N321 CARE PLAN #2

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Lakeview College of Nursing

N321: Adult Health I

Kristal Henry

03/28/2025

Demographics

Date of Admission	Client Initials	Age	Biological Gender
03/23/2025	C.W.	64 y/o	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian/White	Unemployed/Disability	Divorced	Cephalexin Metronidazole Prednisone
Code Status	**Height**	**Weight**	
Full Code	4’11” (149.9 cm)	197.3 lbs (89.4 kg)	

Medical History

Past Medical History: Bipolar disorder, gastroesophageal reflux disease, morbid obesity, hypertension, anemia, astigmatism

Past Surgical History: Uterine loop electrosurgical excision procedure

Family History: Father: Grand mal epilepsy, congestive heart failure. Mother: congestive heart failure. The patient could not give a family history of maternal and paternal grandparents.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): The patient reports no history of tobacco use, no history of alcohol use, and no history of drug use.

Education: High school diploma and some college but has not obtained a college degree.

Living Situation: Currently lives alone in a single-family home in St. Anne, Illinois.

Assistive devices: The patient does not use any assistive devices. She uses glasses to help correct her vision due to her astigmatism.

Admission History

Chief Complaint: Altered mental status

History of Present Illness (HPI)– OLD CARTS

The patient's daughter reported noticing a change in the patient's behavior one day before admission, where she presented to the emergency department on 03/23/2025. The patient herself is unable to specify the exact onset of her altered mental status due to cognitive deficits, but an interview was attempted. She also cannot identify the location of the issue, as she is unable to provide relevant details about her condition. The duration of the altered mental status is unclear from the patient's perspective; however, the daughter noted that the change occurred one day before the emergency department visit. The patient is unable to describe specific characteristics of her mental status change, although she insists that she is not confused. Despite this, she continues to perseverate on the belief that her daughter is deceased, stating, "My daughter passed away." No aggravating factors were identified during the interview, though the patient asked, "Why is my blood pressure so high? I am concerned about that." No aggravating factors are identified when prompted. No relieving factors are mentioned, and the patient did not report anything that alleviated her symptoms. No treatments were attempted before admission, as the daughter brought the patient directly to the emergency department for evaluation. The severity of the altered mental status remains unclear due to the patient's cognitive deficits, although it is significant enough for the daughter to seek medical attention.

Admission Diagnosis

Primary Diagnosis: Encephalopathy

Secondary Diagnosis (if applicable): Hyponatremia

Pathophysiology

Encephalopathy is a dysfunction of the brain activity that is caused by many factors and can lead to altered mental status. Possible triggers for an acute onset of encephalopathy include central nervous system injuries, systemic infections, metabolic imbalances, toxin exposure, medication effects, chronic systemic illnesses, and psychiatric disorders (Veauthier et al., 2021). In patients presenting with altered mental status, labs, and diagnostic imaging are obtained to determine the cause of the encephalopathy. This patient's labs and imaging were unremarkable in diagnosing metabolic, hepatic, uremic, or toxin-induced encephalopathy. The disease process may be related to psychobiological reasons or stroke. Possible other reasons for this patient's encephalopathy may be linked to limbic system encephalopathy, brainstem encephalitis, or neurotransmitter dysregulation due to bipolar disorder.

DISEASE PROCESS

The limbic system is a complex set of brain structures primarily responsible for emotional reactions. This system plays a role in cognitive processes, including learning, motivation, and memory development (Capriotti, 2024). Neurons and glial cells make up this complex system, and any changes physiologically, metabolically, or psychologically can create a disturbance and dysfunction in cognitive functioning (Capriotti, 2024).

When neurons are stimulated too frequently, as in patients with bipolar disorder, the threshold of neural stimulation becomes less and less. Major psychoactive neurotransmitters that influence neural stimulation are serotonin, norepinephrine, dopamine, and gamma-aminobutyric acid (Capriotti, 2024).

