N321 CARE PLAN # 1

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Lakeview College of Nursing

N321: Adult Health I

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Demographics

Date of Admission 9/23/25	**Client Initials** K.C.	**Age** 64 years old	**Biological Gender** Male
Race/Ethnicity White/Caucasian	**Occupation** Unemployed - Disability	**Marital Status** Divorced	**Allergies** No Known Allergies
Code Status Full Code	**Height** 6’	**Weight** 99 kg (218 lb 4.1 oz)	

Medical History

Past Medical History: Patient has a past medical history of having a closed fracture with routine healing, gout, GERD, Hypertension, and Hyperlipidemia.

Past Surgical History: Patient has a past surgical history of having an upper gastrointestinal endoscopy (1/10/2023), a joint Replacement, a colon endoscopy (6/20/2014), and an EGD (6/20/2014).

Family History: Patient stated his mother had heart surgery, and his father had lung cancer and prostate cancer.

Social History (tobacco/alcohol/drugs, including frequency, quantity, and duration of use): Patient denies use of smoking and smokeless tobacco and use of recreational drugs. Patient stated that in the past month, he has been drinking vodka every day.

Education: Patient stated he graduated from high school in 1980 and did not attend college.

Living Situation: Patient lives at home alone; his house has three stairs to get into it with one railing, a shower stool that gets used when giving himself a sponge bath at his bathroom sink. His brother helps him out by doing his laundry and doing his grocery shopping.

Assistive devices: Patient stated he uses a walker when ambulating in the house and uses a cane when walking outside.

Admission History

Chief Complaint: Chief complaint is generalized weakness.

History of Present Illness (HPI)– OLD CARTS

Patient stated, “I was having diarrhea for about a month. I started to feel weak in the past two weeks.” “At first I was able to get up and go to the bathroom, but after a week I was no longer able to get up freely, and I started to go on myself.” “I could no longer get out of bed by myself, and there were times I was lying in poop for hours before my brother could come help me.” “I started to feel like crap, and I started to drink multiple drinks of vodka every day to help with the pain.” “I did not try any other medications to help with the stool.” “I got so weak I was sleeping most of the day, and I could not function at all.” “One day, my brother came over with groceries, and he told me that he was taking me in because I was so bad. He said I was extremely pale, and my legs and bottom had open areas that were getting red and painful.”

Admission Diagnosis

Primary Diagnosis: Acute Kidney Injury (AKI)

Secondary Diagnosis (if applicable): Hyponatremia and diarrhea.

Pathophysiology

Acute kidney injury, also known as AKI, is formerly known as acute renal failure. An acute kidney injury occurs when there is decreased glomerular filtration of the blood, leading to high serum creatinine and fluid retention (Capriotti, 2024). There are four different stages for acute kidney injury. The first stage is the initial stage. During the initial stage, it can last from hours to days until the body starts to manifest changes. The second stage is the oliguric stage, which is where the decrease in glomerular filtration rate results in retention of urea, potassium, sulfate, and creatinine (Capriotti, 2024). During this stage, the formation of urine is significantly decreased. The body will start to show signs of fluid retention. The third stage is the diuretic

phase. This is where the kidneys are trying to recover from the damage and will start to form fibrotic tissue to help the damaged nephrons (Capriotti, 2024). During this stage, the urine output may be increased, but it does not show signs of being concentrated or diluted. The urine may have the same osmolarity as the bloodstream. This indicates that the kidney is excreting urine that does not contain all the waste products from the bloodstream (Capriotti, 2024). The last and final stage is the recovery phase. During this phase, time is needed to help the body recover from the kidney damage. The kidney will start to become healthier, and the urine output will remain increased. Serum lab levels will slowly become normal, although scar tissue may remain on the nephrons (Capriotti, 2024).

Acute kidney injuries can be shown in different ways, depending on what is going on with the patient. Symptoms could include chronic fatigue, anorexia, nocturia, polyuria, and pruritus (Wang et al., 2022). An acute kidney injury can be determined with different lab values. An elevation of creatinine or decreased urine output can be a key sign to look further into a kidney injury (Capriotti, 2024). A kidney injury is determined if the creatinine levels are increased by at least 50 percent from the baseline labs (Capriotti, 2024). There are different stages of AKIs, and each stage is determined by how elevated the creatinine levels are.

