

N321 CARE PLAN #

Ashley Shields

Lakeview College of Nursing

N321: Adult Health I

Kristal Henry

Date: 29 January 2025

Demographics

Date of Admission 1-20-2025	Client Initials AM	Age 59 years old	Biological Gender Female
Race/Ethnicity White	Occupation Unemployed/Disability	Marital Status Legally Separated	Allergies Bee venom, Cephalexin, Cephalosporins, Levaquin, Meperidine, Penicillin, Sulfamethoxazole- trimethoprim, Topiramate, Amantadine, Meclizine, Zinc Oxide, Ciprofloxacin, Silver, Other- environmental allergen- not found in search
Code Status CPR- Full Treatment	Height 64 inches	Weight 80 kg	

Medical History

Past Medical History: Arthritis, asthma, cardiomyopathy, chronic kidney disease, congestive heart failure, fatty liver with encephalopathy, hypertension, left bundle branch block, metabolic acidosis, multiple sclerosis, renal abscess, sepsis, stroke, type 2 diabetes, urinary tract infection.

Past Surgical History: Cholecystectomy, appendectomy, tonsillectomy, uvulectomy, hysterectomy, port placement, urostomy, cesarian section, bladder removal, central venous catheter, right upper gastrointestinal endoscopy, colon surgery, kidney surgery, cardiovascular surgery, laparoscopic inguinal hernia repair

Family History: Mother- diabetes and hypertension. Father- heart attack, hypertension, stroke. Brother- heart disease, alcohol and drug abuse. Sister- high cholesterol, drug abuse, hypertension. Patient stated she was adopted and does not know anything further about other siblings.

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

Patient reports she quit smoking, but has never been exposed to tobacco smoke, no alcohol use, drug use, and never used smokeless tobacco.

Education: Certified Nurses Aid certification

Living Situation: Patient lives at home with her husband and in-home care comes in daily.

Assistive devices: Hoyer lift

Admission History

Chief Complaint: Generalized abdominal pain and vomiting

History of Present Illness (HPI)– OLD CARTS

AM is a 59-year-old female who arrived at the emergency department via ambulance on 1-20-2025 at 1517 with complaints of generalized abdominal pain, vomiting, weakness, and a possible urinary tract infection. The patient reports pain in her back (flank) and abdomen of eight on a zero to ten scale. Patient is alert and oriented x4 and non-ambulatory. Patient appears upset and distressed. Patient refused to give further history.

Admission Diagnosis

Primary Diagnosis: Chronic Kidney Disease

Secondary Diagnosis (if applicable): Small Bowel Obstruction

Pathophysiology

Chronic kidney disease is a condition characterized by the deterioration of nephrons, resulting in renal dysfunction. This can be due to abnormal kidney structure or function. When the renal dysfunction lasts longer than 3 months, it is then considered chronic kidney disease. (Capriotti, 2024, pg. 554). There is a variance for each patient with

the progression of the disease ranging from month to years, depending on the rate of nephron deterioration. The kidneys contain approximately 1 million nephrons, so they can compensate for a significant amount of time before the damage starts to affect the body a great deal (InformedHealth.org, 2024).

Chronic kidney disease usually progresses through 5 stages. Stage 1 shows signs of kidney damage through urinalysis but can maintain normal function with a glomerular filtration rate greater than 90 mL/min. Stage 2 and 3 show reduced kidney functions but the patient still does not show symptoms but hold a glomerular filtration rate of 30-89 mL/min. By stage 4, the kidneys are barely functioning and the patient will have symptoms of anemia, fluid retention, bone pain, weakness, and itching and will have a glomerular filtration rate of 15-29 mL/min. Stage 5 is complete renal failure requiring a kidney transplant or dialysis to prevent toxicity in the body (InformedHealth.org, 2024).

Renal failure is characterized by a glomerular filtration rate of less than 15 mL/min. At this stage, your body can no longer filter the toxins from your body and this causes all of your systems to become impaired or not function all together. Chronic kidney disease can cause fluid overload, putting stress on the respiratory system and can eventually lead to respiratory failure. Chronic kidney disease causes hypertension which puts great stress on the cardiovascular system. Because the body can no longer filter and regulate electrolytes in the body, all of the organs are affected. Encephalopathy is common. Liver damage and failure follow. Because potassium is not regulated properly, heart failure is likely to begin. Chronic kidney disease also causes anemia which causes weakness and fatigue due to low red blood cells and a low hemoglobin level Anemia also makes a person more prone to infections due to a weakened immune system from poor white blood cell production

(Capriotti, 2024, pg. 554-557). Due to the body's need for electrolytes and vitamins, and the dependence on the kidneys to regulate them, whenever the kidneys stop functioning properly, it affects every cell and organ in the body in some way. The signs and symptoms vary depending on which electrolyte and which organ is being impacted at that time.