Norepinephrine is most abundant in the hypothalamus of the brain, as well as in the medial regions of the limbic system. Serotonin has several actions in the brain but is mainly related to mood and behavior. Dopamine is linked to reward, mood regulation, and motivation. A

reduction in norepinephrine, serotonin, and dopamine is commonly associated with depressive episodes in bipolar disorder (Capriotti, 2024). When there is an increase in neurotransmitter activity, specifically in patients with bipolar disorder, it can cause hypomania or fully manic states.

SIGNS & SYMPTOMS

Signs and symptoms of encephalopathy are characterized by mood and behavioral changes, short-term memory problems, impaired awareness, and cognitive dysfunction (Reddy & Culpepper, 2022). This patient presented with a new onset of confusion, which led the team to explore laboratory and diagnostic values to determine the cause of her change in status. Upon assessment, the patient was alert and oriented to person, time, and place but not situation. She can recall important orientation information but is unable to have any forethought about her current cognitive difficulties. She also believes her daughter has passed away, but her daughter is alive and well.

DIAGNOSIS

The physician in the emergency department ordered a complete blood count, comprehensive metabolic panel, urinalysis, blood cultures, liver enzymes, a single-view chest x-ray, and a computed tomography scan of the brain without contrast. Since encephalopathy can be directly related to metabolic and/or physiological changes in the brain, these results are standard for diagnosing encephalopathy.

This patient's lab work was mainly unremarkable. Her electrolyte levels were in range, except for a serum sodium level of 129 mmol/L upon admission when the normal range for sodium is 136-145 mmol/L. Although hyponatremia can be a direct cause of acute confusion, her

serum level was related to her use of diuretics. There was no significant change in mental status after sodium repletion, so the level was most likely not the cause of her altered mental status.

The single-view chest x-ray was ordered due to her cognitive status change and weakness. The radiologist read the x-ray and stated no acute cardiopulmonary disease. The computed tomography of the brain without contrast was ordered due to the patient's altered mental status and was performed in the emergency department to determine if there was an intracranial process responsible for the patient's symptoms. The radiologist read the scan and noted no evidence of acute intracranial process but noted some intracranial vascular calcifications and findings in the cerebral white matter consistent with microvascular ischemic changes.

TREATMENT

Treatment for encephalopathy depends on the patient's laboratory and diagnostic findings. For this patient, the healthcare team began to replete her sodium electrolyte levels and continued her home medications as prescribed. While I was assigned to this patient, her blood pressure was reading high throughout the shift, even though her antihypertensive was given in the morning. The known of her encephalopathy is still unknown. The rounding physician decided to order a magnetic resonance imaging (MRI) without contrast of the patient's brain to rule out a stroke and to provide some direction to the treatment plan. Unfortunately, the MRI was not done on this day, so the findings are unknown to me.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives* (3rd ed., p. 919-920). F.A. Davis.

Reddy, P., & Culpepper, K. (2022). Inpatient management of encephalopathy. *Cureus, 14*(2). https://doi.org/10.7759/cureus.22102

Veauthier, B., Hornecker, J. R., & Thrasher, T. (2021). Recent-onset altered mental status: Evaluation and management. *American Family Physician, 104*(5), 461–470.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Sodium	129 mmol/L	132 mmol/L	136-145 mmol/L	The patient's decreased sodium level may be related to diuretics (Pagana et al., 2023). The value trends towards the normal range by repleting sodium levels via continuous 0.9% normal saline infusion.
Chloride	94 mmol/L	99 mmol/L	98-107 mmol/L	The patient's chloride level is slightly out of range on admission, most likely due to the use of hydrochlorothiazide. Diuretics can cause

				chloride loss through the kidneys, especially when taken over a long period (Pagana et al., 2023). Although it was slightly low upon admission, the level is trending up and is within the normal range of today's value.
Blood Urea Nitrogen	6 mg/dL	6 mg/dL	10-20 mg/dL	The patient's blood urea nitrogen levels are low and not trending, most likely due to polydipsia and overhydration. Overhydration can dilute the blood and lower BUN levels (Pagana et al., 2023). The continuous IV fluids may be why the BUN is not trending toward a normal range.
Blood Urea Nitrogen/Creatinine	8 ratio	9 ratio	12-20 ratio	The blood urea nitrogen and creatinine ratio is

