N431 CARE PLAN # 1

Kelsy Marsh

Lakeview College of Nursing

N441: Adult Health 3

Michele Bergen

09/15/2024

Demographics

Date of Admission 08/26/2024	Client Initials J.H.	Age 75 yrs. old	Biological Gender Female
Race/Ethnicity White	Occupation N/A	Marital Status Divorced	Allergies Keflex (cephalexin)-GI upset, Codeine-Nausea, Penicillin-Rash
Code Status DNR, DNI	Height 5'9" (175.3 cm)	Weight 256 lbs (116.5 kg)	

Medical History

Past Medical History: COVID (1/31/2022), History of COVID-19 (2/17/21), and Shingles (2018)

Past Surgical History: Cholecystectomy and tubal ligation

Family History: Family history includes Diabetes in her brother

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient reports that she has an unknown smoking status. The patient has never used smokeless tobacco. There's no history on file for alcohol use or drug use.

Education: High school diploma

Living Situation: Lives by herself at the Tuscola Health Care Center

Assistive devices: Uses a walker for support

Admission History

Chief Complaint: Anasarca, Bilateral lower extremity edema and redness and left arm, Nausea and vomiting

History of Present Illness (HPI)– OLD CARTS

The patient is a 75-year-old Caucasian female who presents to the emergency department at Carle Foundation Hospital in Urbana, IL with complaints of swelling in both legs and

her left arm. The patient states that the swelling in both of her legs and the left upper extremity has been getting worse over the last 3 weeks. The patient has a history of congestive heart failure. The patient stated that she is compliant with all of her oral medications. The patient does not receive any IV medications currently while living at the Tuscola Health Care Center. The patient denies having any chest pain, shortness of breath, or chest discomfort. The patient denies having pain anywhere on her body.

Admission Diagnosis

Primary Diagnosis: Cellulitis of the lower legs

Secondary Diagnosis (if applicable): Extended- spectrum beta-lactamases (ESBL), Clostridioides difficile (C. Diff)

Pathophysiology

Edema is when the body has swelling that is caused by fluid build-up within the body tissues. Edema can occur within any part of the body, but it is most commonly found within the extremities (hands, feet, arms, and legs). Edema can result from numerous causes, such as congestive heart failure, kidney disease, venous insufficiency, trauma, and medications. It is important that nurses taking care of patients with edema monitor their patients fluid balance, promote mobility, and provide the patient and the patients family with extensive education to manage their condition. It is vital that when a nurse is assessing a clients edema to look at the location, extent, and severity of the edema. It is also important to document any changes in skin color, temperature, or texture that is associated with the edema.

Extended-spectrum beta-lactamase (ESBL) is an enzyme that makes bacteria resistant to certain bacteria. ESBL are commonly known as "superbugs" because they are resistant to many antibiotics such as penicillin and some cephalosporin, which in return makes them difficult to treat (Pagana, 2021). ESBL bacteria can be spread from person to person on contaminated hands of both patients and healthcare workers. The risk of transmission of the condition is at an all time high if the person has diarrhea or a urinary catheter in place. Infections that are caused by ESBL bacteria mainly affect the urinary tract and the intestines.

Clostridioides difficile (C. diff) is a gram-positive type of bacteria that can cause diarrhea and inflammation of the colon, also known as colitis. These rod-shaped bacteria can survive in unfavorable conditions, and are easily transmitted through contact with objects and humans. Some common symptoms of C. diff include: diarrhea, fever, abdominal pain, nausea, and loss of appetite. The more severe cases of C. difficle have symptoms of dehydration, watery diarrhea occurring more than 10 times a day, weight loss, and presence of blood or pus in the stool. If a patient is suspected of having a positive result of C. diff, the nurse for the patient will obtain a stool sample for testing, per the provider's orders. A physician may also order some blood samples for laboratory testing such as: CBC, electrolyte levels, serum Creatinine, albumin levels, and serum lactate levels (Pagana, 2021). To treat the infection, it is vital to start antibiotics immediately. Oral metronidazole treats mild-moderate cases of C. diff, and oral vancomycin treats severe cases of C. diff. Patients with C. diff should also be put on contact precautions, due to the high rate of transmission.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Psychobiology of Behavioral Disorders. In *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives Second Edition* (page 180). F.A. Davis.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Absolute MONO	**1.26**	**1.09**	**0.00-1.10/uL**	**Absolute MONO level was high due to the patient experiencing symptoms of a gastrointestinal infection (Pagana, 2021).**
Absolute Immature Granulocyte	**0.05**	**0.35**	**0.00-0.09/uL**	**Absolute immature granulocyte levels were high, due to this being an early sign of an**