(Capriotti, 2024, pg. 554-555).

The best way to diagnose chronic kidney disease is through laboratory results since the signs and symptoms carry so much variance. A complete blood count (CBC) with differential, serum electrolytes, serum creatinine, total albumin, blood urea nitrogen (BUN), will determine renal function. (Capriotti, 2024, pg. 555). A glomerular filtration rate (GFR) will also be tested to determine how well the kidneys are filtering the blood. The GFR is "the renal blood filtered per unit of time and is directly related to renal perfusion." As stated above, a decreased GFR and the level it is at will determine what stage of renal failure a person is in (Capriotti, 2024, pg. 334).

Treatment for chronic kidney disease varies depending on the symptoms and requires a very complex regimen of medications, fluid, electrolyte and vitamin supplementation. Fluid overload is common with chronic kidney disease and puts stress on many body systems, so maintaining that with diuretics are a primary course of action for these patients. Vitamin and electrolyte supplementation and balance is crucial to maintain homeostasis within the body and preserve the function of each system, especially target organs. Controlling blood glucose levels (Capriotti, 2024, pg. 555). One leading medication is rifaximin to control hepatic encephalopathy (Nurse's Drug Handbook, 2024). The treatment for this will depend on each patient's labs, symptoms, allergies, and medications available.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for Pathophysiology* (3rd ed.). F.A. Davis Company.

InformedHealth.org [Internet]. Cologne, Germany: Institute for Quality and Efficiency in Health Care (IQWiG); 2006-. Chronic kidney disease: Learn More – How does chronic kidney disease progress? [Updated 2024 Sep 11]. Available from:

<https://www.ncbi.nlm.nih.gov/books/NBK492987/>

Nurse's Drug Handbook. (2024). *Nurse's Drug Handbook* (2024 ed.). Wolters Kluwer.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Sodium	140 mmol/L	130 mmol/L	136-145 mmol/L	AM has chronic kidney disease, receives diuretics, has been vomiting which can all cause hyponatremia by causing increased sodium loss in the excretions. AM also has congestive heart failure which allows the body to have more

				free body water so the sodium is not absorbed properly. (Pagana et al., 2023)
BUN	47 mg/dL	35 mg/dL	10-20 mg/dL	The bun level is directly correlated to the function of the liver's ability to metabolize toxins and the kidneys ability to excrete toxins. (Pagana et al., 2023) AM has cirrhosis and chronic kidney disease, leaving both of these key organs unable to eliminate the toxins and maintain homeostasis within the body.
Creatinine	1.04 mg/dL	1.30 mg/dL	0.60-1.00 mg/dL	Creatinine is directly related to the renal system functioning properly and excreting appropriately. AM having diabetes and chronic kidney disease can cause and/or increase the effects of diabetic nephropathy which raise the creatinine level in the body.

				(Pagana et al., 2023)
GFR	60	47	>/= 60	<p>Creatinine is used as an approximation of GFR.</p> <p>Creatinine takes longer to rise, so when it does rise, it indicates a chronic problem and generally suggests a 50% reduction in GFR. (Pagana et al., 2023) Due to AM having chronic kidney disease, it would be expected for the GFR levels to be lower than optimal.</p>
Bun/Creatinine Ratio	45	27	6 to 25	<p>BUN and creatinine levels are often compared together because of their direct relationship to liver and kidney function and how they work together to eliminate toxins from the body. Cirrhosis and chronic kidney disease would affect both of these in a major way causing elevated levels in AM. (Pagana et al., 2023)</p>

Glucose	77 mg/dL	144 mg/dL	70-99 mg/dL	The most common cause of elevated glucose levels is diabetes. Antidepressants, diuretics, and stress can also elevate glucose in the blood. (Pagana et al., 2023) AM has Type 2 diabetes, takes antidepressants and diuretics, and being ill puts a great deal of stress on the body. (Pagana et al., 2023)
Calcium	7.1 mg/dL	7.6 mg/dL	8.7-10.5 mg/dL	Calcium and albumin have a synergistic effect and are often monitored together in patients with renal failure, such as AM has. Almost half of calcium is carried in protein (albumin), so when albumin levels drop, so will calcium levels. (Pagana et al., 2023)
Potassium	2.9 mmol/L	N/A	3.5-5.1 mmol/L	Diuretics can lower potassium levels by excreting too much through the kidneys with non-