Ratio				slightly low due to overhydration and fluid balance issues (Pagana et al., 2023). The value is trending towards a normal range as the patient is being monitored for her fluid volume status.
Glucose	109 mg/dL	112 mg/dL	70-99 mg/dL	The patient's glucose is slightly elevated, which may have been caused by eating close to when the value was taken upon admission or by high stress and anxiety (Pagana et al., 2023). The value is trending away from the normal range and could be related to the timing of the reading and her meals.
Calcium	9.1 mg/dL	8.5 mg/dL	8.7-10.5 mg/dL	The patient's calcium level was normal on admission but is trending

				down. This out-of-range calcium level can be linked to using loop diuretics, such as hydrochlorothiazide (Pagana et al., 2023).
Hemoglobin	11.8 g/dL	11.5 g/dL	12.0-15.8 g/dL	The patient's hemoglobin is slightly low and is trending slowly away from the normal range. Her hemoglobin level may be decreased due to diet, age, activity level, and disease process of her current illness (Pagana et al., 2023).
Hematocrit	35.6%	34.3%	36.0-47.0%	The patient's hematocrit is slightly low and trending down away from normal. This level may be caused by fluid status or the patient's history of anemia (Pagana et al., 2023).

Mean Platelet Volume	7.5 fL	7.3 fL	9.7-12.4 fL	The patient's mean platelet volume is low and trending down from a standard range due to her use of thiazide diuretics and her history of anemia (Pagana et al., 2023).
Neutrophils	74.9%	65.0%	47.0-73.0%	The patient's neutrophils were slightly elevated upon admission, but the level trended into the normal range. This elevated range may be caused by a stress response in the patient's body caused by her cognitive dysfunction or white blood cells in her urine (Pagana et al., 2023).
Lymphocytes	12.5%	22.6%	18.0-42.0%	The patient's lymphocytes were low upon admission but trending into the

				normal range. The low reading could be caused by anemia, vitamin deficiencies, and physical stress (Pagana et al., 2023).
Absolute Lymphocytes	1.00 10^3/mcL	1.80 10^3/mcL	1.30-3.20 10^3/mcL	The patient's absolute lymphocytes were low on admission but trending up into the normal range. This low reading can result from the patient's anemia, onset of acute stress, or vitamin deficiency (Pagana et al., 2023).
Protein, Random Urine	1+	N/A	Negative (-)	The patient's urine was positive for protein on admission, which may be a result of her history of hypertension, which can damage kidney vessels (Pagana et al., 2023).

White Blood Cell Esterase	2+	N/A	Negative (-)	This patient's white blood cell esterase was positive in the urine. This level may indicate a urinary tract infection and/or vaginitis. A culture and urine sensitivity should be tested to see if it is an infection, and a trend should be determined after treatment.

Diagnostic Test & Purpose	Client Signs and Symptoms	Results
03/23/2025 **Chest X-ray Single View** -This is used as a tool to evaluate the lungs, heart, and chest wall to help determine if there is cardiac or respiratory involvement for the patient's weakness and encephalopathy	Weakness and altered mental status upon admission to the emergency department	There is no acute cardiopulmonary disease.

(RadiologyInfo.org, n.d.)		
03/23/2025 **Computed Tomography of the Brain without contrast** -This imaging is used to get multiple views of the internal structure of my patient's head. This is to determine if there are any changes to the structure of my patient's brain, which could be a cause of her encephalopathy and altered mental status (RadiologyInfo.org, n.d.)	Altered mental status upon admission to the emergency department	There is no evidence of an acute intracranial process. Intracranial vascular calcifications and findings in the cerebral white matter are consistent with microvascular ischemic changes.
03/24/2025 **Magnetic Resonance Imaging of the Brain without contrast** - This was ordered due to the patient's consistent high blood pressure readings and confusion to rule out an ischemic or hemorrhagic	Altered mental status and hypertension	The test was ordered on 03/24/2025 but was not performed while I was caring for the patient.

stroke. This diagnostic tool identifies and accurately characterizes disease processes in a more detailed image (RadiologyInfo.org, n.d.)		