There are other lab values that are taken into consideration for kidney injuries, such as electrolytes, BUN, arterial blood gases, and CBC (Capriotti, 2024). Urine cultures can be difficult to obtain if there is a decrease in urine. If the concentration of urine is high, it could help determine a kidney injury (Capriotti, 2024). There are diagnostic tests that can be done, such as a radiographic image of the kidneys. A radiographic image could show if there is an obstructive change or a structural change to the kidneys (Capriotti, 2024). Vascular imaging, MRI, and a

renal biopsy can also be done to help determine whether there is any change to the kidneys or a blockage causing the injury (Capriotti, 2024).

Clinical treatment is primarily based on symptoms and supportive treatment. This can include dialysis, renal replacement therapy, and fluid administration (Wang, et al., 2022). The underlying cause of the kidney injury will determine how the treatment will go. If the patient develops an absence of urine, Lasix may be prescribed to help the patient urinate (Capriotti, 2024). Electrolytes will be given to help balance them back to a normal level. Cardiac monitoring is needed to detect any cardiac changes that are involved in the imbalance of electrolytes (Capriotti, 2024). A discontinuation of NSAIDs is recommended to help decrease any further damage to the kidneys. A dietitian may be able to help the patient come up with a better diet that will help decrease the sodium intake and not be harmful to the kidneys.

My patient was first brought into the emergency department, showing signs of dehydration and incontinence of bowel. My patient had not had frequent urination but was underdetermined since the patient was incontinent of both. There was no X-ray or vascular imaging done to determine the kidney injury. There was an ultrasound done on the kidneys to help see any visual changes. Routine labs were also done, which included CBC, BMP; most labs were focused on kidney functions. The GFR rate was low upon admission, and since treatment has been started, the GFR rate has normalized. The only treatment they are currently on is medications to help normalize electrolyte levels. The patient was admitted into the ICU and received fluids, which have since been discontinued.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Wang, Y., Liu, S., Liu, Q., & Lv, Y. (2022). The interaction of central nervous system and acute kidney injury: Pathophysiology and clinical perspectives. *Frontiers in Physiology, 13,* 826686. https://doi.org/10.3389/fphys.2022.826686

Laboratory/Diagnostic Data

Lab Name	Admission Value 9/23/25	Today's Value 9/29/25	Normal Range	Reasons for Abnormal
Sodium	**120 mEq/L**	**131 mEq/L**	136-145 mEq/L	Sodium could be low due to deficient dietary intake, GI loss, or peripheral edema (Pagana, et al., 2025).
Potassium	**3.4 mEq/L**	**3.1 mEq/L**	3.5-5 mEq/L	Potassium could be low due to deficient dietary intake, or diarrhea (Pagana, et al., 2025).
Chloride	**84 mEq/L**	104 mEq/L	98-106 mEq/L	Chloride could be low due to metabolic alkalosis, or hypokalemia (Pagana, et al., 2025).
CO2 Venous	**13 mm Hg**	**21 mm Hg**	35-45 mmHg	A CO2 blood test can be done to help determine any kidney disorders. Low CO2 levels can be a cause

				from weakness, and kidney diseases (Pagana, et al., 2025).
Anion Gap	**23.0 mEq/L**	6.0 mEq/L	2-12 mEq/L	An anion gap lab test can be done to help determine if there is an imbalance in electrolytes. Abnormal reasons can include renal failure, and low albumin (Pagana, et al., 2025).
BUN	**47 mg/dL**	**27 mg/dL**	10-20 mg/dL	BUN could be elevated due to dehydration, or impaired kidney function (Pagana, et al., 2025).
GFR	**10**	>60	>90	GFR could be low due to kidney disease, and inflammation of the glomeruli (Pagana, et al., 2025).
BUN/Creatinine Ratio	**8** mg/dL	**31** mg/dL	6-25 mg/dL	BUN/creatinine ratio could be low due to kidneys not properly functioning, or

