N441 CARE PLAN #1

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Lakeview College of Nursing

N441: Adult Health 3

Michele Bergen

10/15/2024

Demographics

Date of Admission 8/29/2024	**Client Initials** W.P.	**Age** 73 years old	**Biological Gender** Female
Race/Ethnicity White	**Occupation** Retired	**Marital Status** Married	**Allergies** Hydrocodone-Acetaminophen
Code Status Full Code	**Height** 5'2	**Weight** 156 lbs.	

Medical History

Past Medical History: Breast Cancer, Hyperlipidemia, Cirrhosis, Depressive Disorder Diabetes Mellitus Type 2, Arthritis of both knees. Hypertension, High Cholesterol

Past Surgical History: Left Breast Mastectomy, Mammoplasty, Hysterectomy, Colonoscopy, Wisdom teeth extraction

Family History: Breast Cancer- Paternal Aunt, Maternal Cousin, Paternal Cousin Diabetes- Maternal Aunt

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Former tobacco user (1 pack per day for 25 years, Quit in 1993)/ No alcohol, No drugs

Education: Some college

Living Situation: Lives w/ husband

Assistive devices: Wheel chair and walker

Admission History

Chief Complaint: Altered Mental Status

History of Present Illness (HPI)– OLD CARTS

On August 29th, 2024, W.P., was admitted to the Carle Foundation Hospital due to altered mental status. The onset of this symptom occurred in the morning of August 29th, while the patient was at home with her husband. W.P. told her husband she didn't know where she was and

wanted to go home. Because of W.P.’s husbands concerns, she was brought to the Emergency Department by EMS.

Upon initial assessment by the emergency room registered nurse, slurred speech and confusion were noted. The patient's condition was also noted to be severe. The nurse checked her temperature and she was feverish with a temperature of 102.4 degrees Fahrenheit. It was observed that questions seemed to exacerbate the symptoms (adding to the confusion) and rest was reported as a known relieving factor. W.P. is currently under medical treatment in the Cardio Pulmonary Department at Carle Foundation Hospital, where prescribed medications are being administered to manage the condition.

To combat confusion, the patient was reoriented several times at home and in the hospital. It is important to note that the patient experienced the symptoms before coming to the ER. This case shows the significance of prompt medical attention and intervention when experiencing symptoms of severe infection, and the importance of continued care and monitoring in a hospital setting.

Admission Diagnosis

Primary Diagnosis: Sepsis

Secondary Diagnosis (if applicable):

Pathophysiology

Sepsis is a critical medical condition that occurs when an infection progresses to a more advanced and dangerous stage (American Thoracic Society, 2021). Sepsis is a systemic response to an infection in the body. In our patient, the infection started in the patients heel due to an untreated infection. When the systemic response becomes severe, it can lead to widespread

inflammation, organ dysfunction, and a heightened risk of death. Sepsis is a life-threatening condition (American Thoracic Society, 2021).

Common signs and symptoms of sepsis are high fever (seen in our patient), rapid heart rate, rapid breathing, low blood pressure (seen in our patient), and altered mental state (also seen in our patient) (Mayo Clinic, 2023). Our patient experienced all of the symptoms listed, which was enough for the physician to suspect a systemic infection. Because of the signs and symptoms and diagnostic testing, W.P. was admitted to the hospital. If sepsis is not treated, it can lead to severe sepsis. Severe sepsis is characterized by the same symptoms as sepsis but with the added presence of organ dysfunction or failure. Organs such as the heart, kidneys, liver, and lungs may not function properly, and this can lead to life-threatening complications (Mayo Clinic, 2023).

Diagnosing sepsis requires a combination of tests and the overall clinical judgment of the healthcare provider. A physical examination, clinical assessment, and lab tests (including lactic acid levels, CBC, inflammatory markers, microbiological tests, blood gas analysis, imaging studies, and urine analysis) are used to diagnose sepsis (American Thoracic Society, 2021). Early recognition, intervention, and immediate medical attention are crucial to improving the chances of survival in cases of sepsis. All of the measures mentioned above were used to diagnose W.P.