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T.J., Pagana, T.N. (2023). *Mosby's diagnostic & laboratory test reference*. (16th ed.). Elsevier.

RadiologyInfo.org. (n.d.). *Chest X-ray*. Retrieved March 26, 2025, from https://www.radiologyinfo.org/en/info/chestrad

RadiologyInfo.org. (n.d.). *Head CT (computed tomography)*. Retrieved March 25, 2025, from https://www.radiologyinfo.org/en/info/headct

RadiologyInfo.org. (n.d.). *Magnetic Resonance Imaging (MRI)*. Retrieved March 26, 2025, from https://www.radiologyinfo.org/en/mri

Active Orders

Active Orders	Rationale
Admission Weight	An admission weight is ordered to assess fluid status and ensure proper medication dosages.
Insert and Maintain Peripheral IV	An IV insertion and maintenance order ensures proper intravenous medications can be given and is a safety mechanism in case of

	an emergent event. It is also to be maintained to ensure proper IV patency.
Intake & Output	Intake and output are ordered to assess fluid status and ensure the patient's diuretic works correctly. This should be documented every shift. Intake should include oral and IV fluids, and output should include urine, loose stool, emesis, or any other lost liquid body fluid.
Maintain IV while on telemetry	Since the patient is on cardiac monitoring via a portable telemetry box, maintaining a patent IV is needed in case emergent medication needs to be given for unsafe cardiac rhythms.
Notify Physician	The order is to notify a physician if the patient's pulse is <50 or >120, the respiratory rate is <10 or >30, the temperature is >101.5, the urine output is <240 mL/8hr, the systolic blood pressure measures <85 or >180, the diastolic blood pressure measures <50 or >105, if the pulse oximeter reads <90%, or if there is a new onset or worsening of pain level.
Notify Physician for symptomatic bradycardia and/or ventricular arrhythmias	This order is placed in case the patient becomes bradycardic with symptoms or if the

	heart rate reads as a ventricular arrhythmia since both of these may be life-threatening and require immediate intervention.
Nursing Night Calls	This nursing night call order is a reference for nurses to notify a physician during nighttime hours. This includes vital signs outside set parameters, sudden changes in the patient's condition, reactions to medications, critical or abnormal lab values, and safety concerns like falls.
Telemetry Monitoring	Cardiac telemetry monitoring is ordered for 48 hours on this patient, indicated by an acute neurologic event such as altered mental status. This ensures that if there is cardiac involvement, a telemetry technician can call with dangerous rhythms or changes within the patient's cardiac rhythm.
Up as tolerated	This order is placed so the nurse and healthcare team know the patient can be out of bed for toileting or exercise as she can tolerate.
Vital signs per unit routine	Vital signs are ordered every 4 hours so that the nurse can document any changes in the

	patient's vitals and see trends or changes in status for the patient.
Diet: Cardiac Restrictions: Cardiac	The diet order is a cardiac diet due to the patient's history of morbid obesity and hypertension. This diet order ensures proper nutrition concerning the cardiovascular system so electrolyte levels can be balanced without damaging effects on the heart.

Medications

Home Medications (Must List ALL)

Medications	Reason for taking
Ascorbic Acid 500 mg	The patient is taking this medication as a vitamin C supplement to improve immune functioning and overall health.
Aspirin 81 mg	The patient is taking aspirin daily to decrease the risk of venous thromboembolism formation since she has a history of hypertension.
Loratadine 10 mg	The patient is taking loratadine to treat symptoms of seasonal allergies.

Losartan 50 mg	The patient is taking losartan daily to treat her hypertension by lowering blood pressure and reducing the workload on the cardiac system.
Multi-vitamin 1 tablet	The patient takes this multivitamin to supplement her diet to support general health and immune functioning.
triamterene-hydrochlorothiazide 37.5-25 mg	The patient takes triamterene-hydrochlorothiazide to remove excess fluid from her body and reduce the edema in her lower extremities.