				infection (Pagana, 2021).
HCO3	**N/A**	**21.4**	**21.5-25.5 mmol/L**	**Low bicarbonate levels indicate that the body is having trouble maintain its acid-base balance, due to chronic diarrhea (Pagana, 2021).**
p02	**N/A**	**45.3**	**35.0-45.0 mmHg**	**A high partial pressure of oxygen in the blood can indicate to us that the patient has increased oxygen levels in the inhaled air (Pagana, 2021).**
C. Difficile Detection	**N/A**	**Positive**	**Negative**	**C. diff testing checks a sample of your stool for signs of an infection with a bacteria called C. diff (Pagana, 2021).**
Potassium	**N/A**	**3.4**	**3.5-5.1 mmol/L**	**Potassium levels are low due to diarrhea and certain medications. This explains why the**

				patient is experiencing fatigue.
BUN	**N/A**	**5**	**10-20 mg/dL**	**The BUN is low due to the body not getting the appropriate amount of nutrients that it needs to function properly.**
Calcium	**N/A**	**8.4**	**8.9-10.6 mg/dL**	**The calcium levels are low due to not having enough vitamin D within the body.**

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
Lower Extremity Venous Duplex (08/26/2024)	**Left extremity pain and redness**	**No evidence of lower extremity deep venous thrombosis bilaterally in the visualized venous segments.**
Echocardiogram (08/28/2024)	**Concerns for congestive heart failure.**	**The left ventricle is normal in size. There is borderline**

		concentric left ventricular hypertrophy. No regional wall motion abnormalities noted in the visualized segment. Probably preserved left ventricular systolic function. Left ventricle ejection fraction is probably around 60-65%. The right ventricle is not well visualized.
ECG 12 LEAD (09/10/2024) Monitor QT interval	**This was done to help diagnose a variety of heart-related conditions.**	**The patient has normal sinus rhythm, low voltage QRS, and borderline ECG**
US ABDOMEN RT UPPER QUADRANT (08/27/2024)	**Patient complained of abdominal pain.**	**Decreased sensitivity due to the**

		patient body habitus and overlying bowel gas. The pancreas is not well visualized due to overlying bowel gas. Patent portal vein with hepatopetal flow.
XR CHEST AP (09/13/2024) **To rule out fluid overload**	**This was ordered due to ruling out cardiac issues, including any chest pain or shortness of breath.**	**Stable asymmetric elevation of the right hemidiaphragm, with right basilar atelectasis.**

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

Active Orders

Active Orders	Rationale
Regular diet	**Client is on soft bite size diet at home**
Patient is 2 assist to ambulate	**Client is unsteady**
Turn Q2H	**To prevent bed sores**

02 at 2 L PRN per nasal cannula to keep 02 >90%	**Routine protocol**
Access central venous/midline/PICC	**May use for blood draws**
Incentive spirometer	**Q1H**
Urinary catheter care	**PRN**
Intake & Output Q shift	**Routine**
Daily weight before breakfast	**Measure fluid**
Vital signs Q4H	**Routine**
Inspect pressure injuries Q shift	**Keep up on the skin breakdown, and monitor wounds**

Medications

Home Medications (Must List ALL)

