept Map (20 Points):

Subjective Data

- The patient stated, "I do not know where I am at"
 - She fell at home on 3-30-24
 - She was in no pain
 - That she does not smoke
- She has a drink (wine) every 1-2 weeks

Nursing Diagnosis/Outcomes

1. Risk for confusion disorientation as evidence by patient not knowing where she was.
Outcome- The patient would respond to questions and know where she was
2. Risk for electrolyte imbalance related to dehydration as evidence by the patient's poor skin turgor
Outcome- The patient would consume the daily recommended amount of water
3. Risk for imbalanced nutrition related to patient's malnutrition as evidence by patient being underweight
Outcome- Patient will show no evidence of further weight loss
4. Risk for DVT related to sedentary lifestyle as evidence by her not being able to get out of bed
Outcome-The patient remains free from developing a DVT

Objective Data

- X Ray that showed that she had Slight increase of interstitial markings in both lungs and appears unchanged
 - 1 void of urine
 - Drank 30ml of water
- CT of the brain that showed no swelling, hemorrhage, or hydrocephalus
 - Hct was 32.5
 - Glucose was 122
 - No UTI

Client Information

The patient is a 91-year-old female presenting to the hospital after a fall at home. She lives at home alone. She has a history of cataract removal, hysterectomy, total knee replacement. She is partial code status with no CPR.

Nursing Interventions

Assess the patient's LOC
Talk slowly and clear and allow patient to respond
Assess patient's fluid status and labs
Offer patient sips of water
Record patient's weight at the same time everyday
Assist with eating meals
Observe patient for shortness of breath.
Encourage extensions and flexion of the legs

Medications

- Heparin-** To prevent blood clots
- Thiamine-** To help with B1 levels
- Prochlorper-** To help with nausea