				<p>potassium sparing loop diuretics. AM is taking furosemide, which is a loop diuretic.</p> <p>(Pagana et al., 2023)</p>
Chloride	116/mmol/L	N/A	98-107 mmol/L	<p>Hyperchloremia is normally are part of a shift of multiple electrolytes, such as sodium and bicarbonates and they also act in a synergistic way. If sodium rises, so does chloride. This is a common occurrence with renal dysfunction.</p> <p>(Pagana et al., 2023)</p>
Phosphorus	N/A	2.3 mg/dL	2.5-4.5 mg/dL	<p>Dietary phosphorus is mostly absorbed in the small intestine and a small bowel obstruction could cause malabsorption.</p> <p>Due to AM having a small bowel obstruction, an NG tube was also inserted with suctioning which would deplete more phosphorus from the</p>

				<p>body.</p> <p>(Pagana et al., 2023)</p>
Albumin	2.1 g/dL	2.1 g/dL	3.5-5.0 g/dL	<p>The majority of protein in the body is albumin and is synthesized in the liver.</p> <p>Cirrhosis impairs the liver's ability to function which lowers the albumin levels.</p> <p>(Pagana et al., 2023)</p>
GFR Non-African	54	42	>= 60	<p>GFR non-African is a 24-hour urine collection to determine creatinine clearance (CC). This formula is used to determine renal function using serum creatinine levels with age and numbers combined with sex and ethnicity. It is referred to as e-GFR. It is another tool used to determine renal function comparing similar ages, ethnicities, sexes, and stages of renal failure.</p> <p>(Pagana et al., 2023)</p>

GFR African	60	51	>/= 60	GFR African is used the same as stated above. However, it is believed African Americans have a higher creatinine level due to a higher muscle mass. (Williams, 2023)
Glucose Bedside POCT	N/A	241 mg/dL	70-99 mg/dL	This is the most common glucose test run and is done quickly. It is a simple finger stick used to monitor diabetes. (Pagana et al., 2023)
RBC	2.69 10(6)/mcL	2.62 10(6)/mcL	3.80-5.30 10(6)/mcL	Chronic kidney disease causes poor bone marrow production resulting in insufficient numbers and anemia. (Pagana et al., 2023)
HGB	7.6 g/dL	7.5 g/dL	12.0-15.8 g/dL	Hemoglobin levels are directly related to RBCs, so low RBC levels caused by anemia would also be the cause for low hemoglobin levels. The medication Rifampin can also lower hemoglobin levels and

				AM is currently taking this drug. (Pagana et al., 2023)
Hematocrit	23.1%	22.3%	36.0-47.0%	As with RBC and hemoglobin, hematocrit is also measured by the number of RBCs. Anemia will also cause hematocrit levels to be low. (Pagana et al., 2023)
Platelet	144 10(3)/mcL	100 10(3)/mcL	140-440 10(3)/mcL	Chronic kidney disease causes poor bone marrow production, resulting in lower platelet counts since platelets are produced in the bone marrow.. (Pagana et al., 2023)
RDW	19.1%	19.0%	11.8-15.5%	Red blood cell distribution width measures variation in size of erythrocytes. It is used to detect potential problems, including cardiovascular diseases, such as congestive heart failure. (Fava et al., 2019)

Lymphocytes	N/A	14.3%	18-42%	<p>Chronic kidney disease suppresses bone marrow production and lymphocytes are produced in the bone marrow.</p> <p>(Pagana et al., 2023)</p>
Monocytes	N/A	14.7%	4.0-12.0%	<p>Monocytes are slightly different than other white blood cells because they can be produced faster and stay in the circulating blood longer. This can allow their numbers to stay more consistent and not drop as quickly.</p> <p>(Pagana et al., 2023)</p>
CO2 Venous	5.7 mmol/L	N/A	22-30 mmol/L	<p>This test is used to assess the pH status of the patient using carbon dioxide and electrolyte levels. Decreased levels indicate metabolic acidosis and renal failure for AM.</p> <p>(Pagana et al., 2023)</p>
Total Protein	5.7 g/dL	N/A	6.0-8.0 g/dL	Total protein is used in

				<p>combination with albumin/globulin ratio to detect liver failure. Normally, all three are not low together. However, chronic kidney disease combined with cirrhosis can affect these numbers.</p> <p>(Pagana et al., 2023)</p>
A/G Ratio	0.6	N/A	1.0-2.2	<p>This is suspected to be the same as with total protein listed above.</p> <p>(Pagana et al., 2023)</p>
Urinalysis on Admission				
Protein	2+	N/A	Negative	<p>Proteinuria is a strong indicator of renal failure and diabetes.</p> <p>(Pagana et al., 2023)</p>
Blood	1+ ery/uL	N/A	Negative	<p>Chronic kidney disease and a severe urinary tract infection could cause blood to be present in urine.</p>