Sepsis is a medical emergency and requires prompt treatment to prevent further deterioration of organ function and potential death. Patients with sepsis may require intensive medical intervention, including treatment in an intensive care unit (ICU), and may need measures such as mechanical ventilation, IV fluid, medications to support blood pressure, anticoagulants, and antibiotics to target the underlying infection. In W.P., blood pressure medicine, anticoagulants, IV fluid, and antibiotics were used to treat the infection. IV fluid and antibiotics are the two most important treatments for sepsis (American Thoracic Society, 2021).

Pathophysiology References (2) (APA):

Mayo Clinic. (2023, February 10). *Sepsis: Symptoms and causes*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214

American Thoracic Society. (2021). *Sepsis, severe sepsis, and septic shock*. American Thoracic Society. https://www.thoracic.org/patients/patient-resources/managing-the-icu-experience/sepsis-severe-sepsis-and-septic-shock.php

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
RBC	2.55	2.42	3.50-5.20	Reduced red blood cell production due to systemic inflammatory response- sepsis (Pagana et al., 2018).
Hgb	10.9	9.2	11-16	Reduced red blood cell production due to systemic inflammatory response- sepsis (Pagana et al., 2018).
AST	60	45	5-34	Sepsis may have caused liver dysfunction (Pagana

				et al., 2018).
ALT	51	18	0-55	Sepsis may have caused liver dysfunction (Pagana et al., 2018).
Glucose	453	101	74-100	The patient is diabetic and the admission value could represent an uncontrolled diabetic condition (she has Type 2 diabetes) or could also be a result of sepsis which can increase as a stress response to the infection and inflammation (Pagana et al., 2018).
Sodium	124	138	136-145	Sepsis affects the fluid balance which may results in hyponatremia (Pagana et al., 2018).
Potassium	7.1	5.2	3.5-5.1	Sepsis can cause electrolyte imbalances including hyperkalemia but we see this condition

				normalizing post infection (Pagana et al., 2018).
Chloride	94	110	98-107	Hyperchloremia and hypochloremia are seen in patients with sepsis (Pagana et al., 2018).
BUN	72	24	10-20	High BUN levels are seen in patients with sepsis (Pagana et al., 2018).
Creatinine	1.9	1.93	0.55-1.02	High creatinine levels are seen in patients with sepsis (Pagana et al., 2018).
Albumin	2.8	2.4	3.4-4.8	Low albumin levels are seen in patients with sepsis (Pagana et al., 2018).
Bilirubin	2.2	1.1	0.2-1.2	High bilirubin levels are seen in patients with sepsis (Pagana et al., 2018).

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**

CT of brain w/ contrast- check for bleeding in brain	Altered mental status, confusion	Negative
Wound culture- check for infection in wound on heel	Redness, yellow pus, swelling, and fever	Positive- MRSA and Enterococcus faecalis
Chest Xray- checking for secondary infections	Sepsis diagnosis	Negative

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.

Active Orders

Active Orders	Rationale
Diabetic Diet- high protein	Patient is diabetic
Weight Bearing Limitations	Patient is working with PT to become more active
AC/HS Blood Sugar	Patient is diabetic
Pneumatic compression stockings	on unaffected leg to prevent blood clots and to increase circulation
Ensure use of hearing aids and glasses	Patient has hearing and vision deficits
Wound Care	Daily wound care is needed to heal infection
Patient Education	Understanding Sepsis

Monitor bowel and bladder functions	Patient had previous issues with constipation related to medication. Patient had previous issues with urine output related to Sepsis.
Contact Isolation	Open wound
Wound care dressings daily	Open wound on heel

Medications

Home Medications (Must List ALL)

