

N431 CARE PLAN #2

Xitlally Bonilla

Lakeview College of Nursing

N321: Adult Health II

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11-21-2024

Demographics

Date of Admission 11-17-24	Client Initials C.C.	Age 71	Biological Gender Female
Race/Ethnicity White	Occupation retired	Marital Status married	Allergies Adhesive, Keflex, Mobic, amoxicillin, aspirin, Erythromycin, Kenalog, Macrobid, Marcaine, Nickel, NSAIDS, Sulfa
Code Status Full Code	Height 5'3 (160.02 cm)	Weight 153 lb (69.7 kg)	

Medical History

Past Medical History:

- Achilles Bursitis and tendonitis
- anterior acute kidney injury,
- allergic rhinitis
- back pain
- bipolar 2 disorder
- calculus of kidney and ureter
- cataract
- chest pain
- chronic cystitis
- chronic fatigue
- complex regional pain syndrome
- depression
- regional pain syndrome
- Degenerative Joint Disease

- **fibromyalgia**
- **gastroesophageal reflux disease**
- **gout**
- **hiatal hernia**
- **hyperlipidemia**
- **hyperthyroidism**
- **Irritable bowel syndrome**
- **Migraines**
- **mitral valve disorder**
- **obstructive uropathy**
- **ovarian tumor**
- **Pain in left ankle**
- **Pancreatitis**
- **plantar fascial fibromatosis**
- **pyuria**
- **renal disease stage 3**
- **senile nuclear sclerosis**
- **thoracic outlet syndrome**
- **tibialis and tendonitis**
- **tinnitus**
- **urinary tract infection**

Past Surgical History:

- **4/12/18 left arthrodesis**

- 3/2/21 right arthrodesis
- bladder repair
- 8/7/14 left cataract removal
- 8/21/14 right cataract removal
- 1/6/16 Cystoscopic calculus removal
- 2/3/16 colonoscopy
- Hysterectomy
- 3/2/21 left foot soft tissue procedure
- 11/2/21 right foot soft tissue procedure
- 12/16/19 lumbar discectomy right
- 2/19/72 ovary removal
- PR appendectomy
- PR gallbladder removal
- Salpingo-oophorectomy at 18 years old
- 7/2/23 and 6/10/24 upper GI endoscopy

Family History:

Mother:

- Hypertension
- Stage 3 kidney disease
- Osteoporosis
- Thyroid problems

Father:

- Bipolar

- **Esophageal cancer**
- **Hearing loss**
- **Heart issues**
- **Seizure**
- **Psychiatric conditions**
- **Thyroid issues**

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

The patient denies any current use of alcohol, tobacco, and drugs. She mentioned she smoked about a pack a day for two years, 50 years ago. However, the patient wears a buprenorphine patch, which is commonly used as a treatment for opioid addiction. The patient does not appear to be a reliable source of information.

Education: Attended college for one year

Living Situation: Lives at home with her husband and one cat.

Assistive devices: States that she uses no assistive devices other than hearing aids and glasses.

Admission History

Chief Complaint: She presented to the emergency department for altered personality and a change of level of consciousness.

History of Present Illness (HPI)– OLD CARTS

This patient is a 71-year-old female who presented to the emergency department with her husband. Due to having heavy confusion, being jittery, and having an altered level of consciousness, the husband answered a lot of the questions in the emergency room. When I

asked the patient questions, she could answer most of my questions, but there were still signs of confusion around the event.

The patient states that she went to the emergency department on Friday the 15th due to her being jittery, nonstop talking, being confused, and constantly moving. She attributed her altered level of consciousness to having an allergic reaction to doxycycline for bronchitis. Her whole body was affected since she constantly talked, moved, and had visual changes. This lasted the whole weekend until she entered the emergency department on Sunday. When trying to ask her about any associated and aggravating factors or relieving factors, she ignored the question and kept talking about her symptoms. She mentioned that she tried to cover her mouth with her hand to stop talking as much, but it didn't work. When I asked her about any treatment, she said that she would probably have to start a new treatment with antibiotics. Her altered level of consciousness was severe. She stated that she was "bouncing off the walls" and "could not sit on the toilet and peed all over the bathroom."

Admission Diagnosis

Primary Diagnosis: Acute Metabolic Encephalopathy.