				(Pagana et al., 2023)
RBC	3-5/hpf	N/A	0-2/hpf	As stated above, chronic kidney disease and a severe urinary tract infection could cause red blood cells to be present in urine. (Pagana et al., 2023)
WBC Esterase	3+	N/A	Negative	A positive test for leukocytes in the urine indicates a urinary tract infection. (Pagana et al., 2023)
Bacteria	Moderate/ hpf	N/A	Negative/ hpf	Bacteria can be present in a urine specimen can be due to contamination. However, in this case, the bacteria has likely invaded the urinary tract causing an infection. (Pagana et al., 2023)
WBC	6-10/hpf	N/A	0-5/hpf	Increased white blood cell count is an indication of an infection, such as a urinary tract infection (Pagana et al., 2023)

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
<p>Computed tomography (CT) is a noninvasive diagnostic test which allows medical personnel to view the inside of the body without doing harm to the patient. A CT of the abdomen and pelvis without contrast was used to try to identify the cause of abdominal distention and pain AM was having. (Pagana et al., 2023)</p>	<p>AM was experiencing abdominal distention, abdominal pain, and vomiting.</p>	<p>This test found AM had a small bowel obstruction, blocking air and feces from evacuating the intestine causing pain to the patient. The CT identified ascites. Ascites is the buildup of fluid in the peritoneal cavity, most commonly caused by cirrhosis. (Chiejina et al., 2023)</p> <p>The CT identified enlarged lymph nodes surrounding the retroperitoneal region and cysts in contact with the right iliac fossa. (Pagana et al., 2023)</p>
<p>X-rays are also a noninvasive diagnostic test to view structures inside the body. An x-ray of the chest was ordered to confirm</p>	<p>AM had a NG tube placed to administer medications and to suction secretions due to the small bowel</p>	<p>The x-ray showed the NG tube appeared to be in the correct location. However, the tip of the NG tube was not visible on the x-ray.</p>

<p>proper placement of a Nasogastric (NG) tube and this is considered the “gold standard” to confirm placement. (Pagana et al., 2023)</p>	<p>obstruction.</p>	
<p>An Abdominal KUB (kidney, ureter, bladder) Flat Plate x-ray is used to view the mid-lower abdominal area to identify small bowel obstructions and paralytic ileus. (Pagana et al., 2023)</p>	<p>AM was having abdominal pain and distention.</p>	<p>The x-ray revealed a large amount of feces, air buildup, and a fecal obstruction on the left side located in the jejunum. The x-ray also confirmed the tip of the NG tube was properly placed.</p>

Diagnostic Test Reference (1) (APA):

Chiejina M, Kudaravalli P, Samant H. Ascites. [Updated 2023 Aug 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from:

<https://www.ncbi.nlm.nih.gov/books/NBK470482/>

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<https://doi.org/10.21037/atm.2019.09.58>

Pagana, K.D., Pagana, T.J., & Pagana, A. (2023). *Mosby's Diagnostic and Laboratory Test Reference* (6th ed.). Elsevier.

Williams P. (2023). Retaining Race in Chronic Kidney Disease Diagnosis and Treatment. *Cureus*, 15(9), e45054. <https://doi.org/10.7759/cureus.45054>

Active Orders

Active Orders	Rationale
Diabetic Consistent Carbohydrate Diet Medium Calorie	AM had unstable blood glucose levels during her admission and a consistent diet would help control glucose and keep it in a more preferable range.
Inpatient Consult to General Surgery	AM had a small bowel obstruction detected and an order was entered to consult with surgery to advise on a course of action to evacuate the obstruction.
Occupation Therapy Consult to Evaluate and Treat	Occupational therapy was consulted to determine what further assistance/needs AM would need upon discharge.
Respiratory Pulse Ox	AM required monitoring of oxygen saturations.
Admission Weight	Admission weight is required to determine medication dosages necessary to treat AM.
Covid 19, Influenza, Pneumonia test	All patients are tested for these diseases upon