Brand/ Generic	**Bayer/ Aspirin**	**Lasix/ Furosemide**	**Norvasc/ Amlodipine**	**Wellbutrin/ Bupropion**	**Trulicity/ Dulaglutide**	**Neurontin/ Gabapentin**
Classification	**NSAID**	**Loop Diuretic**	**Calcium Channel Blocker**	**Antidepressant /Norepinephrine/ dopamine**	**GLP-1 agonists**	**Anticonvulsants**

				reuptake inhibitor		
Reason Client Taking	**To help relieve pain**	**To treat edema**	**High Blood Pressure**	**Depressive Disorder**	**Improve blood sugar**	**To help relieve pain**
List two teaching needs for the medication pertinent to the client	**Always take this medication with food. Drink adequate fluids when taking aspirin.**	**Patient should take this medication as directed. Caution patient to change positions slowly to minimize hypotension.**	**Take amlodipine as directed. Shake the suspension well before each use to mix the medication evenly.**	**Take medication exactly as directed. Take tablets whole- do not crush split or chew them.**	**Take medication as directed. Use in a different place each time you give an injection.**	**Always take gabapentin exactly as described. Take medication with a full glass of water.**
Key nursing assessment(s) prior to administration	**Assess for signs of bleeding. Assess pain level.**	**Assess daily weight and electrolytes prior to administration.**	**Assess the patients blood pressure and apical pulse during therapy**	**Assess for pregnancy status. Assess baseline mental status**	**Assess for low blood sugar. Assess for swelling or lump in neck.**	**Assess pain level. Assess other medications patient may have taken as Gabapentin is not to be taken with antacids.**
Brand/ Generic	**Novolog/ Insulin aspart**	**Levemir/ Insulin Detemir**	**Freestyle Lite Meter**	**Zoloft/ Sertraline**	**Crestor / Rosuvastatin**	
Classification	**Ultra rapid acting insulin**	**Long-acting form of insulin**	**Class 2 medical device**	**Selective serotonin reuptake inhibitor**	**HMG-CoA reductase inhibitors**	
Reason Client Taking	**To improve glycemic control**	**Helps treat diabetes**	**To check blood sugar levels**	**Depressive Disorder**	**High cholesterol**	

List two teaching needs for the medication pertinent to the client	**Make sure a meal is consumed within 15 minutes of administration. Follow insulin regimen.**	**Always inject your insulins separately. Use different body area every time you give a shot.**	**Keep meter in 40- 104 degrees Fahrenheit for accurate readings. Only use Free Style Lite test strips with this meter**	**Take medication around the same time daily. Take sertraline as directed.**	**Do not miss any doses. Take medication around the same time daily**	
Key nursing assessment(s) prior to administration	**Check patient's blood glucose level**	**Check patient's blood glucose level**	**Check the date on the test strips.**	**Assess baseline mental status**	**Assess any joint or muscle pain- may be drug induced myopathy**	
Brand/ Generic						
Classification						
Reason Client Taking						
List two teaching needs for the medication pertinent to the client						
Key nursing						

assessment(s) prior to administration						

Hospital Medications (Must List ALL)

Brand/ Generic	**Wellbutrin/ Bupropion**	**Zoloft/ Sertraline**	**Lasix/ Furosemide**	**Gabapentin**	**Lantus/ Insulin Glargine**	**Lovenox (Pro)/ Enoxaparin**
Classification	**Antidepressant/ Norepinephrine/ dopamine reuptake inhibitor**	**Selective serotonin reuptake inhibitor**	**Loop Diuretic**	**Anticonvulsants**	**Long-acting insulin**	**Anticoagulant**
Reason Client Taking	**Depressive Disorder**	**Depressive Disorder**	**To treat edema**	**To help relieve pain**	**To help treat diabetes**	**Reduce clotting ability of the blood**
List two teaching needs for the medication pertinent to the client	**Take medication exactly as directed. Take tablets whole- do not crush split or chew them**	**Take medication around the same time daily. Take sertraline as directed.**	**Patient should take this medication as directed. Caution patient to change positions slowly to minimize hypotension.**	**Always take gabapentin exactly as described. Take medication with a full glass of water.**	**Should be taking once per day. Should be taken at the same time every day**	**There may be bruising at the injection site. Injection should be given at the same time daily.**
Key nursing	**Assess for pregnancy**	**Assess baseline**	**Assess daily**	**Assess pain level.**	**Assess for symptoms of**	**Assess for signs**