				malnutrition (Pagana, et al., 2025).
Glucose	**128 mg/dL**	**102 mg/dL**	70-99 mg/dL	Glucose levels could be high to do some medications, or infection (Pagana, et al., 2025).
Calcium	9.9 mg/dL	**8.1 mg/dL**	8.5-10.2 mg/dL	Calcium levels could be low due to kidney damage and vitamin D deficiency (Pagana, et al., 2025).
Phosphorus Total Protein	**9.6 mg/dL**	**1.6 mg/dL**	2.8-4.5 mg/dL	Phosphorus total protein levels could be abnormal due to kidney or liver disease (Pagana, et al., 2025).
AST	**111 units/L**	N/A	0-35 units/L	AST could be elevated due to acute renal disease or hepatic cirrhosis (Pagana, et al., 2025).
GFR Non African American	**10**	>60	>90	GFR non African American levels could be low due to kidney disease or high blood pressure

				(Pagana, et al., 2025).
GFR African American	**12**	>60	>90	GFR African American lab levels could be low due to damage to the kidneys, or high blood pressure (Pagana, et al., 2025).
Hemoglobin	**17.5 g/dL**	N/A	13.5-17.5 g/dL	Hemoglobin could be high due to hypoxia, or certain medications (Pagana, et al., 2025).
Hematocrit	**52.0**	N/A	41-50%	Hematocrit levels could be high due to being dehydration (Pagana, et al., 2025).
Neutrophils	**80.2**	N/A	40-60%	Neutrophils could be high due to inflammation or infection (Pagana, et al., 2025).
Lymphocytes	**11.0**	N/A	1.0-4.8 (µL)	Lymphocytes could be high due to infection (Pagana, et al., 2025).
Absolute	**0.60**	N/A	1.0-4.8 (µL)	Absolute lymphocytes

Lymphocytes				could be high due to infection (Pagana, et al., 2025).

Current Diagnostic Test & Purpose	Clients Signs and Symptoms	Results and correlate to client diagnosis and condition
CT head or Brain wo Contrast – Mental Status Changes, Unknown Cause	Patient came into the ER confused and lethargic.	No acute intracranial findings. Patient was admitted for acute kidney injury, was home having diarrhea for a month long.
XR Chest Single View – Chest Pain	No signs or symptoms to have a chest x-ray. May have been ordered with patient being lethargic and lying in bed for a long period of time.	Old right-sided fractures, heart normal in size, lung volumes are low, no focal air space disease, no pneumothorax or large pleural effusion. Patient was bedridden for the past couple weeks from having

		chronic diarrhea.
US Renal Complete – Acute Kidney Injury	No signs or symptoms to determine an ultrasound. Patient came in with edema in lower extremities and abnormal labs.	No hydronephrosis. Limited visualization of the renal parenchyma. No visualization of the urinary bladder.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's diagnostic & laboratory test reference*. Elsevier.

Active Orders

Active Orders	Rationale
Adult Diet Diet Type: Renal	Diet order for patient to order food and allowed to eat and drink.
IP Consult to Nephrology	Consult to nephrology due to be patient being admitted for an acute kidney injury.
Culture Anaerobic with Culture, Aerobic	Wound culture ordered for the present wounds.
UR Creatinine Random	Creatinine is monitored to determine function of kidneys.
UR Sodium (Na) Random	Sodium is monitored to help measure level due to patient has high blood pressure.