	<p>admission to determine if isolation precautions are necessary to ensure the safety of the staff and other patients.</p>
Discharge orders reviewed by Pharmacy	<p>Pharmacy must perform a medication reconciliation of old and new prescriptions as a safety precaution for the patient.</p>
Enteral Tube Insertion	<p>Enteral tubes are used to provide adequate nutrition to patients.</p>
For blood sugar 70 mg/dL or less	<p>Complications can arise with consistent low glucose levels, so monitoring and providing appropriate snacks is necessary to avoid this or rectify it.</p>
Insert Nasogastric Tube	<p>AM required this to administer proper nutrition and administer meds. Due to the small bowel obstruction, it would provide necessary suctioning of gastric secretions as needed.</p>
Insert/Maintain Peripheral Intravenous Line	<p>Intravenous lines allow for medications and fluids to be administered.</p>
Intake/Output	<p>Monitoring intake and output is essential for AM due to chronic kidney disease and the small bowel obstruction. This is also a tool used to help alert staff to potential issues</p>

	related to kidney function, bowel issues, and malnutrition.
Maintain Intravenous Line while on Telemetry	AM has congestive heart failure and you want a clear and stable line in place in case you need to administer medications quickly.
Nasogastric Tube Maintenance	This is used to ensure the line does not get clogged and is functioning properly.
Notify Physician	AM was experiencing hypoglycemia, hyperglycemia, bradycardia, tachycardia, arrhythmias, and abnormal vital signs. The physician wanted to be notified to determine a course of action for treatment and response to treatment.
Nursing Night Calls	Maintain IV and non-violent restraint renewal.
Patient May Shower	This reduces the risk for infection.
Perform POC Blood Glucose	AM is diabetic and needs her blood glucose monitored,
Post Hypoglycemic Treatment and Blood Sugar >80 mg/dL	This is to provide nutrition to AM when she is able to raise blood glucose levels.
Saline Lock Intravenous Line	AM was receiving medications through her intravenous line.
Up As Tolerated	This encourages mobility and health

	promotion for AM.
Vital Signs	Taking vital signs during an initial encounter establishes a baseline and is used to monitor AM throughout her admission.

Medications

Home Medications (Must List ALL)

Medications	Reason for taking
albuterol 108 (90 base) MCG/ACT Aerosol Solution	“To prevent exercise-induced bronchospasm” (<i>Nurses Drug Handbook</i> , 2024)- AM has a history of asthma.
baclofen (Lioresal) take one 20 mg tablet PO 3x daily.	“Used to treat muscle spasticity, particularly in patients with conditions like spinal cord lesions and multiple sclerosis.” (Ghanavatian, Derian, 2024). AM has multiple sclerosis.
bisacodyl 10 mg suppository	“A diphenylmethane derivative stimulant laxative” (Lawrencia et al. 2024). AM is immobile and highly prone to constipation.

carvedilol (COREG) 25 mg tablet PO 2x daily	“To control hypertension” (Nurses Drug Handbook, 2024). AM has hypertension.
cetirizine (Zyrtec) 10 mg tablet PRN	“To treat acute urticaria” (Nurses Drug Handbook, 2024). AM has unknown environmental allergies.
cholecalciferol (Vitamin D3) 2,000-unit capsule	“Vitamin D deficiency is associated with type 2 diabetes” (Al-Hashimi, Abraham, 2024). AM has type 2 diabetes.
EPINEPHrine (EpiPen) 0.3 mg/mL Solution Auto-injector- 0.3 mg/mL by IM route PRN for anaphylaxis	“To provide emergency treatment of allergic reactions (Type 1), including anaphylaxis to allergen immunotherapy, biting and stinging insects, diagnostic testing substances, drugs, foods, and other allergens, as well as exercise-induced or idiopathic anaphylaxis (Nurses Drug Handbook, 2024). This is likely due to AM having an allergy to bee venom. However, she is also allergic to many medications, so it could have an intended use for one or more of those as well.
ferrous sulfate 325 (65 Fe) mg tablet- 1 tablet PO every 7 days (Wednesdays)	“To prevent iron deficiency based on recommended daily allowances” (Nurses Drug Handbook, 2024). Chronic kidney disease is causing anemia which is the likely