Secondary Diagnosis (if applicable): Acute bronchitis due to Rhinovirus

Pathophysiology

Introduction

Renal failure is a serious disease that can cause many complications in the body. The kidneys' primary function is filtering blood waste and preventing toxic build-up. Stage three renal failure indicates that the kidneys are damaged but still work well enough that dialysis is not needed (Capriotti, 2020). However, even though the kidneys are still working, complications like acute metabolic encephalopathy can still occur when combined with other conditions.

Disease Process

Acute metabolic encephalopathy occurs when the body is experiencing a lack of vitamins, glucose, or oxygen (Cleveland Clinic, 2024). Metabolism involves the body breaking down foods and drinks for the brain to have energy (Cleveland Clinic, 2024). Confusion and disorientation can manifest if the brain does not have the energy needed to function. Since this is an acute condition, it may go away on its own, but it is still essential to find the underlying condition that caused the encephalopathy to develop.

Signs and Symptoms

Confusion and disorientation are the most common signs of encephalopathy (Capriotti, 2020). This patient presented to the emergency department with altered levels of consciousness, a change in personality, and generalized confusion.

Diagnosis

Since acute metabolic encephalopathy can be caused by other conditions like heart failure, liver failure, or diabetes, it is important to order a variation of labs to find out what may have caused this problem (Cleveland Clinic, 2024). This patient already has stage three renal failure, so the labs were more focused on that because it was the most likely causative agent. The

basic metabolic panel found low potassium levels, while the renal function panel found low calcium, phosphorus, albumin, and potassium levels. The panel also found an increase in glucose, creatine, and chloride. These renal labs and the lack of oxygen in relation to the Enterovirus, combined with the confusion, all point toward acute metabolic encephalopathy.

Treatment

Treatment for acute metabolic encephalopathy focuses on treating the underlying problem; for this patient, it would be treating her electrolyte imbalances. The patient is currently taking potassium, calcium, and phosphorus.

Clinical Data

As stated previously, the declining function of this patient's kidneys is most likely the reason for the development of acute metabolic encephalopathy. The patient's renal function and metabolic panel showed increased creatinine, glucose, and chloride with decreased calcium, phosphorus, albumin, and potassium.

Pathophysiology References (2) (APA):

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

Cleveland Clinic. (2024). *Metabolic Encephalopathy*.

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

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
absolute eosinophils	0.84 10 ³ /uL	N/A	0-0.5 10 ³ /uL	Eosinophils are a type of white blood cells that are

				used to fight off infection. Since this patient has rhinovirus there will be more eosinophiles to fight off the infection.
albumin	N/A	3.0 g/dL	3.4-4.8 g/dL	Low albumin levels are a sign of kidney disfunction (Pagana et al., 2023).
phosphorus	N/A	1.5 mg/dL	2.5 mg/dL	Some drugs can cause decreased levels of phosphorus. This patient takes estrogen, antacids, and albuterol, which are all known to lower phosphorus (Pagana et al., 2023).
Glucose	99 mg/dL	117 mg/dL	74-100 mg/dL	The patient is not diabetic so her glucose levels may have been raised due to recently having eaten something.
Calcium	9.3 mg/dL	8.4 mg/dL	8.9-10.6 mg/dL	Renal Failure can cause hypocalcemia, and this patient has stage three kidney failure (Pagana et al., 2023).
Creatinine	1.60 mg/dL	1.44 mg/dL	0.55-1.02 mg/dL	Elevated levels of creatinine can be caused by reduced renal blood flow (Pagana et al., 2023). The patient's renal failure could cause this
Chloride	107 mmol/L	108 mmol/L	98-107 mmol/L	The patient's chloride is only slightly elevated, this could simply be due to dehydration or signs of her kidney disfunction (Pagana et al., 2023).
Potassium	3.2 mmol/L	3.0 mmol/L	3.5-5.1 Mmol/L	The patient could have low potassium because she is taking furosemide (Pagana et al., 2023).
Rhino-Enterovirus	Detected	N/A	nonreactive	The client currently has rhino-Enterovirus which is the reason why the lab came back reactive.

Leukocyte	Moderate	N/A	Negative	Leukocyte esterase present in a urinalysis can be a sign of UTI.
WBC	133 uL	N/A	0-25 uL	An elevated amount of WBC is a sign that the body is fighting off an infection.