Hospital Medications (Must List ALL)

Brand/Generic	ascorbic acid/ Easy-C 500 mg oral once daily	aspirin/ Bayer Plus 81 mg oral once daily	enoxaparin/ Lovenox 40 mg subcutaneous injection once daily	losartan/ Cozaar 50 mg oral once daily
Classification	Water soluble vitamin/ Antioxidant	Platelet aggregation inhibitor/	Anticoagulant/ Low molecular weight heparin	Antihypertensive /Angiotensin II Receptor Blocker

		Salicylate		
Reason Client Taking	The patient takes this as a vitamin supplement to boost immunity, healing, and general health.	The patient is taking this medication to prevent clot formation, which may be increased due to hypertension.	The patient is taking this subcutaneous injection daily while inpatient at the hospital to prevent blood clots.	The patient is taking this medication daily to lower her blood pressure and decrease the risk of stroke and other adverse events from hypertension.
Key nursing assessment(s) prior to administration	The nurse should prioritize separating antacids or calcium supplements while taking ascorbic acid, as these can interfere with absorption in the body (Jones &	The nurse should assess for signs of bleeding, bruising, or hematochezia. The nurse should also evaluate laboratory results, a fall risk score for	The nurse should assess the injection site and rotate sites with each dose. Check the patient for signs of bruising, bleeding, or any adverse effects of the injection, and monitor the laboratory results	The nurse should assess the patient's vital signs before administering this medication. If the blood pressure is too low, the medication should be withheld. The

	Bartlett Learning, 2023).	the patient, and a Braden score (Jones & Bartlett Learning, 2023).	for signs of thrombocytopenia (Jones & Bartlett Learning, 2023).	nurse should also educate the patient to get up slowly and call for assistance since this medication may cause orthostatic hypotension (Jones & Bartlett Learning, 2023).
Brand/Generic	multivitamin-minerals/ No brand name 1 tablet by mouth once daily	potassium chloride SA/ Klorcon M 40 mEq by mouth once daily	triamterene-hydrochlorothiazide/ Maxzide 37.5 - 25 mg by mouth once daily	0.9% sodium chloride/ Normal saline Continuous IV infusion at a rate of 125 mL/hr
Classification	Dietary Supplement/ Vitamin	Oral potassium supplement/ Electrolyte replacement	Combination diuretic/ Potassium-sparing & thiazide	Isotonic fluid/ Crystalloid

			diuretic	
Reason Client Taking	The patient takes this multivitamin with minerals to supplement her diet and improve healing and immunity.	The patient is taking an oral potassium supplement to maintain adequate potassium levels in the blood since she takes a diuretic for excess fluid volume.	The patient is taking a combination diuretic to eliminate excess fluid from her body while maintaining potassium. This medication also aids the kidneys in excreting excess electrolytes from the body via urine to decrease blood pressure and edema.	The patient takes a continuous IV infusion of 0.9% normal saline to replete her sodium electrolyte levels since they were slightly low upon admission. The fluids were discontinued at the end of the shift due to her hypertension and large urine output.
Key nursing assessment(s) prior to administration	N/A	The nurse should monitor the patient's serum	The nurse should assess the intake and output of the patient during the	The nurse should assess the patient's fluid status from the

		potassium levels so that they do not become hyperkalemic or hypokalemic (Jones & Bartlett Learning, 2023). The nurse should also educate the patient on the importance of potassium supplementation using diuretics (Jones & Bartlett Learning, 2023).	shift and the trends of the I&O, as well as monitor blood pressure, as diuretics can cause hypotension. The nurse should also consider the patient's mobility status for safety since she will get up to use the washroom often (Jones & Bartlett Learning, 2023).	I&O record and document how much fluid the patient receives orally and intravenously. The nurse should also evaluate the IV's patency, ensuring it is not infiltrated (Jones & Bartlett Learning, 2023).