	reason AM is iron deficient.
fluticasone (Flonase) 50 mcg/ACT suspension	“To prevent asthma attacks, alone or with oral corticosteroids as maintenance therapy” (Nurses Drug Handbook, 2024). AM has asthma.
folic acid (Folvite, Vitamin B9) 1 mg tablet PO 1x daily	“To treat folic acid deficiency” (Nurses Drug Handbook, 2024). Kidney disease can impair folic acid production/absorption.
furosemide (Lasix) 20 mg tablet- take two 20 mg tablet PO daily	“To reduce edema caused by cirrhosis, heart failure, and renal disease, including nephrotic syndrome” (Nurses Drug Handbook, 2024). AM has renal disease, congestive heart failure, and cirrhosis.
insulin Lispro 20 units before meals	“To improve glycemic control in patients with diabetes” (Nurses Drug Handbook, 2024). AM has Type 2 diabetes.
lactulose (Chronulac) 10 GM/15 mL- take 30 mL PO 2x daily BID morning/bed.	“To treat constipation” (Nurses Drug Handbook, 2024). AM is immobile and highly susceptible to constipation and has a small bowel obstruction.
miconazole 2% powder for 10 days	AM likely had a fungal infection on her skin or in her skin folds.
naloxone (Narcan) 4mg/0.1 mL- 1 spray via	AM has been on opioid medications for pain

nasal route PRN opioid reversal	management on and off for years, including tramadol, and likely keeps this in case of an overdose.
ondansetron (Zofran) 4 mg tablet PRN	“To treat nausea and vomiting” (Nurses Drug Handbook, 2024). AM has been suffering from nausea and vomiting for an unknown period of time.
Pantoprazole (Protonix) 40 mg tablet PO every 12 hours	“To treat esophagitis associated with gastroesophageal reflux disease (GERD) (Nurses Drug Handbook, 2024). AM is immobile and “bed bound” which can often cause acid reflux when you are in a supine position.
Polyvinyl alcohol-povidone (Hypotears) 5-6 mg/mL- put 2 drops in affected eye 3x daily PRN	This is an over-the-counter medication used to treat dry eyes.
rifAXIMin (Xifaxan) 550 mg tablet – 1 table PO 2x daily	“To reduce risk of overt hepatic encephalopathy” (Nurses Drug Handbook, 2024). AM has cirrhosis which is impairing the ability to remove toxins from the body. Toxicity buildup from liver disease can impair brain function, so this medication is used to reduce that risk.

<p>Sodium bicarbonate 650 mg tablet- 2 tablets PO 3x daily</p>	<p>“To treat hyperacidity” (Nurses Drug Handbook, 2024). AM has had metabolic acidosis, likely due to chronic kidney disease.</p>
<p>Spironolactone (Aldactone) 25 mg tablet- 1 tablet PO daily</p>	<p>“As adjunct to increase survival and to reduce need for hospitalization for heart failure when used in addition to standard therapy in patients with sever heart failure and reduced ejection fraction. Used to treat hypertension in adults with a GFR between 30-50, edema associated with nephrotic syndrome and hepatic cirrhosis ” (Nurses Drug Handbook, 2024). AM has congestive heart failure, hypertension, cirrhosis, chronic kidney disease, and her GFR labs were at 47.</p>
<p>traMADol HCl 25 mg tablet- take 1 tablet PO 3x daily PRN</p>	<p>“To relieve pain severe enough to require opioid like treatment and for which alternative treatment options such as nonopioid analgesics or opioid combination products are inadequate or not tolerated” (Nurse’s Drug Handbook, 2024). AM has had multiple health concerns requiring pain management, including MS, and this is likely the best option to treat her pain.</p>

Venlafaxine (Effexor- XR) 75 mg capsule SR 24 hr- take 1 capsule PO daily	“To treat and prevent relapse of major depression” (Nurse’s Drug Handbook, 2024) AM has suffered from depression
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Hospital Medications (Must List ALL)