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
CBC w/ Diff	A complete blood count can get a good amount of information on how the body is functioning (Pagana et al., 2023). The complete blood count may have been able to reveal why the patient had a change in personality.	The patient had elevated absolute eosinophils.
Basic Metabolic Panel This test is used to check the functioning of the kidneys and monitor how they are excreting.	The patient had an altered level of consciousness, was jittery, and acting differently. An accumulation of toxins or if the kidney isn't functioning well can cause these neurological changes.	The BMP showed elevated creatine and low potassium.
Respiratory Pathogens Panel	Because the patient had a cough that was not going away, they did this panel to see what the causative agent was.	The panel came back positive for Rhinovirus.
Magnesium	An increased amount of magnesium is common in people with kidney issues. This test was ordered to make see if the patient had increased levels (Pagana et al., 2023).	She had a normal range of magnesium.
U/A w/ reflex culture	UTIs are a common reason why elderly patients have altered levels of consciousness. This was ordered to see if the altered level of consciousness was due to a UTI.	Moderate amounts of Leukocyte Esterase was found in the urinalysis.
Urine Drug Screen	Since the patient had an altered level of consciousness and was acting different, they wanted to rule out any incidence of drugs.	The results were negative.
Renal function panel	The patient has a history of renal disease. The altered level of consciousness could have also been due to a buildup of toxics in the kidneys, thus ordering a renal function test.	-The patient had decreased calcium, phosphorus, albumin, and potassium. -The patient had increased glucose,

		creatinine, and chloride.
CT Brain w/o contrast	This CT scan was ordered because the patient was exhibiting altered levels of consciousness and the ED wanted to rule out any stroke or hemorrhage.	-No signs of infarction or hemorrhage. -Only age related changed to the brain.
XR Chest PA/LAT	The patient had a consistent cough for the last three weeks with no signs of improvement. The chest X-Ray was used to see if there were any signs of pneumonia.	-The x-ray showed a thickening of the bronchial wall, which is due to mild airway inflammation. -signs of cardiomegaly -no infiltrates present

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's diagnostic and laboratory test reference* (Sixteenth edition). Elsevier.

Active Orders

Active Orders	Rationale
Intake and Output Q Shift	Since this patient has metabolic encephalopathy, it is important to measure their output and intake.
Vital signs Q4H	Vital signs or taken every four hours to see if there is a change in the client's condition.
Known OSA protocol	They want to check if the patient has OSA and needs a CPAP.
Positive OSA protocol	This would have been used if the patient had OSA.
Inspect skin for pressure ulcer within 24 hours of admission. Notify physician.	The hospital wants to make sure that the patient is not coming in with a pressure ulcer and claiming that it developed during their stay.
Activity- increase as tolerated	The patient should be moving around as

	tolerated to decrease chance of DVT/PE.
Notify physician	SBP- 90</>100. Temp 97</> 100.4 HR- 50</>120 O2 sat- <92% RR 10</>30 These are all signs of a worsening condition, so it is important to report to the physician.
Patient refuses nicotine replacement therapy	The patient doesn't use any nicotine, so she doesn't need replacement therapy.
Bilateral compression stockings pneumatic	This are to promote blood flow to the legs and prevent DVT formation.
Initiate hospbasiccare 1027- hospitalized patient PRN pain med substitution	This order might be to give the patient some other type of PRN medication for pain.
Moderate risk of DVT/PE	The patient having limited activity while being in the hospital could increase their risk of DVT/PE.
Regular diet	The patient doesn't have diabetes, cardiac issues, or any reason to be on a different diet.
Isolation-contact/droplet	The patient currently has rhinovirus which is a virus that is spread through droplet precautions. That is why this isolation is necessary.

Medications

Home Medications (Must List ALL)

Brand/ Generic	baclofen/ Gablofen	Primrose oil/ Evening primrose oil	furosemide/ Lasix	levothyroxine / Tirosint	lotepredno l etabonate/ Lotemax	rabeprazo le/ Aciphex
Classificati on	Skeletal muscle relaxants gamma- Aminobutyric Acid-ergic A	Dietary suppleme nt Herbal products	Loop diuretic Antihyperten sive	Synthetic thyroxine Thyroid hormone replacement	Ophthalm ic steroids	Proton Pump inhibitor Antiulcer