Prioritize Three Hospital Medications

Medications	Why this medication was	List 2 side effects. These

	chosen	must correlate to your client
1. Losartan (Cozaar)	I chose this medication because the patient has hypertension and fluid volume excess. Maintaining a proper blood pressure reading directly influences her symptoms of encephalopathy and can reduce the possibility of stroke.	**1.** This medication can cause hyperkalemia, so it is a severe side effect, considering she is taking oral potassium supplements and on telemetry monitoring (Jones & Bartlett Learning, 2023). **2.** This medication can cause hypotension, becoming a safety issue when the patient transfers or ambulates in the hospital (Jones & Bartlett Learning, 2023).
2. Triamterene-hydrochlorothiazide (Maxzide)	I chose this medication because the patient is edematous, hypertensive, and on a continuous infusion of normal saline.	**1.** This medication can cause hyponatremia, which the patient had upon admission. Ensuring proper sodium levels in the blood

	With all that, this combined diuretic ensures the patient gets rid of excess fluid while maintaining proper electrolyte levels.	is important for her cognitive functioning and overall fluid status (Jones & Bartlett Learning, 2023). **2.** This medication can cause dizziness and orthostatic hypotension, which can become a safety issue since the patient will get up to void in the bathroom many times after administration (Jones & Bartlett Learning, 2023).
3. Enoxaparin (Lovenox)	I chose this injection because of the importance of venous thromboembolism prophylaxis, as this patient is at a very high risk for a blood clot or stroke.	**1.** This medication can cause bleeding due to the anticoagulant effects of the drug. Safety is a significant concern for this patient, given how frequently she has to get out of bed and her fall risk (Jones & Bartlett Learning, 2023).

		2. Thrombocytopenia may be a side effect, and platelet levels should be monitored since the patient also takes an antiplatelet daily (Jones & Bartlett Learning, 2023).

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2023). *2024 Nurse's Drug Handbook* (23rd ed.). Jones & Bartlett.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and oriented to person, place, and time but disoriented to situation with no signs of distress. The patient's overall appearance is well-groomed, calm, and cooperative.
Infection Control precautions:	The patient is on standard precautions.
Client Complaints or Concerns:	She has no complaints but is concerned about her blood pressure readings, which have been consistently high throughout the shift. Apart from that concern, no other concerns are voiced.

VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	*Taken at 0710 on 03/24/2025* Temperature: 98.8 degrees Fahrenheit Respiratory Rate: 17 respirations per minute Pulse: 99 beats per minute Blood Pressure: 173/93 Oxygen: 97% on room air
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:** **Interventions:**	*Taken at 0710 on 03/24/2025* The patient reports a 0 out of 10 on the numerical scale for pain. With a rating of 0, there is no location, severity, characteristic, or intervention.
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:**	*Size of IV:* 20 gauge *Location of IV:* Left posterior forearm *Date on IV:* 03/23/2025 placed in ED *Patency of IV:* Flushes easily without complaint and has blood return. *IV dressing assessment:* Tegaderm over IV site with clear tape anchoring the loop, no signs of infiltration, no blood on dressing, slight ecchymosis surrounding the IV site from

	insertion. *Fluid Type/Rate:* 0.9% Normal Saline 1000 mL continuous infusion at 125 mL/hr.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Skin color is a pale tan, warm to the touch, and dry with no signs of moisture or diaphoresis. Skin turgor quickly returns to its original state in <3 seconds on the bilateral upper extremities. No rashes were noted, but a small 1.5 cm bruise was noted around the IV site. No wounds are present, although there is redness around the left upper side of the nasal bridge from her glasses missing a cushion. The skin on her bilateral lower extremities is warm and dry, and dry patches on the lower portion of her right and left legs were noted. **Braden Score: 19** Sensory Perception: 4 Moisture: 3 Activity: 3 Mobility: 3