Brand/ Generic	Carvedilol (Coreg) 25 mg tablet- 1 tablet PO 2x daily	Folic acid (Folvite, Vitamin B9) 1 mg tablet PO 1 x daily	rifaximin (Xifaxan) 550 mg tablet- 1 tablet PO 2x daily	Spironolactone (Aldactone) 25 mg tablet- 1 tablet PO daily	Venlafaxine (Effexor-XR) 75 mg capsule SR 24 hr- 1 capsule PO daily
Classification	Pharmacologica l class: nonselective beta-blocker and alpha-1 blocker. Therapeutic class: Antihypertensiv e, heart failure treatment adjunct. (Nurse's Drug Handbook, 2024)	Vitamin supplement due to vitamin deficiency. (Nurse's Drug Handbook, 2024)	Pharmacologic al class: Rifamycin. Therapeutic class: antibiotic. (Nurse's Drug Handbook, 2024)	Pharmacologic al class: Potassium- sparing diuretic. Therapeutic class: diuretic. (Nurse's Drug Handbook, 2024)	Pharmacologic al class: Selective serotonin and norepinephrine reuptake inhibitor (SSNRI). Therapeutic Class: antidepressant. (Nurse's Drug Handbook, 2024)
Reason Client Taking	AM has hypertension.	Chronic Kidney Disease inhibits the ability to produce and absorb folic acid and the patient has a deficiency. (Nurses Drug Handbook, 2024).	This drug is used to prevent hepatic encephalopathy due to impaired liver function (cirrhosis), which the patient has. (Nurses Drug Handbook, 2024).	Patient has congestive heart failure, hypertension, and hypokalemia. Spironolactone help eliminate excess water from the body while preserving potassium.	Patient suffers from depression.
Key nursing assessment(s) prior to administratio n	The nurse should assess the patients vitals for adequate blood pressure before administering as this medication can cause hypertension, palpitations, and heart failure. They should also review blood glucose levels to establish a baseline as this medication can mask hypoglycemia. (Nurses Drug Handbook, 2024).	The nurse should review the labs to confirm the folic acid levels were below optimal range prior to administration. (Nurses Drug Handbook, 2024).	The nurse should assess the patient having cirrhosis (hepatic impairment) and anemia, as this drug can escalate both of these issues. (Nurses Drug Handbook, 2024).	The nurse should assess blood pressure and edema to establish a baseline to evaluate an effective response to the medication once the patient is receiving it. (Nurses Drug Handbook, 2024).	The nurse should request an ECG/EKG to check for prolonged QT because this medication can exacerbate heart failure. The nurse should also begin potassium replacement therapy for hypokalemic patients prior to administration to avoid a cardiac event. (Nurses Drug Handbook, 2024).

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Heparin	<p>This medication is a high-risk drug and has to be closely monitored.</p> <p>(Nurse's Drug Handbook, 2024)</p>	<p>1. Abdominal distention and pain caused by heparin could be overlooked for abdominal distention and pain cause by the small bowel obstruction, leading to a more complex issue.</p> <p>2. Asthma is a side effect of heparin, and for a patient who already has an asthma diagnosis, this could be more likely to result in AM having an asthma attack.</p> <p>(Nurse's Drug Handbook, 2024)</p>
2. Carvedilol	<p>This medication is contraindicated for patients with asthma, heart failure, and hepatic impairment.</p> <p>(Nurse's Drug Handbook, 2024)</p>	<p>1. Carvedilol can cause hyperglycemia, hypertension, and heart failure are all current ailment AM is experiencing.</p> <p>2. This medication can also cause elevated liver enzymes, BUN levels, and creatinine levels.</p> <p>(Nurse's Drug Handbook, 2024)</p>
3. Furosemide	<p>This medication is contraindicated for patients with hepatic ascites or cirrhosis. (Nurse's Drug Handbook, 2024)</p>	<p>1. Furosemide can cause anemia, which the patient has already has.</p> <p>2. This medication causes hyponatremia, hypokalemia and hypochloremia, which the patient has and can cause cardiovascular complications, especially in a patient with hypertension and congestive heart failure.</p> <p>(Nurse's Drug Handbook, 2024)</p>

Medications Reference (1) (APA)

Al-Hashimi N, Abraham S. Cholecalciferol. [Updated 2024 Jan 10]. In: StatPearls [Internet].

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Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL:	Patient was alert and oriented x4 person,
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Alertness: Orientation: Distress: Overall appearance: Infection Control precautions: Client Complaints or Concerns:	<p>place, time, and reason for being here. Patient appeared disheveled but not in distress. Patient asked several times when they (EMS) would be here to get her to take her home.</p>
VITAL SIGNS: Temp: 97.6 oral Resp rate: 18/min Pulse: 71 BPM B/P: 131/47 Oxygen: 98% Delivery Method:	<p>Patient's temperature was 97.6 oral, respirations were 18/min, pulse was 71 BPM, B/P was 131/47, and oxygen saturation was 98%.</p>
PAIN ASSESSMENT: Time: 3:00 p.m. Scale: 0-10 Location: All over Severity: 6 Characteristics: Not specified Interventions: Repositioning	<p>Patient rated her pain at a 6 on a 0-10 scale. Patient stated she hurt all over but it is what she is used to. We repositioned the patient to try to alleviate some pain and adjusted her pillows.</p>
IV ASSESSMENT: Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment: Fluid Type/Rate or Saline Lock:	<p>Patient had an IV in her left lower arm earlier in the day, but it was removed due to discharge prior to my assessment. There was bruising where the IV had been.</p>
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:	<p>Patient had a pale, dry, warm skin. Normal hair distribution throughout. Skin turgor normal. Patient had bruising on arms bilaterally, abdomen, and chest.</p>
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	<p>Head and neck are symmetrical, trachea is midline, head is normocephalic, thyroid not palpable, lymph nodes not palpable, no lump, lesions, or nodules noted. Sclera has a slight yellowing, conjunctiva is pink and moist with no drainage. Ears are symmetrical. Patient has poor dentition and is missing several teeth.</p>