OT Evalute and Treat Pt Evaluate and Treat	Patient has been bedridden for the past month and has generalized weakness. PT and OT will help the patient get stronger and be able to move around more.
Aerosol Nebulizer – Subsequent RT Assessment for Albuterol and Ipratropium Treatment Plan	Respiratory therapist is needed to help monitor oxygen levels and needs to oxygen if needed. Nebulizer and inhalers are prescribed in case patient has issue breathing with being in bed.
Admission Weight	Weight is needed to monitor for fluid retention if any, and for weight-based drugs.
Cardiac Monitoring	Cardiac monitoring is important. It can show if the patient is having different cardiac rhythms.
Insert and/or Maintain Indwelling Urthraal Catheter (Foley)	Patient has skin breakdown in perineal area and is incontinent. The foley can help the skin heal without having urine or stool sit on the open areas.
Insert/Maintain Peripheral IV	Patient has IV medications ordered and fluids.
Intake and Output	Intake and output are ordered to ensure the patient is not having more in then out and to see if the patient is retaining any fluid.
Maintain IV While on Telemetry	IV access may be needed with cardiac issues.

Notify Physician (Specify) – pulse less than 50 or greater than 120, respiratory less then 10 or greater than 30, temperature > 101.5, urinary output < 240 mL/8 hour, SBP < 85 or > 180, diastolic BP < 50 or > 105, pulse < 90, new onset pain or worsening pain	Physician should be notified if there are any significant changes with vitals signs. Major changes could mean the patient is declining and a new treatment plan may be needed.
Notify Physician – Symptomatic Bradycardia	Physician should be notified when patient starting to show symptoms of bradycardic to ensure if other testing or medications are needed.
Notify Physician – Ventricular Arrhythmias	Physician should be notified when patient is showing arrhythmias to ensure if other testing or medications are needed.
Notify Physician When Prior to Admission (PTA) Medication Review Has Been Completed	Medication review is important to ensure no medications that will be order will be contraindicated with each other.
Nursing Communication – Offer Prune Juice If Available On The Patients Diet	Prune juice can help the patient pass stools if constipated.
Nursing Communication – Please Provide Patient Education To Reduce/Avoid Constipating Foods Such As Red Meet, Fried, or Fatty Foods, Milk, Cheese	Education is important about constipation. Due to the patient is bedridden at this time and cannot ambulated freely, constipation can happen more often. Ensuring they are educated about eating the right foods can help

	prevent constipation.
Nursing Communication – Promote Adequate Fluid Intake And Encourage Increase Fluid Intake If Not On A Fluid Restriction	Patient should be drinking adequate fluids to help stay hydrated and ensure electrolytes are balanced.
Obtain Bilateral Blood Pressures	Patient has history of high blood pressure. Bilateral blood pressure should be taken to see any differences.
RT Therapy Assessment Score	Respiratory is needed in case patient is need of oxygen.
Saline Lock IV	Saline lock is important to ensure there is access when medication is administered or fluids.
Up With Assistance	Patient should be ambulated if they are able to ensure the wounds do not get worse along with helping the patient get better.
Vital Signs	Vitals signs are used to monitor the patients' blood pressure. Patient has a history of hypertension.
Wound/Ostomy Consult	Patient has wounds on coccyx and bilateral wounds on lower extremities. Wounds need to be consulted to ensure the right treatment is being done and what medications or dressings can be used to help promote healing.

Hospital Medications (Must List ALL)

Brand/ Generic	amlodipine (Norvasc)	Aspirin (Vazalore, Sloprin, Empirin, Bayer Aspirin)	cholestyramine (Questran, Questran Light)	Heparin (Pordine)	Prednisone (Deltasone)	Pregabalin (Lyrica)
Dose, frequency, route	5 mg, Daily, Oral	81 mg, Daily, Oral	4 g, 2x Daily, Oral	5,000 units, 3x Daily (Q8 hours), Subcutaneous Injection	40 mg, Daily, Oral	35 mg, 3x Daily, Oral
Classification (Pharmacological and therapeutic and action of the drug	Pharmacologic Class: Calcium Channel Blocker Therapeutic Class: Antianginal Antihypertensive Action: Inhibits transportation of calcium into the myocardial and vascular smooth muscle, resulting in contraction (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Salicylate Therapeutic Class: NSAID (anti-inflammatory, antiplatelet, antipyretic, nonopioid analgesic) Action: Reduces inflammation and fever by inhibiting the production of prostaglandins (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Bile Acid Sequestrants Therapeutic Class: Lipid-Lowering Agents Action: Binds bile acids in the gastrointestinal tract which results in increased clearance of cholesterol (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Anticoagulant Therapeutic Class: Anticoagulant Action: Inhibits effects of antithrombin on factor Xa and thrombin (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Corticosteroids Therapeutic Class: Anti-inflammatories, immune modifiers Action: Suppresses inflammation and the normal immune response (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Gamma aminobutyric acid Gaba analogues, nonopioid analgesics Therapeutic Class: Analgesics, anticonvulsants Action: Binds to calcium channels to regulate neurotransmitter release (*2025: NDH: Nurse's drug handbook*, 2024).
Reason	Patient is	Patient is	Patient	Patient is	Patient is	Patient is