	Nutrition: 3 Friction & Shear: 3 There are no drains present for this patient. An external female catheter was placed on the external genitalia and connected to continuous suctioning. No redness or wounds were noted around the external catheter.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The head is normocephalic in shape and symmetrical. The trachea is centrally positioned without deviation. No palpable lymph nodes are noted. Bilateral carotid pulses are present and rated 2+. Bilateral ears were inspected with a pen light. Bilateral ears are intact with no wounds, lesions, or deformities. Cerumen is noted bilaterally inside the external auditory canals. Bilateral pupils are equal, round, and reactive to light and accommodation (PERRLA), measuring 3mm in size. Extraocular movements (EOMs) are intact bilaterally. The sclera is white bilaterally, and the cornea is clear in both eyes, with no

	visible drainage. The eyes exhibit exotropia bilaterally, and the patient does not complain of visual deficits. The nasal septum is midline, and bilateral turbinates are moist and pink, with no visible drainage or bleeding. The patient is missing teeth on the upper and lower jaws. She has six teeth on the upper jaw and five on the lower jaw. Both upper and lower teeth appear to have signs of dental caries, as they have a dark brown color and tooth decay on the distal portions. .
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 ☐**	Clear S1 and S2 heart sounds are auscultated with no evidence of murmurs, rubs, or gallops. The cardiac rhythm is normal sinus rhythm, with periods of sinus tachycardia, as evidenced by her telemetry reading. Bilateral carotid pulses 2+, Bilateral radial pulses 2+, bilateral brachial pulses 1+. Bilateral popliteal pulses 1+, bilateral posterior tibial

Location of Edema:	pulses 1+, bilateral dorsalis pedis pulses 1+. Capillary refill is <3 seconds on the bilateral upper and lower extremities. There is no evidence of neck vein distention. Edema is noted in the patient's bilateral lower extremities. Right and left leg edema is non-pitting and 2+. Right and left feet have pitting edema 2+. No edema is noted anywhere else on the patient's body.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient exhibits no use of accessory muscles for breathing. Respiratory rate is within normal limits at 17 breaths per minute. Breathing is symmetrical and unlabored. Breath sounds are clear in the anterior and posterior lung fields, including the right upper, middle, and lower quadrants, as well as the left upper and lower quadrants. No crackles, rhonchi, or wheezes are present. There are no diminished lung sounds in any of the bilateral lung fields.

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 ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	The patient's diet at home is a regular diet with no restrictions. Her current inpatient diet order is a cardiac diet with low sodium, low trans and saturated fats, and controlled carbohydrates. The client is tolerating this diet well. *Height:* 4'11" (149.9 cm) *Weight:* 197.3 lbs (89.4 kg) Bowel sounds are normoactive upon auscultation in all four abdominal quadrants. The client's last bowel movement was 03/23/2025. On palpation, the abdomen is soft and nontender. No enlargement of organs or masses is detected in any of the four abdominal quadrants. There is no tenderness at the costovertebral angle. The abdomen is not distended, and no incisions, scars, drains, or wounds are observed.

	The patient does not have an ostomy, nasogastric tube, or feeding tube/PEG tube present.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	The patient's urine is yellow and clear, with no foul odor. There is a large quantity of urine with voids due to the administration of a diuretic. The quantity of urine was not measured, but the patient had 6-7 voids, with one or two incontinent episodes. The patient stated no pain with urination. The patient is not on dialysis. The external genitalia appears pink and moist, with no signs of wounds, drainage, or excoriation. There is no indwelling catheter, but an external female catheter is in place at the end of the shift.
Intake (in mLs) **Output (in mLs)**	**Intake**: 2,690 mL (1 cup orange juice, 1 cup coffee, 1 cup of diet pop, 1 cup orange juice, 1 cup of orange juice, 1 cup total of ice chips, continuous IV infusion of 0.9% NS at 125 mL/hr for 10 hours on shift). The patient was asking for a new drink every 30 minutes.

	Output: 7 void occurrences witnessed No urine was measured, but the external catheter was placed at the end of the shift to measure. I witnessed two large incontinent voids in an adult brief, one incontinent void on an incontinence brief, and four voids in the toilet.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	Both upper and lower extremities exhibit a full range of motion bilaterally. Hand grips, hand pulls, and hand pushes demonstrate normal and symmetrical strength bilaterally. Pedal pushes in the lower extremities are strong and equal bilaterally. A gait belt is used as a supportive device since the patient is on IV fluids to prevent falls. The patient requires 1x assist for meal setup and 1x assist to transfer to stand and walk to the washroom but does her hygiene independently. Morse Fall Scale: History of falling: 0 Secondary diagnosis: 15