	gonist					
Reason Client Taking	It is used to control muscle spasms.	Stated “it helps my hair grow and makes it shiny”.	This can reduce any edema caused by the patient’s renal disease	The patient has hypothyroidism.	For her dry eyes	Used to treat GERD
List two teaching needs for the medication pertinent to the client	<ul style="list-style-type: none"> -The medication should not be abruptly stopped because it can cause hallucinations and seizures (WebMD, n.d.). -This medication can be taken with or without food. 	<ul style="list-style-type: none"> -I would advise the client to always let her providers know that she is using this supplement because providers should also know about supplements as well. -The client should be taught signs of bleeding because this can affect clotting factors (Drugs.com, 2024). 	<ul style="list-style-type: none"> -The patient should take their last daily dose of furosemide hours before they go to avoid sleep interruption (NDH, 2023). -The patient should reduce sodium intake and increase potassium intake (NDH, 2023). 	<ul style="list-style-type: none"> -The patient should take this medication on an empty stomach (NDH, 2023). -The patient should take any antacids and calcium four hours apart from taking levothyroxine (NDH, 2023). 	<ul style="list-style-type: none"> -The patient should know that prolonged use of medication can cause glaucoma (Drugs.com, 2023). -The patient should wash their hands before applying the medication (NDH, 2023). 	<ul style="list-style-type: none"> -The patient should notify their provider if they develop persistent diarrhea with fever and abdominal pain (NDH, 2023). -The patient should know that they may develop a vitamin B12 deficiency if they take this medication for longer than three years (NDH, 2023).
Key	-The nurse	-I would	-I would	-The nurse	-The	-The

nursing assessment(s) prior to administration	should perform a musculoskeletal assessment to see how bad the muscle spasms are.	check the patients' clotting factors since she is also taking heparin.	weigh the client, check for any signs of edema, and check their daily output.	should order thyroid levels to see her thyroid function.	nurse should check PERLA and do an optic assessment.	patient's magnesium level should be monitored while taking this medication.
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Hospital Medications (Must List ALL)

Brand/ Generic	acetaminophen/ Tylenol	albuterol/ ProAir HFA	allopurinol/ Zyloprim	atorvastatin/ Lipitor	benzonatate/ Zonatuss	buprenorphine/ Butrans
Classification	Nonsalicylate Antipyretic	Adrenergic Bronchodilator	Xanthine oxidase inhibitor Antigout	HMG-CoA reductase inhibitor Antihyperlipidemic	Antitussive Cough suppressant	Opioid Opioid analgesic
Reason Client Taking	Used for pain rated 1-3	Albuterol can help treat difficulty breathing due to extreme cough. My client had reported having a consistent cough for more than three weeks.	This patient has a past medical history of gout.	The patient has a medical history of hyperlipidemia.	Used to reduce the patient's cough	Client stated that she does not currently use any drugs, so this patch is more likely used for pain rather than opioid addiction treatment.
List two teaching needs for the medication pertinent to the client	-The patient should not take over 4,000 mg of acetaminophen per day. -If pain or fever is still present after taking the medication, the patient should notify their provider.	-The client needs to be educated on how to use an inhaler properly. -The client also needs to be educated that the inhaler needs to be cleaned once a week and let air dry (NDH, 2023).	-Allopurinol should be taken after meals. -Kidney stones can develop when taking allopurinol, so it is important to have the	-Atorvastatin should be taken at the same time each day so that it can maintain its effects (NDH, 2023). - Grapefruit products	-This medication should be stored at room temperature away from light, heat, and moisture (Drugs.com, 2023). -This medication should be swallowed	-The client is using a transdermal patch so she should be taught that she should wait 21 days before she applies the patch to the same spot (NDH, 2023).