Client Taking	taking amlodipine for hypertension	taking this med for mild pain or fever.	has hyperlipidemia.	taking heparin to help prevent deep vein thrombosis.	taking prednisone to help reduce any inflammation that may be from the acute kidney injury.	taking pregabalin for nerve pain.
Two contraindications (pertinent to the client)	1. Severe hepatic impairment 2. Systolic BP < 90 mm Hg	1. GI ulcers 2. Fever	1. History of constipation 2. Biliary obstruction	1. Severe hepatic impairment. 2. Severe uncontrolled hypertension.	1. Alcohol intolerance 2. Untreated infections	1. Renal impairment 2. Respiratory impairment
Two side effects or adverse effects (Pertinent to the client)	1. Peripheral Edema 2. Diarrhea	1. Diarrhea 2. Heartburn	1. Abdominal discomfort 2. Vitamin K deficiency	1. Elevated liver enzyme 2. Injection site hematoma	1. Hypertension 2. Decreased wound healing	1. Edema 2. Diarrhea
Key nursing assessment(s) prior to administration	1. Check patient's blood pressure (*2025: NDH: Nurse's drug handbook*, 2024). 2. Check patient's renal function (*2025:*	1. Assess patient's pain level (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess vitals signs (temperature) (*2025: NDH:*	1. Assess frequency and consistency of stools (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess lab	1. Assess for any signs of bleeding (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess aPTT levels prior to administration	1. Assess for signs of infection (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess CBC and electrolytes (*2025:*	1. Assess patient for any behavioral changes (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess creatine levels (*2025: NDH:*

	NDH: Nurse's drug handbook, 2024).	*Nurse's drug handbook*, 2024).	values such as AST, ALT, and chloride to insure they are severely increased (*2025: NDH: Nurse's drug handbook*, 2024).	(*2025: NDH: Nurse's drug handbook*, 2024).	*NDH: Nurse's drug handbook*, 2024).	*Nurse's drug handbook*, 2024).

Brand/ Generic	Sodium Bicarbonate	sodium chloride (Slo-Salt)	cholecalciferol (Vitamin D3)	Calcium Gluconate	potassium chloride (Klor-con, K-Tab, Slow-K)	Acetaminophen (Tylenol)
Dose, frequency, route	1200 mg, 3x Daily, Oral	1 g, 2x Daily, Oral	100 mg, Daily, Oral	2 g, Once, IVPB	40 mEq, Once, Oral	650 mg, Q4 hour PRN, Oral
Classification (Pharmacological and therapeutic and action of the drug	Pharmacologic Class: Alkalinizing agents Therapeutic Class: Antiulcer Agents Action: Acts a	Therapeutic Class: Mineral and Electrolyte replacement/supplement Action: Helps maintain fluid and electrolyte balance and acid-base	Pharmacologic Class: Fat Soluble vitamins Therapeutic Class: Vitamins Action: promotes intestinal absorptio	Therapeutic Class: Mineral and Electrolyte replacements/ supplements Action: Maintain cell membrane and capillary permeability (*2025: NDH:*	Therapeutic Class: Mineral and electrolyte replacements/ supplements Action: Maintains acid-base balance and isotonicity (*2025: NDH:*	Therapeutic Class: Antipyretics, nonopioid analgesics Action: Inhibits synthesi