	Unable to finish assessment due to EMS transport.
CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:	Clear S1 and S2 sounds. No rubs, murmurs, or gallops noted.
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	Breath sounds were clear in all lobes bilaterally with no distress. No crackles, rhonchi, or wheezing noted. Normal rate and pattern 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: Ostomy: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Patient is advised to be on a diabetic diet at home but does not appear to be compliant. Patient does not care for the food provided in the hospital. Patient is 64 inches tall and weighs 80 kg. Patient has an ostomy on the left upper quadrant. Unable to finish assessment due to EMS transport.
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Patient has significant skin breakdown with open wounds on her coccyx and buttock. Vaginal area had no noted skin breakdown. Patient scored a 10 on the Braden scale which places her as high risk for skin breakdown. Patient had yellow clear urine in the catheter bag. I was unable to measure the amount and finish this assessment due to EMS transport.

Type: Size:	
Intake (in mLs) Output (in mLs)	Intake- 1030 mL Output- 480
MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 75 Activity/Mobility Status: Immobile Activity Tolerance: Independent (up ad lib) Needs assistance with equipment Needs support to stand and walk	Patient is full assist, Hoyer lift, and immobile in bed. Patient was listed as a moderate fall risk in her chart. However, I scored her at a 75, which places her as a high fall risk. I was unable to complete this assessment due to EMS transport.
NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:	Patient is alert and oriented x4. Mental status is intact. Patient can communicate clearly but has a slight slur due to poor dentition. I was unable to complete this assessment due to EMS transport.
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):	I was unable to complete this assessment due to EMS transport.

Discharge Planning

Discharge location: Patient is going home to her husband.

Home health needs: Patient will require home health care and needs 24 hour care.

Equipment needs: Hoyer li

Follow up plan: Appointment with dietician recommended. Follow-up with renal specialist. I would also recommend her to start working with physical therapy to avoid losing mobility and regaining some of what has been lost.

Education needs: Patient needs reeducation about glucose control, diabetic diet, hydration and high fiber diet, and skin care to avoid further breakdown.

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 intervention s
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 			

<p>1. Impaired skin integrity related to immobility as evidenced by open wounds. (Phelps, 2023, pg. 318)</p>	<p>The patient has open wounds on her coccyx and buttock areas.</p>	<p>Patient will show improved or healed lesions or wounds. (Phelps, 2023, pg. 318)</p>	<p>1. Provide supportive measures by assisting with hygiene frequently and as needed, administer pain medication, and monitor effectiveness</p> <p>2. Instruct patient and family in the skin care regimen to ensure compliance. (Phelps, 2023, pg. 318)</p>	<p>I spoke with AM about her skin condition and made sure she knew I put barrier cream in her bag before she was transported by EMS.</p>
<p>2. Ineffective health management related to ineffective choices in daily living as evidence by current health status. (Phelps, 2023, pg. 143)</p>	<p>Patient is hyperglycemic, has electrolyte imbalances, and is hypertensive.</p>	<p>Patient will perform health maintenance activities according to level of ability such as taking medications on schedule, staying hydrated, and eating 3x daily. (Phelps, 2023, pg. 143)</p>	<p>1. Discuss health maintenance needs with patient while carrying out routine activities to reinforce their importance.</p> <p>2. Consult with social services or other health care team members to identify health care resources, and help patient contact and arrange for follow up. (Phelps, 2023, pg. 144)</p>	<p>The patient was discharged before I got a chance to fully go over these things. Ideally, I would have preferred to speak to her and her in home health care nurse to address health concerns and ways to manage her health better.</p>
<p>3. Impaired mobility related to neuromuscular disorder as evidenced by decreased range of</p>	<p>Patient is unable to bend or rotate her ankles and her toes are contracted.</p>	<p>Patient or family member will carry out mobility regimen. (Phelps,</p>	<p>1. Perform ROM exercises, unless contraindicated, at least once every shift. Progress from</p>	<p>Patient will require far more than can be done in one shift and is not very cooperative</p>

<p>motion. (Phelps, 2023, pg. 213)</p>		<p>2023, pg. 214)</p>	<p>passive to active as tolerated.</p> <p>2 Turn and position patient every 2 hours. (Phelps, 2023, pg.)</p>	<p>when you try to move her legs.</p>
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Other References (APA):

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