			client drink at least 2L of water per day (NDH, 2023).	should be avoided when taking this medication (NDH, 2023).	whole because chewing it can cause side effects (Drugs.com, 2023).	- If the adhesive of patch begins to wear off, she can tape the edges with first aid tape (NDH, 2023).
Key nursing assessment(s) prior to administration	A pain assessment should be done prior to administration to make sure this is the appropriate medication to relieve the pain they are feeling.	-The nurse should do a respiratory assessment to make sure the client's condition is not getting worse. -The nurse should also check the client's potassium levels before administration. This client already has hypokalemia, and albuterol may cause transient hypokalemia (NDH, 2023).	It is key for the nurse to check renal labs prior to administration because it can worsen the client's renal disease (NDH, 2023).	The nurse should do a musculoskeletal assessment because atorvastatin can cause myalgia, myopathy or neck rigidity (NDH, 2023).	-The nurse should do a respiratory assessment to see if the patient's cough is improving.	-I would do a pain assessment and a deeper social and medical history on this patient. When asked if she was in any pain she said no and rated it 0/10 but she also stated no drug use.
Brand/ Generic	calcium carbonate/ Tums	ceftriaxone/ Rocephin	vitamin D3/ Cholecalciferol	clonazepam/ Klonopin	duloxetine/ Cymbalta	estradiol/ Estrace
Classification	Calcium salts antacid	Third generation cephalosporin Antibiotic	Vitamin d analogs supplements	Benzodiazepine, Anticonvulsant	Selective serotonin and norepinephrine reuptake inhibitor Antidepressant	Estrogen Hormone
Reason Client Taking	Tums can be used to lessen an upset stomach. The client has a history of IBS so it could be used to relieve any symptoms of that.	The patient had a suspected UTI because of her altered level of consciousness and was given this as treatment.	The patient has a low calcium and vitamin D helps absorb calcium	Clonazepam can be used to treat bipolar disorder.	This is used to treat the client's depression.	Used for postmenopausal symptoms like vaginal atrophy.
List two teaching needs for the medication pertinent	-Calcium carbonate should be taken 1 to 2 hours after a meal (NDH, 2023). -Since the	-The patient needs to know that they need to receive the whole series of	-Vitamin D3 needs to be away from moisture, light, and heat. -It is best to take vitamin D3 after a meal to aid in absorption.	-The client needs to know that this medication should not be abruptly stopped	-Teach the client to report signs of bleeding, like bruises or nosebleeds, to the provider because this medication can	-If the client is taking Estrace vaginal cream, she needs to remain in a recumbent position for 30 minutes after

to the client	patient is also taking levothyroxine, they should take that medication 4 hours before or after taking calcium (NDH, 2023).	antibiotic to kill the infection. -Take this medication at the same time every day.		(NDH, 2023). -Tablets should not be broken, crushed, or chewed (NDH, 2023).	increase the risk of bleeding (NDH, 2023). -This medication should not be stopped abruptly.	applying the cream (NDH, 2023). -The patient needs to report any signs of vaginal bleeding (NDH, 2023).
Key nursing assessment(s) prior to administration	-I would assess calcium levels prior to administration.	-In the patient allergies it is stated that she is allergic to amoxicillin. I would want to do some type of allergy assessment or ask about her allergic reaction to amoxicillin to determine if she actually is allergic to that antibiotic.	The nurse should monitor levels of calcium prior to giving the medication.	-Clonazepam can cause suicidal ideations. I would assess if the client is feeling suicidal or has had any thought about hurting herself or others.	-The nurse should assess for serotonin syndrome (agitation, chills, confusion, fever, diarrhea) (NDH, 2023).	-I would do an optic assessment on this patient because she had mentioned to me that she was seeing "weird objects" or that her vision was slightly off. This medication can cause keratoconus which could potentially worsen her vision (NDH, 2023).
Brand/ Generic	guaifenesin/ Mucinex	Heparin/ Hepalean	Melatonin/ Circaden	ondansetron/ Zofran	oxcarbazepine/ Trileptal	panteprazole/ Protonix
Classification	Expectorants Airway secretion	anticoagulant Anticoagulant	Minerals and electrolytes	Selective serotonin receptor antagonist antiemetic	Carboxamide derivative Anticonvulsant	Proton pump inhibitor antiulcer
Reason Client Taking	The patient is taking this to clear any sputum production.	In the active orders it is stated that the client has a	If the client has difficulty falling asleep	Client is taking it for nausea and vomiting.	Oxcarbazepine can sometimes be used to treat and manage bipolar disorders (NDH, 2023).	Used for symptoms of GERD