assessment(s) prior to administration	**status. Assess baseline mental status**	**mental status**	**weight and electrolytes prior to administration.**	**Assess other medications patient may have taken as Gabapentin is not to be taken with antacids.**	**hyperglycemia and hypoglycemia**	**of neurological impairment**
Brand/ Generic	**Mycamine / Micafungin**	**Humalog/ Insulin Lispro**	**Klor-Con/ Potassium Chloride**	**Duphalac/ Lactulose**	**Claritin/ Loratadine**	**Vancor/ Vancomycin**
Classification	**Antifungal drug/ echinocandins**	**Fast acting type of insulin**	**Electrolyte supplement**	**Osmotic laxative**	**Second generation antihistamine**	**Glyco peptide antibiotics**
Reason Client Taking	**Fungal Infection**	**Helps treat diabetes**	**Treats hypokalemia**	**Treats constipation**	**Treats patient's seasonal allergies**	**Bacterial infection**
List two teaching needs for the medication pertinent to the client	**Use exactly as directed. Take medicine at regular intervals**	**Do not take with nay other insulin. This usually injected 15 minutes before or after a meal**	**Take by mouth as directed by doctor. Do not lie down for at least 10 minutes after taking this medication**	**Take lactulose as directed. May take up to 48 hours to work**	**Take once per day. Symptoms should subside rapidly.**	**Take the entire prescription even when feeling better**
Key nursing assessment(s) prior to administration	**Assess for signs of hemolytic anemia**	**Assess blood glucose level**	**Assess most recent potassium levels**	**Assess therapeutic response**	**Assess for a therapeutic response**	**Assess blood pressure periodically and compare to**

						normal values
Brand/ Generic	**Aldactone/ Spironolactone**					
Classification	**Mineralocorticoid receptor antagonist**					
Reason Client Taking	**Treat high blood pressure**					
List two teaching needs for the medication pertinent to the client	**Try not to take too close to bed time. Medicine may increase urination.**					
Key nursing assessment(s) prior to administration	**Assess fluid status and blood pressure**					

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Gabapentin	**Helps patient with nerve pain**	**1. Assess for change in patient's behavior** **2. Drowsiness**
2. Micafungin	**Helps to clear up infection**	**1. Anxiety** **2. Bleeding gums**

3. Vancomycin	**Helps to clear infection**	**1. Abdominal pain** **2. Nausea**

Medications Reference (1) (APA)

Jones & Bartlett Learning. (2020). *Nurse's drug handbook*. Composition and Project Management: S4Carlisle Publishing Services.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL:	
Alertness:	Patient appears alert
Orientation:	Patient is oriented to person, place, and time
Distress:	Patient is well groomed and seems to be in no acute distress
Overall appearance:	Patient's overall appearance is good
Infection Control precautions:	Contact Isolation
Client Complaints or Concerns:	No concerns or complaints at this time
VITAL SIGNS:	
Temp:	98.4-oral
Resp rate:	16
Pulse:	72
B/P:	124/80
Oxygen:	98
Delivery Method:	Room Air
PAIN ASSESSMENT:	
Time:	0845
Scale:	0-10
Location:	N/A
Severity:	0
Characteristics:	N/A
Interventions:	N/A
IV ASSESSMENT:	Central Venous Catheter
Size of IV:	6.6 port
Location of IV:	Subclavian
Date on IV:	9/12/2024
Patency of IV:	IV is patent
Signs of erythema, drainage, etc.:	Smooth, dry, and intact
IV dressing assessment:	Transparent, No signs of infection
Fluid Type/Rate or Saline Lock:	Saline Lock
INTEGUMENTARY:	

Skin color: **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 16** **Drains present: Y☐ N ☒** **Type:**	Skin is pink Skin is dry upon palpation Skin is warm Normal skin turgor No rashes or lesions. Bruise on left ac from previous IV insertion Patient has a dressed wound on left heel.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Symmetrical, trachea is midline without deviation, thyroid is non- palpable, no noted nodules. Bilateral carotid pulses 2+, no prominent lymphadenopathy. No palpable deformities, lumps, or lesions. Bilateral sclera white with slight redness from dryness/discomfort. Left and right cornea show nuclear cataracts. Bilateral conjunctiva pink, no visible drainage. Lids are moist and pink without lesions. Septum is midline with no visible drainage production. Sinuses are nontender. Posterior pharynx and tonsils look moist and pink without exudate noted. Uvula is midline, soft palate rises and falls symmetrically. Hard palate intact. Dentition is abnormal- no teeth, oral mucosa is moist and pink and brown but without lesions noted. Patient uses dentures.
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:**	. S1 and S2 are clear without murmurs, gallops, or rubs. Normal rate and rhythm. Peripheral pulses are diminished. Lower legs are palpable. Capillary refill is less than 3 seconds. No edema noted

RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal rate and pattern of respirations. Symmetrical and non-labored, no cough. Posterior lung sounds are normal
GASTROINTESTINAL: **Diet at home:** **Current Diet:** **Is Client Tolerating Diet?** **Height: 5'2** **Weight:156** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Abdomen is soft, nontender, no organomegaly or masses upon palpation in all four quadrants. Bowel sounds are active in all four quadrants. Last bowel movement was today 10/13/24 No pain or mass felt when palpated No visible distention, incisions, scars, drains, or wounds on abdomen are noted.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: Yes** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Yellow Clear 120 mL
Intake (in mLs) **Output (in mLs)**	240 mL 120 mL
MUSCULOSKELETAL: **Neurovascular status:**	Lower extremities have limited ROM due to

ROM: **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 36** **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	generalized weakness and edema. Hand grips demonstrate equal and normal strength. Pedal pushes are weak but equal in strength**.** Weight Bearing as tolerated Gait is not well balanced or smooth; the patient requires assistance with ambulation(walker/wheelchair).
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient responds well to stimuli, obeys commands, and A&Ox4. Strength is normal and equal in the upper extremities but equal and weakened in lower extremities. Mental status, speech, sensory, and LOC are all intact.
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):**	Ego Integrity vs. Despair (65+) Patient is calm and cooperative. She is not religious. Her husband visits and lifts her spirits, we've observed.

Discharge Planning

Discharge location: The patient is going home with her husband.

Home health needs: Home health care, wound care, Physical Therapy

Equipment needs: The patient will be using the same equipment she has at home

Follow up plan: Plans to follow up with rheumatology and primary care

Education needs: Education about sepsis and infection

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. Increased risk for infection related to compromised immune system evidenced by an open wound	**W.P.'s wound on heel is thought to be the cause for the sepsis infection**	**Patient will know sooner if she is ill**	**1. Patient will check her temperature 3x daily** **2. Patient will contact physician if feeling weak and/ or tired**	**W.P.'s husband is aware of the signs of infection and will help W.P. remain compliant and utilize interventions**
2. **Ineffective tissue perfusion related to an interruption of blood flow as evidenced by slow capillary refill and lower extremity diminished pulses**.	**The client has diminished pulses in lower extremity pulse points**	**Patient will have improved blood flow**	**1. Patient will remain compliant with physicians' orders for PT** **2. Patient will contact physician if changes are noticed**	**Patient and husband are aware that physical therapy is necessary to improve blood flow.**
3. Electrolyte imbalance related to	**Electrolyte imbalance can cause many**	**The client's electrolyte**	**1. The patient will continue to take all**	**The patient and husband understand**

recent sepsis diagnosis evidenced by potassium chloride prescription	**issues- including cardiac. This issue needs to be fixed**	**imbalance will be balanced and potassium chloride will no longer be needed.**	**prescribed medicine** **2. The patient will be seen by a physician if signs of fluid imbalance are seen- such as edema**	**the dangers of electrolyte imbalance**
4. Knowledge deficit related to sepsis disease process evidenced by untreated infection	**The patient needs to know the severity of sepsis and that if it leads to septic shock, death may occur.**	**The patient will understand the sepsis disease process and have any suspected infection seen by a physician**	**1. The patient will regularly inspect skin for signs of infection.** **2. The patient will get medical attention if infection is suspected**	**The patient and husband know that sepsis can lead to death and will monitor patient for signs of infection**
1. Ineffective coping related to threat to health as evidenced by sleep disturbances	**The patient needs to get rest in order to heal.**	**The patient will get proper rest at night and coping with health issues will be better**	**1. Discussion about melatonin** **2. Create a bedtime routine with patient**	**The patient and husband understand how important sleep is to the patients healing process**

Other References (APA):