Brand/Generic	**Lorazepam/ Ativan 0.25 mg tablet**	**Fluticasone furoate-vilanterol (Breo Ellipta) 200-25 mcg/dose**	**Levothyroxine /Levoxyl 75 mcg tablet**	**Acetamino phen/ Tylenol 500 mg**	

		inhaler 1 puff			
Classification	**Anti-Anxiety Benzodiazepines**	**Beta-Adrenergic and Glucocorticoid Combo**	**Thyroid Hormones**	**Nonsalicylate**	
Reason Client Taking	**Anxiety**	**Allergy symptoms such as sneezing, itching and stuffy nose.**	**Low thyroid activity**	**Pain**	
List two teaching needs for the medication pertinent to the client	**If Lorazepam makes you feel sleepy, do not drive, ride a bike, or use tools or machinery (Jones and Bartlett Learning, 2021).** **Do not drink alcohol while taking Lorazepam.**	**If you forget a dose, use it as soon as you remember, unless it's almost time for your next dose.** **Using too much fluticasone or using it for a long time may increase your risk of adrenal gland problems (Jones and Bartlett Learning, 2021).**	**Levothyroxine should not be used alone or along with other treatments to treat obesity or cause weight loss.** **Levothyroxine should be taken on an empty stomach with water, at least 1 hr. before eating (Jones and Bartlett Learning, 2021).**	**Take acetaminophen exactly as directed on the package label.** **Do not take more acetaminophen or take it more often than directed, even if you still have fever or pain.**	
Key nursing assessment(s) prior to administration	**Assess heart rate, ECG, and heart sounds (Jones and Bartlett Learning, 2021).**	**Report any signs of headache, toothache, or painful white patches in the mouth or throat to the provider (Jones and Bartlett Learning, 2021).**	**Assess heart rate, ECG, heart sounds, and especially during exercise (Jones and Bartlett Learning, 2021).**	**Perform patient assessments, such as vital signs, lung sounds, or pain level (Jones and Bartlett Learning, 2021).**	
Brand/Generic	**ROPINIROLE/ REQUIP 0.25 mg tablet TID**	**Metoprolol succinate ER (Toprol XL) extended release tablet 50 mg**	**Miconazole/ Carrington 2% topical powder**		
Classification	**Antiparkinsonism drugs**	**Beta-Adrenergic Blocking Agents**	**Topical antifungal**		
Reason Client Taking	**Muscle spasms/poor muscle control**	**High blood pressure**	**Rash between breast folds**		
List two teaching needs for the medication pertinent to the client	**Your doctor will adjust your dose as needed and tolerated.** **Take**	**Take the medication as exactly as prescribed.** **Do not suddenly stop taking this**	**To use topical miconazole, wash the affected area and dry thoroughly.**		

	ropinirole at around the same time everyday.	**medication.**	**Do not use an airtight bandage.**		
Key nursing assessment(s) prior to administration	**Assess dizziness, drowsiness, and syncope of the patient.**	**Monitor the patients blood pressure and heart rate**	**Monitor patient for any pain, swelling or itching.**		
Brand/Generic	**Acetaminophen/Tylenol 500 mg tablet**	**Montelukast (Singulair) 10 mg tablet**	**Tiotropium bromide (Spiriva Respimat) mist for inhalation**		
Classification	**Analgesic/ Antipyretic**	**Leukotriene Receptor Antagonist**	**Anticholinergics**		
Reason Client Taking	**PRN For mild pain rated 1-3 or for pain rated higher than 3 and patient requests acetaminophen or temp >100.4F**	**Wheezing, difficulty breathing, chest tightness**	**COPD**		
List two teaching needs for the medication pertinent to the client	**Take acetaminophen exactly as directed on the package label.** **Do not take more acetaminophen or take it more often than directed, even if you still have fever or pain.**	**Usually taken once a day with or without food (Jones and Bartlett Learning, 2021).** **Taking this medication with alcohol or Benadryl may make you drowsy.**	**Use this medicine only as directed by your doctor.** **Do not use more of it, and do not use it more often.**		
Key nursing assessment(s) prior to administration	**Perform patient assessments, such as vital signs, lung sounds, or pain level (Jones and Bartlett Learning, 2021).**	**Monitor for mood/behavior changes, including suicidal thinking.**	**Use in caution with patients who have urinary retention. The nurse needs to keep an eye on urinary signs and symptoms of bladder-neck obstruction.**		

Hospital Medications (Must List ALL)