		moderate risk for developing DVT/PE, so the heparin is to prevent that.				
List two teaching needs for the medication pertinent to the client	-Doses should be measured with dosing syringes or a medicine cup (Drugs.com, 2024). -The patient should drink extra fluids to help loosen the congestion (Drugs.com, 2024).	-The client should be told that they should avoid taking other medications like aspirin or ibuprofen because it can interact with heparin (NDH, 2023). -The client should be taught to watch for black tarry stools because it is a sign of bleeding.	-The patient should take melatonin thirty minutes before they plan on falling asleep. -The patient should avoid coffee, tea, soda, energy drinks, or any caffeine products because they will have a counter effect on the melatonin.	-Zofran can be taken with or without food. -When taking Zofran out of the package, the medication should not be pushed out (NDH, 2023). The film should be peeled back.	-Patient should be taught that the signs of low sodium are confusion, lack of energy, nausea, or tiredness and that signs should be reported to the provider (NDH, 2023). -This medication should not be abruptly stopped in any circumstance.	-Medications should be swallowed whole (NDH, 2023). -If the client experiences diarrhea the provider should be notified (NDH, 2023).
Key nursing assessment(s) prior to administration	-The nurse should do a respiratory assessment to see if airway is improving.	The nurse should check blood clotting labs prior to administration.	The nurse should assess their sleep wake cycle to make sure it is not altered.	-The patient's hypokalemia should be corrected before giving ondansetron because it can increase the QT-interval (NDH, 2023). -Order an EKG.	-The nurse should monitor sodium levels, especially because this is an elderly patient (NDH, 2023).	-The nurse should assess the patient's urine because this medication can cause a decrease in urination or hematuria (NDH, 2023). -Monitor PT or INR (NDH, 2023).
Brand/ Generic	potassium chloride/ Neo-K	potassium sodium phosphate s/ Phos-Nak	prochlorperazine/ Compazine	QUetiapine/ Seroquel	rizatriptan oral disintegrating/ Maxalt	
Classification	Electrolyte cation Electrolyte replacement	Minerals and Electrolytes Supplement	Piperazine phenothiazine Antiemetic	Dibenzothiazepine derivative Antipsychotic	Selective serotonin receptor antagonist Antimigraine	
Reason	The client	The	Can be used	Can be used	This is used for	

Client Taking	has low potassium levels	patient has low levels of phosphorus and potassium.	for nausea and vomiting or if the client has non-psychotic anxiety.	to treat her depression.	the patient's migraines.	
List two teaching needs for the medication pertinent to the client	<p>-The client can take this medication by dissolving it in 4 oz. of warm water.</p> <p>-The client should be taught how to check their radial pulse so that they can notify the provider of any rhythm changes (NDH, 2023).</p>	<p>-The patient should take this medication with a full glass of water and alongside meals (Drugs.com, 2023).</p> <p>-The patient should know that they need frequent blood and urine tests while taking this medication (Drugs.com, 2023).</p>	<p>-Can be administered with or without food.</p> <p>-The drug should be kept away from any sunlight (NDH, 2023).</p>	<p>-When taking this medication, the patient should rise slowly from a laying or seated position to reduce the risk of fainting or getting dizzy (NDH, 2023).</p> <p>-This medication should not be stopped abruptly because it can cause withdrawal symptoms (NDH, 2023).</p>	<p>-The patient should remove the medication from the packet with dry hands and by peeling the film back (NDH, 2023).</p> <p>-The patient should know not to take another form of antimigraine medication 24 hours after taking this one (NDH, 2023).</p>	
Key nursing assessment(s) prior to administration	-The nurse should monitor the patient's potassium levels and check any EKG changes.	-The nurse should assess the patient's blood and urine lab results prior to giving medication.	-The nurse should do cardiac assessment prior to administration because this medication can cause hypotension and tachycardia (NDH, 2023).	-Assess the patient for signs of tardive dyskinesia like involuntary movements of eyelids, face, jaw, mouth, or tongue (NDH, 2023).	-The nurse should perform a pain assessment to see how severe the migraine is.	

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Ceftriaxone	I chose this antibiotic because it is being used to treat her UTI. An UTI can quickly become a serious complication in older adults. It can lead to sepsis and altered levels of consciousness, which the patient is already exhibiting.	1. This antibiotic can cause nephrotoxicity which can worsen the patient's preexisting renal disease (NDH, 2023). 2. This medication can cause dyspnea which can exacerbate the patient's consistent cough (NDH, 2023).
2. Potassium Chloride	The client has low potassium levels which can cause abnormal heart rhythms and shallow respirations. It is important for the client to take potassium supplements.	1. This medication can cause bloody stools, diarrhea, or GI bleeding (NDH, 2023). 2. Too much potassium can cardiac arrest, chest pain, and EKG changes (NDH, 2023).
3. Albuterol	The client is experiencing a cough that has lasted three weeks, has diminished lung sounds, and a low oxygen saturation. These are all respiratory issues, so it is important for the patient to take her albuterol to help any compromise of her respiratory system.	1. This medication can cause coughing and shortness which can worsen the client's already bad condition (NDH, 2023). 2. This medication can also cause tremors and hyperkinesia (NDH, 2023). The patient already mentioned she was jittery and had tremors over the past weekend.

Medications Reference (1) (APA)

2023 nurse's drug handbook. (2023). Jones & Bartlett Learning.

Multum, C. (2024). *Evening primrose*. Drugs.com. <https://www.drugs.com/mtm/evening-primrose.html>.