	Ambulatory Aid: 0 IV Therapy: 20 Gait: 10 Mental Status: 0 Fall Score: 45 - the patient is at a low fall risk. The patient can tolerate moderate physical activity and knows her physical ability.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient can move all extremities well. PERRLA is intact bilaterally. Cranial nerves I-VII are intact. Strength is equal bilaterally for the upper and lower extremities. The patient is oriented to person, time, and place. Her mental status is calm, cooperative, alert, and able to follow commands. She is unable to give a proper health history and has some delusions about her daughter's death even though she is alive. The patient cannot recall what brought her into the hospital but knows she is currently a

	patient at OSF Hospital. The patient's speech is clear, well-articulated, and able to vocalize needs properly. The patient's level of consciousness is awake, alert, and responsive.
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):**	The patient cannot vocalize coping methods that she uses in her life when asked during the assessment. According to Piaget's Theory, the patient is currently at the concrete operational stage. She can demonstrate the ability to think logically about concrete events but struggles with abstract or hypothetical concepts. The patient stated she does not practice any religion, and it does not have much meaning in her life. The patient verbalizes a love for her daughter and appreciates her as a support. With that, the patient thinks the daughter has passed away, even

	though she has been told she is still alive. The patient also verbalizes comfort in living alone in a single-family home and appreciates independence.

Discharge Planning

Discharge location: The patient will most likely get discharged back to her single-family home in St. Anne, IL.

Home health needs: The patient will need to regularly check her blood pressure at home since she had asymptomatic hypertension while inpatient. She will not need further home health care since she lives independently.

Equipment needs: The patient will require an at-home sphygmomanometer to check her blood pressure routinely.

Follow-up plan: The patient should schedule appointments with her primary care physician to reassess her prescriptions. The patient should also follow up with psychiatry to assess her mental status and determine if medication is needed.

Education needs: The patient should be educated on medication management and how to take her blood pressure at home at the recommended frequency. The family should also be provided education on early signs and symptoms of confusion.

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. Ineffective brain tissue perfusion related to altered sodium levels as evidenced by confusion and peripheral edema.	I chose this diagnosis due to the patient's acute altered mental status upon admission and her hyponatremia.	The patient will improve cognitively, and their sodium levels will trend into the normal range.	**1.** Administer an infusion of sodium chloride to replete the sodium electrolyte and improve tissue perfusion in the brain **2.** Assess the	The patient will improve in cognition and have a normal neurological assessment, and her lower extremity swelling will decrease.

			patient's cognitive status, lower extremity edema, vital signs, and fluid balances to ensure her body maintains health to improve her cognitive functioning (Phelps, 2023).	
2. Disturbed thought processes related to insufficient tissue perfusion to the brain secondary to	I chose this diagnosis due to the patient having an altered mental status, which may be related to her high blood pressure readings	The patient will have blood pressure readings within the normal	**1.** Assess and monitor blood pressure regularly per protocol and document readings into the electronic	The patient will demonstrate improved cognitive status, and the blood pressure will be in the standard target range

hypertension, as evidenced by difficulty communicating verbally.	and inadequate tissue perfusion in the brain.	range and improve cognitively.	health record (Phelps, 2023). **2**. Monitor the patient's neurological status to determine if there is a change in orientation and alertness.	(Phelps, 2023).
3. Anxiety related to elevated blood pressure and cognitive impairment, as evidenced by verbalized concerns and expressions of distress.	I chose this diagnosis due to the amount of concern the patient had over her blood pressure and also not knowing why she was in the hospital.	The patient will verbalize decreased anxiety and subjective distress (Phelps, 2023).	**1.** Assess the patient's level of anxiety and physical manifestations of distress (Phelps, 2023). **2**. Provide education to the patient on	The patient will report lessened or absent symptoms of anxiety and will verbalize coping skills to use in terms of stress or anxiety (Phelps, 2023).

			how to best support worrying thoughts and answer any questions she has about her blood pressure and medications.	

Other References (APA):

Phelps, L.L., (2023). *Nursing diagnosis reference manual.* (12th ed.). Wolters Kluwer.