Brand/Generic	**Potassium chloride 20 mEq/100 mL IVPB**	**Benztropine/ Cogentin 0.5mg tablet**	**Docusate Sodium (Colace) 100 mg capsule**	**Enoxaparin (Lovenox) Syringe 40mg**		
Classification	**Potassium Replacement**	**Antiparkinsonism Drugs**	**Laxative**	**Heparin**		
Reason Client Taking	**Low potassium levels**	**Muscle control**	**Stool softener**	**Risk of DVT**		
List two teaching needs for the medication pertinent to the client	**Take this medication by mouth as directed by the provider.** **To prevent stomach upset, take each dose with a meal and a full glass of water.**	**This may cause visual hallucinations, vivid dreams, or paranoia (Jones and Bartlett Learning, 2021).** **If the patient experiences signs of paranoia, the medication should be stopped.**	**Do not take more or less of it or take it more often than prescribed by the doctor.** **Swallow the docusate capsules whole.**	**It's important you give injections at the same time each day.** **It is important to continue it until told to stop.**		
Key nursing assessment(s) prior to administration	**Monitor the patients potassium levels and ask them if they take a potassium-sparing diuretic**	**Assessing for tremors, rigidity, and shuffling gait.**	**Nausea or vomiting due to the requirement of consuming a significant amount of fluid.**	**Lovenox should not be used in patients who are actively bleeding or who have a low count of blood cells.**		
Brand/Generic	**Acetaminophen rectal suppository 650 mg**	**Famotidine (Pepcid) injection 20 mg IV PUSH**	**Potassium chloride extended release tablet 40 mEq**	**Tamsulosin (Flomax) 0.4 mg capsule**		
Classification	**Analgesic/Antipyretics**	**Histamine H2-Receptor Inhibitors**	**Potassium Replacement**	**Alpha blockers**		

Reason Client Taking	**PRN For mild pain rate 1-3 or for pain rated higher than 3 and patient requests acetaminophen or temp> 100.4F**	**Heart burn**	**Vitamin Replacement**	**Benign Prostatic Hypertrophy**		
List two teaching needs for the medication pertinent to the client	**Take acetaminophen exactly as directed on the package label.** **Do not take more acetaminophen or take it more often than directed, even if you still have fever or pain.**	**Can be taken with or without food.** **Take 15-60 minutes before eating food or drinking beverages that can cause indigestion.**	**Take this medication by mouth as directed by the provider.** **To prevent stomach upset, take each dose with a meal and a full glass of water.**	**Do not take more or less of this medication unless prescribed by the doctor.** **Swallow capsules whole, do not chew.**		
Key nursing assessment(s) prior to administration	**Perform patient assessments, such as vital signs, lung sounds, or pain level (Jones and Bartlett Learning, 2021).**	**Assess the patient for signs of mental/mood changes, such as confusion.**	**Monitor the patients potassium levels and ask them if they take a potassium-sparing diuretic**	**Assess and monitor the blood pressure of the patient.**		
Brand/Generic	**Albumin, 25% infusion 50g IV 120 mL/hr**	**Vancomycin oral solution 125 mg QID**				
Classification	**Plasma Proteins**	**Antibiotics**				
Reason Client Taking	**PRN x 1 dose due to low levels**	**C. Diff**				
List two teaching needs for the medication pertinent to the client	**Do not mix with any medications.** **Do not dilute with water for injections.**	**Patients should take their medication as prescribed and avoid taking other antibiotics.** **Patients should wash their hands**				

		with soap and water often.				
Key nursing assessment(s) prior to administration	**Ensure that the patient is hydrated, to prevent hypervolemia.**	**Patients should be in a private room, and have their room cleaned regularly.**				

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Metoprolol succinate ER (TOPROL XL) extended release tablet 50 mg	**This medication was important because it is treating the patients high blood pressure**	**1. Rash 2. Swelling of the hands and feet**
2. Vancomycin oral solution 125 mg	**This is used to treat C. diff**	**1. Severe diarrhea 2. Change in amount, color of urine**
3. Acetaminophen	**Used for pain control**	**1. Dizziness/Tired/Weakness 2. Vomiting**

Medications Reference (1) (APA):

Learning, J. &. B. (2021). *2021 Nurse's Drug Handbook*. Jones & Bartlett Learning.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: Alertness: Orientation: Distress: Overall appearance: Infection Control precautions: Client Complaints or Concerns:	**Patient is A&O x4 somewhat groomed, no acute distress. Patient is on contact precautions due to C. diff and ESBL. Precautions used when in contact with the patient were wearing a gown and gloves. The isolation is: contact/soap and water every time there was interaction with the patient.**

VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	**Temp: 98.1 F Oral** **Resp rate: 22** **Pulse: 85 bpm** **B/P: 124/60** **Oxygen: 93%** **Delivery Method: Room Air**
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:** **Interventions:**	**Time: 1530** **Scale: 0 on a numerical scale** **Location: N/A** **Severity: N/A** **Characteristics: N/A** **Interventions: N/A**
IV ASSESSMENT: **Size of IV: 22g** **Location of IV: Right arm** **Date on IV: 9/13/2024** **Patency of IV: blood returned noted; flushed** **Signs of erythema, drainage, etc.: N/A** **IV dressing assessment: antimicrobial disk placed, new dressing 9/15/24, transparent semipermeable dressing applied** **Fluid Type/Rate or Saline Lock: Capped, alcohol impregnated cap present**	**LDA midline (placement 09/13/2024)** **Size of IV: 22g** **Location of IV: Right arm** **Date on IV: 9/13/2024** **Patency of IV: blood returned noted; flushed** **Signs of erythema, drainage, etc.: N/A** **IV dressing assessment: antimicrobial disk placed, new dressing 9/15/24, transparent semipermeable dressing applied** **Fluid Type/Rate or Saline Lock: Capped, alcohol impregnated cap present**
INTEGUMENTARY: **Skin color: WNL for ethnicity** **Character: skin is swollen and red** **Temperature: skin is warm upon palpation** **Turgor: clients skin is elastic** **Rashes: rash noted underneath clients breast folds** **Bruises: no bruises noted** **Wounds: no wounds noted** **Braden Score: 18** **Drains present: Y☐ N ☐** **Type: N/A**	**Skin color: WNL for ethnicity** **Character: skin is swollen and red** **Temperature: skin is warm upon palpation** **Turgor: clients skin is elastic** **Rashes: rash noted underneath clients breast folds** **Bruises: no bruises noted** **Wounds: no wounds noted** **Braden Score: 18** **Drains present: Y☐ N ☐** **Type: N/A**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is symmetrical to the neck. Hair is light grey and evenly distributed. Neck is symmetrical to head and moves without difficulty. Trachea is midline without deviation. Ears have no bumps or deformities. Eyes have bilateral white scleras with clear**

	corneas. Nose is midline to the face, bilateral turbinates without drainage. Mouth/teeth the oral mucosa is pink and moist without lesions. .
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema: Bilateral legs**	**Clear +S1, S2 without murmurs, gallops or rubs. Normal sinus rhythm. Peripheral pulses 2+ bilaterally. Capillary refill is less than 3 seconds. No JVD noted. Edema is noted to be on bilateral lower extremities and the left upper arm.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Respirations are unlabored and regular. No use of accessory muscles is noted. Breath sounds are clear bilaterally.
GASTROINTESTINAL: **Diet at home:** **Current Diet:** **Is Client Tolerating Diet?** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds: 9/09/24 medial coccyx (moisture associated skin damage)** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Diet at home is regular. Current diet is regular with soft bite size food. Client tolerates diet somewhat. Height: 175.3 cm and Weight: 256 lbs. Bowel sounds were normoactive in all 4 quadrants upon auscultation. Last BM: 9/15/2024 watery stool. Palpation: abdominal pain in the RUQ, no organomegaly noted. No abdominal distention was noted. Client does not have an ostomy or a nasogastric tube, or a PEG/feeding tube. Wounds: 9/09/24 medial coccyx (moisture associated skin damage)
GENITOURINARY: **Color: yellow** **Character: clear, without odor** **Quantity of urine: 100 ml** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐**	**Color: yellow** **Character: clear, without odor** **Quantity of urine: 100 ml** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals: genitals intact**