	neutralizing gastric acid (*2025: NDH: Nurse's drug handbook*, 2024).	equilibrium (*2025: NDH: Nurse's drug handbook*, 2024).	n of dietary calcium (*2025: NDH: Nurse's drug handbook*, 2024).	*Nurse's drug handbook*, 2024).	*Nurse's drug handbook*, 2024).	s that may serve as mediators of pain and fever (*2025: NDH: Nurse's drug handbook*, 2024).
Reason Client Taking	Patient is taking sodium bicarbonate for GERD.	Patient is taking sodium chloride to help bring up sodium and chloride levels.	Patient is taking Vitamin D3 to help bring up calcium levels.	Patient is taking calcium gluconate to help bring up calcium levels.	Patient is taking potassium chloride because potassium and chloride lab values were low.	Patient is taking acetaminophen for mild pain or fever.
Two contraindications (pertinent to the client)	1. Hypocalcemia 2. Renal failure	1. Diarrhea 2. Renal failure	1. Malabsorption problems 2. Hypercalcemia	1. Renal calculi 2. Renal disease	1. Renal impairment 2. GI hypomotility	1. Hepatic impairment 2. Alcohol intolerance
Two side effects or adverse effects (Pertinent to the client)	1. Hypocalcemia 2. Gastric distention	1. Edema 2. Hypokalemia	1. Elevated liver enzymes 2. Hypertension	1. Constipation 2. Nausea	1. Diarrhea 2. Weakness	1. Hypertension 2. Renal failure
Key nursing assessment(s) prior to administration	1. Assess for any epigastric or abdo	1. Assess patient for symptoms of hyponatremia (*2025: NDH:*	1. Assess patient for vitamin defici	1. Assess patient for symptoms of hypocalcemia (*2025:*	1. Assess for symptoms of hypokalemia (*2025: NDH: Nurse's*	1. Assess for pain level (*2025: NDH*

	minal pain (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess lab values for sodium, calcium, and bicarbonate (*2025: NDH: Nurse's drug handbook*, 2024).	*Nurse's drug handbook*, 2024). 2. Assess lab values for sodium, potassium, bicarbonate, and chloride (*2025: NDH: Nurse's drug handbook*, 2024).	ency (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess calcium, and phosphorus lab values (*2025: NDH: Nurse's drug handbook*, 2024).	*NDH: Nurse's drug handbook*, 2024). 2. Assess calcium lab values (*2025: NDH: Nurse's drug handbook*, 2024).	*drug handbook*, 2024). 2. Assess potassium and chloride lab values prior to administration (*2025: NDH: Nurse's drug handbook*, 2024).	*: Nurse's drug handbook*, 2024). 2. Assess vital signs for fever (*2025: NDH: Nurse's drug handbook*, 2024).
Brand/ Generic	albuterol (Accuneb, Proair Respiclick, VoSpire ER)	calcium carbonate (Amitone, Calcarb, Cal-Plus)	loperamide (Imodium A-D)	magnesium hydroxide (Alamag, Maalox, Rulox)	Melatonin (Pineal Hormone)	Menthal-Zinc Oxide
Dose, frequenc	2.5 mg, Q4 hours	1000 mg, Q8 hours PRN,	2 mg, 4x Daily	30 mL, Daily PRN, Oral	6 mg, Nightly PRN, Oral	0.44-0.6%,