Multum, C. (2024). *PHOS-Nak*. Drugs.com. <https://www.drugs.com/mtm/phos-nak.html>.

Puckey, M. (2024). *Guaifenesin*. Drugs.com. <https://www.drugs.com/guaifenesin.html>.

Thorton, P. (2023). *Lotemax*. Drugs.com. <https://www.drugs.com/lotemax.html>.

Thorton, P. (2024). *Benzonatate*. Drugs.com. <https://www.drugs.com/benzonatate.html>.

WebMD. (n.d.). *Baclofen- uses, side effects, and more.* <https://www.webmd.com/drugs/2/drug-8615/baclofen-oral/details>.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

<p>GENERAL: Alertness: Alert and talkative. Orientation: A/O x4 Distress: No distress Overall appearance: Put together, friendly, approachable Infection Control precautions: Contact and Droplet precautions. Client Complaints or Concerns: None</p>	<p>Even though the patient expressed that she was confused on certain things and couldn't clearly explain why she went into the emergency department, she was able to correctly answer person, place, time, location.</p>
<p>VITAL SIGNS: Temp: 97.9 F Resp rate: 16 Pulse: 67 B/P: 103/63 Oxygen: 90 Delivery Method: room air</p>	
<p>PAIN ASSESSMENT: Time: 3:05 pm Scale: 0-10 Location: no where Severity: none Characteristics: none Interventions: none</p>	<p>The client stated that she was in no pain.</p>
<p>IV ASSESSMENT: Size of IV: 20 gauge Location of IV: left antecubital Date on IV: 11-17-24 Patency of IV: patent Signs of erythema, drainage, etc.: IV dressing assessment: Tegaderm and tape Fluid Type/Rate or Saline Lock:</p>	<p>There was dried blood on the dressing on the IV but there was no swelling, drainage, or redness. No fluids were running.</p>
<p>INTEGUMENTARY: Skin color: white, pale Character: dry, thin Temperature: slightly cold Turgor: slight tenting but goes down Rashes: none Bruises: on knee</p>	<p>The patient pointed out that she had a healing cut on her right foot and then a bruise on her left knee from her recent fall.</p>

<p>Wounds: on leg Braden Score: 19 Drains present: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Type:</p>	
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>The client had pink moist mucous membranes. Client had all her teeth but slightly poor dentation. Client stated that she wears hearing aids, but she wasn't wearing any during the time of the assessment. Head is symmetrical, nose is midline with a bit of snot. Carotid pulse was present and palpable 3+. Trachea was midline and not deviated.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: all were present and palpable 3+ Capillary refill: less than three seconds 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>Clear, no murmurs or gallops. S1 and S2 are present</p>
<p>RESPIRATORY: Accessory muscle use: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Breathing sounds were diminished on all lobes. The patient had a consistent dry cough with a small amount of sputum production.</p>
<p>GASTROINTESTINAL: Diet at home: regular Current Diet: regular Is Client Tolerating Diet? yes Height: 160 cm Weight: 69.7 kg Auscultation Bowel sounds: normoactive Last BM: 11-15-2024 Palpation: Pain, Mass etc.: none Inspection: Distention: none Incisions: none Scars: none Drains: none Wounds: none Ostomy: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Nasogastric: Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Size:</p>	<p>No pertinent findings in GI assessment. No distention or bruising on the abdomen.</p>

Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	
GENITOURINARY: Color: pale yellow Character: client stated that it has been clear. Quantity of urine: a lot Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:	Patient stated that she doesn't go to the bathroom too often but when she does, she produces big quantities of urine.
Intake (in mLs) 945 mLs Output (in mLs)	Output was not being measured.
MUSCULOSKELETAL: Neurovascular status: ROM: full range of motion Supportive devices: currently none Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 15 Activity/Mobility Status: mobile. Activity Tolerance: mild tolerance Independent (up ad lib) she is independent Needs assistance with equipment Needs support to stand and walk	She mentioned she can move around independently but while use a walker if she is walking a lot. For example, she said that she took a walker when she went to Disney World a few years ago. She also motioned using a wheelchair two years ago. She has a full range of motions with strong grips, pushes, pedal pulls, and pushes.
NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: A/O x4 Mental Status: Good mental status Speech: Clear speech and responses Sensory: Was able to respond to touch when doing her assessment. LOC: Slightly confused on past events that	The patient had clear speech and responses to all the questions I had asked her. However, she seemed confused on the events leading up to her admission. She wasn't sure when she had experienced her fall and wasn't entirely sure what does she had started her antibiotic.

had happened but was aware of what was currently going on. Fully alert.	
PSYCHOSOCIAL/CULTURAL: Coping method(s): Watching Tv and going on her phone. Developmental level: Integrity vs Despair Religion & what it means to pt.: Not religious Personal/Family Data (Think about home environment, family structure, and available family support):	She has a good circle of friends, family, and support. Said her husband had been in once during her stay. She also mentioned that all her family and friends knew she was hospitalized.