Inspection of genitals: genitals intact **Catheter: Y ☐ N ☐** **Type: external urinary catheter** **Size: N/A**	**Catheter: Y ☐ N ☐** **Type: external urinary catheter** **Size: N/A**
Intake (in mLs) **Output (in mLs)**	**Intake: 340 ml** **Output: 300 ml**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	Nail beds pin in all 4 extremities bilaterally. Extremities, all 4 warm bilaterally. Patient was in bed most of the day. Client used a walker when needing to get up and ambulate. Handgrips and pedal pushes equal bilaterally. Client used assistance with mainly all activities. Patient is a high fall risk. Fall score is 45. Client needs support with equipment and with standing/walking.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW: Client moves all extremities somewhat well, just very slowly. **PERRLA: PERRLA bilaterally.** **Strength equal: Strength is equal in arms and legs bilaterally** **Cognition/mental status: Client is anxious, confused and restless due to hypoxia.** **Speech: Speech is somewhat clear and organized.** **Sensory: No sensory issues noted.** **LOC: Client is alert and oriented to self, place, date, and reason why she is in the hospital.**
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):**	Client talks with her daughter to assist with any pain she may have. Client has a high school diploma and understands what is being told to her about her plan of care. Client is divorced, but the patient's daughter comes to visit her and read books to her. The client did not discuss religion.

Discharge Planning

Discharge location: Tuscola Health Care Center

Home health needs: Client could use a home health nurse to ensure that he is using her medications, walker, and eating appropriately.

Equipment needs: Walker

Follow up plan: Follow up with her provider.

Education needs: Educate on walker assistance, nutrition, and taking medications.

Nursing Process

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	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**
1. Excess fluid volume related to excessive fluid intake as evidenced by edema.	**Excess fluid or fluid overload is important to edema because it's the cause of the swelling that occurs with edema.**	**The patient will maintain clear lung sound and the absence of symptoms of respiratory distress.**	**1. Encourage a low-sodium diet.** **2. Weigh daily.**	**1. Large amounts of sodium cause the body to retain water in an attempt to dilute it, which causes fluid overload.** **2. Daily**

				weights can assess the effectiveness of diuretic therapy. Educating to patients with CHF, that if they notice a weight gain of 5 lbs. in a week, or 2 lbs. overnight, they should contact their doctor.
2. Imbalanced nutrition related to the medical diagnosis of C. difficile infection as evidenced by a positive C. difficile stool culture	**Malabsorption of nutrients is another common side effect of C. diff.**	**Patient will adhere to infection control interventions to prevent the spread of C. difficile.**	**1. Start antibiotics immediately.** **2. Implement contact precautions.**	**1. Oral vancomycin treats severe cases of C. difficile. Teach the patient to take the medication as ordered.** **2. Patients with C. difficile should be on contact precautions. Advise the patient and visitors of the**

				following: wash hands with soap and water after every restroom use, emphasize hand washing before eating and contact with visitors, and placing the patient in an isolated room.
3. Risk for falls related to assistive device use as evidenced by walker usage.	**The client seems to be unsteady when using the walker**	**The patient will remain free of falls.**	**1. Assess muscle strength, coordination, and use of devices.** **2. "Use the Morse fall scale. The Morse Fall scale is used to identify risk factors for potential falls in hospitalized patients" (Phelps, 2022).**	**Both the patient and the patient's daughter were completely on board with this new regimen. They are both aware that the patient is not independent, especially with her walker, so they completely agree to use the Morse Fall Scale.**
4. Risk for impaired tissue integrity	**The client is unable to get out of bed**	**Client will be able to get out of**	**1. Inspect clients skin every shift**	**Early detection of changes prevents or minimizes skin**

related to decreased physical activity as evidenced by the wound on the patient's coccyx	**easily for activity.**	**bed more often to take care of the breakdown of skin on the coccyx.**	**2. Monitor the dressing of the coccyx to make sure it doesn't become worse.**	**breakdown (Phelps, 2022).** **Correct placement and frequent inspection of devices prevent skin breakdown (Phelps, 2022).**
1. Acute pain related to persistent diarrhea evidenced by complaints of abdominal pain.	**Assess reports of abdominal cramping or pain, noting location, duration and intensity (0-10 scale). Investigate and report changes in characteristics .**	**The patient reports relief from abdominal cramping.**	**1. Position the patient comfortably** **2. Administer pain medications**	**The patient tolerated this well. The daughter said that it would be a good idea for the patient to write down these symptoms in a book.**

Other References (APA):

Phelps, L. (2022). ***Nursing Diagnosis Reference Manual*****. LWW.**