y, route	PRN, Nebulizer	Oral	PRN, Oral			Daily PRN, Topical
Classification (Pharmacological and therapeutic and action of the drug	Pharmacologic Class: Adrenergic Therapeutic Class: Bronchodilator Action: Relaxes the airway smooth muscles with bronchodilation (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Antacid Therapeutic Class: Mineral and Electrolyte replacements/ supplements Action: Maintains cell membrane and capillary permeability (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Opioid receptor agonist Therapeutic Class: Antidiarrheals Action: Reduces the amount of stool (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Antacids Therapeutic Class: Antiulcer agents Action: Neutralizes gastric acid (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Sedative Therapeutic Class: Sedative/Hypnotics Action: Regulates the hormone secreted by the pineal gland to help regulate the normal sleep/wake cycle (*2025: NDH: Nurse's drug handbook*, 2024).	Therapeutic Class: Topical skin protectant Action: Acts a skin barrier over an affected area of skin (*2025: NDH: Nurse's drug handbook*, 2024).
Reason Client Taking	Patient is taking albuterol for any wheezing or shortness of breath.	Patient is taking calcium carbonate for heartburn and indigestion.	Patient is taking loperamide for diarrhea.	Patient is taking magnesium hydroxide for constipation.	Patient is taking melatonin to help with sleep.	Patient is taking Menthal-Zinc Oxide to help protect bottom area.
Two contraindications (pertinent to the client)	1. Cardiac disease 2. Hypertension	1. Renal impairment 2. Cardiac disease	1. Alcohol intolerance. 2. Hepatic impairment	1. Renal failure 2. Dehydration	1. Hypertension 2. Diabetes Mellitus	1. Do not use on open areas 2. Do not use if allergic to any

						products
Two side effects or adverse effects (Pertinent to the client)	1. Hypertension 2. Hypokalemia	1. Nausea 2. Arrhythmias	1. Abdominal discomfort 2. Drowsiness	1. Diarrhea 2. hypermagnesemia	1. Abdominal cramps 2. Drowsiness	1.Redness 2.Irritation
Key nursing assessment(s) prior to administration	1. Assess patient's lung sounds (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess patients' pulse and blood pressure (*2025: NDH: Nurse's drug handbook*, 2024)	1. Assess patient's bowel sounds and inspect the abdomen (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess lab values for calcium and sodium (*2025: NDH: Nurse's drug handbook*, 2024).	1. Assess skin turgor (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess frequency and consistency of stools (*2025: NDH: Nurse's drug handbook*, 2024).	1. Assess for heartburn and indigestion (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess potassium and calcium levels (*2025: NDH: Nurse's drug handbook*, 2024).	1. Assess patient's sleep patterns (*2025: NDH: Nurse's drug handbook*, 2024). 2. Obtain blood glucose and monitor lipid panel (*2025: NDH: Nurse's drug handbook*, 2024).	1.Assess skin integrity prior to use (*2025: NDH: Nurse's drug handbook*, 2024). 2.Assess for any redness or irritation area area (*2025: NDH: Nurse's drug handbook*, 2024).

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Brand/ Generic	ondansetron (Zofran, Zuplenz)	polyethylene glycol (GlycoLax, MiraLax)	senna (Ex-Lax, Senokot)			
Dose, frequency, route	4 mg, Q6 hours PRN, Oral 4 mg, Q6 hours PRN, IV	17 g, 2x Daily PRN, Oral	8.6 mg, 2x Daily PRN, Oral			
Classification (Pharmacological and therapeutic and action of the drug	Pharmacologic Class: Five ht3 Antagonists Therapeutic Class: Antiemetics Action: Blocks serotonin receptor sites located in the vagal nerve terminals (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Osmotics Therapeutic Class: Laxatives Action: Draws water into the lumen of the gastrointestinal tract to increase peristalsis (*2025: NDH: Nurse's drug handbook*, 2024).	Pharmacologic Class: Stimulate Laxatives Therapeutic Class: Laxatives Action: The components of senna alter water and electrolytes in the large intestines. This helps increase peristalsis (*2025: NDH: Nurse's drug handbook*, 2024).			
Reason Client Taking	Patient is taking ondanset	Patient is taking polyethylene	Patient is taking senna to			

	ron to help with any nausea.	glycol to help with any constipation.	help with any constipation.	[redacted]
Two contraindications (pertinent to the client)	1. Hepatic impairment 2. Abdominal surgery	1. Abdominal pain 2. Gastric retention	1. Abdominal pain 2. Known alcohol intolerance	
Two side effects or adverse effects (Pertinent to the client)	1. Increased liver enzyme 2. Diarrhea	1. Abdominal bloating 2. Abdominal cramping	1. Diarrhea 2. Electrolyte imbalance	
Key nursing assessment(s) prior to administration	1. Assess for nausea and vomiting (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess patients EKG and labs for hypokalemi	1. Assess bowel sounds and any abdominal distention (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess consistency and amount of stool (*2025: NDH: Nurse's drug handbook*, 2024).	1. Assess bowel sounds and any abdominal distention (*2025: NDH: Nurse's drug handbook*, 2024). 2. Assess consistency and amount of	

	a (*2025: NDH: Nurse's drug hand book,* 2024) .		stool (*2025: NDH: Nurse's drug handb ook,* 2024).	[redacted]