Discharge Planning

Discharge location: Her home with her husband and cat.

Home health needs: She mentioned that she will get a new prescription.

Equipment needs: None

Follow-up plan: She stated that she will have a follow-up appointment the following week after she is discharged.

Education needs: When I asked the client about her follow-up plan, she mentioned that she would “cancel her appointment because she doesn’t want to go.” The client needs to be educated on why keeping her appointment is important and necessary to ensure her treatment is beneficial.

Nursing Process

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

Nursing Diagnosis	Rationale	Outcome Goal (1 per dx)	Interventions (2 per goal)	Evaluation of interventions
<ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 			

<ul style="list-style-type: none"> Listed in order by priority – highest priority to lowest priority pertinent to this client 				
<p>Ineffective airway clearance related to having a consistent cough as evidenced by frequent coughing attacks with very little sputum clearance (Phelps, 2023).</p>	<p>I chose this diagnosis because the patient has an ineffective cough that has been going on for three weeks now.</p>	<p>It is important for this patient's airway to remain patent for the entirety of their hospital stay.</p>	<ol style="list-style-type: none"> The nurse should assess the patient's respiratory status every four hours (Phelps, 2023). The patient should avoid being supine for long periods of time because it decreases lung expansion (Phelps, 2023). 	<p>The lung sounds should become clear and less diminished during the remainder of her hospital stay (Phelps, 2023).</p>
<p>Impaired memory related to not remembering the events that led her to the emergency room as evidenced by having trouble remembering what day she went into the emergency room and only knowing what happened because her husband told her (Phelps, 2023).</p>	<p>This diagnosis was chosen because the patient had a significant loss of memory over the course of the weekend. She could not clearly explain what had happened to her and could barely remember the fall she had sustained. I also chose this because I think her altered memory is due to her metabolic encephalopathy.</p>	<p>The goal would be for the patient not to experience any further memory loss and that she can remember the events of her hospital visit after she is discharged.</p>	<ol style="list-style-type: none"> The nurse observe the patient's thought process during their shift and make sure to record and document any changes (Phelps, 2023). We should encourage the patient to express their feelings in relation to their memory loss (Phelps, 2023). 	<p>Since the nurse has a follow up appointment scheduled for the week after her discharge, she should express her feelings about the memory loss and ask her questions pertinent to her stay at the hospital (Phelps, 2023).</p>
<p>Acute confusion in relation to altered</p>	<p>I would say that the patient was</p>	<p>The patient will remain</p>	<ol style="list-style-type: none"> The nurse should assess 	<p>The best evaluation</p>

<p>personality as evidenced to nonstop talking, being jittery, and noticing visual disturbances (Phelps, 2023).</p>	<p>still slightly confused when I was in there during her assessment. She mentioned that she had visual disturbances and was noticing very small details like a random wire sticking out of the wall.</p>	<p>calm, and her confusion will lessen by the time she is discharged.</p>	<p>the patient's level of consciousness and changes in behavior frequently to have comparisons if she worsens (Phelps, 2023). 2. Reassure the patient that the confusion will only be temporary to help reduce their anxiety (Phelps, 2023).</p>	<p>would be that the patient does not experience any falls or injury during an episode of confusion (Phelps, 2023).</p>
<p>Risk for adult falls in relation to already falling once and not remembering how it happened.</p>	<p>I chose this diagnosis because she had already suffered a fall and she couldn't recall how or why it happened, just that she knew that she didn't hit her head. Her falling once puts her at risk for falling again.</p>	<p>The patient will not have a fall during her hospital stay.</p>	<p>1. Since the patient fell at home the nurse should provide additional household safety to prevent any further falls (Phelps, 2023). 2. The client stated that she used hearing aids but wasn't wearing any during her assessments. I would advise her to wear her aids to minimize any deficits that could lead to falls.</p>	<p>The patient and her family will be able to point things out that put the patient at risk for a fall.</p>

Other References (APA)

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