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. amlodipine	Patient has a history of hypertension, and we want to keep it monitored. The patient is having high blood pressures while in the hospital.	1. Peripheral Edema 2. Diarrhea
2. prednisone	Patient was admitted for an acute kidney injury, and the prednisone is helping with the inflammation that is associated with it.	1. Hypertension 2. Decreased wound healing
3. Sodium Bicarbonate	Patient's sodium and chloride levels have been low since admission. Bicarbonate is	1. Hypocalcemia 2. Gastric distention

	finally within normal limits, however; their sodium levels are still low. We want to make sure they do not stay low because they could start to show symptoms of hyponatremia.	

Medications Reference (1) (APA)

2025 NDH: Nurse's drug handbook. (2024). Jones & Bartlett Learning.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions:** **Client Complaints or Concerns:**	Patient is alert and oriented x4. Patient can state where he is, what day it is, and why is at the hospital. Patient looks to be in pain but denies any. Patient is wearing a hospital gown and has sock on top of head to help keep himself warm. Patient is on contact isolation of testing positive for Salmonella in stool. Negative for Colistrive difficile (C. diff).
VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	0848 98 (Temporal) 18 RR 91 Pulse 159/95 BP 99% Room Air 1118 97.7 (Temporal) 20 RR 80 Pulse 146/87 BP 96% Room Air

PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:** **Interventions:**	0730 0-10 Rate 0 for pain. 1400 0-10 Rate 4 for pain. In lower extremities, aching and burning sensation.
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:**	Left Antecubital IV. 20 gauge. IV is patent, dressing is clean and dry. No signs on drainage or erythema. Saline Lock. Left Midline in upper left arm. Dressing is clean and intact, patent. No signs of drainage or erythema.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin color is pale. Redness on lower extremities and around scabs. Skin is flaky, dry, scabs on arms and legs. Skin is cool to touch. No rashes. Bruises on abdomen and legs. Patient has wounds on peri area, lower thoracic spine, back of right calf, and back of left calf. Braden score is a 13. No drains present.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical. Trachea is midline, no signs on JVD. No palpation of lymph nodes. Nose is symmetrical. No signs of drainage or discharge. .
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	Patient denies chest pain and shortness of breath. Clear S1 and S2 noted with no murmurs, gallops, or rubs. Apical pulse palpable at the 5th intercostal space at midclavicular line. Normal rate and rhythm. Capillary refill less than 3 seconds. JVD absent. Bilateral pulses palpable grade 2+. Bilateral lower extremities 2+.
RESPIRATORY:	Patient denies shortness of breath. No

Accessory muscle use: Y☐ N ☒ **Breath Sounds: Location, character**	retractions or accessory muscle use. Chest rise and fall are equally bilateral.
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:**	Patient has a general diet at home. Current diet is a renal diet, and patient is tolerating diet well. Patient is 6 foot tall and weighs 99 kg. Bowel sounds are present in all four quadrants and hyperactive. Patient's last bowel movement was 9/29. Patient has a rectal tube that was placed 9/24. No pain or mass upon palpation. Abdomen is round, bruising on lower abdomen from heparin shots. No ostomy. No nasogastric tube. No feeding tube or PEG tube.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:**	Urine color is yellow, orderless, no cloudiness. 575 mL of urine from foley. No pain with urination. No dialysis. Perineal area is red and excoriated. Foley was placed 9/23, 10 mL balloon size.
Intake (in mLs) **Output (in mLs)**	Intake 240 mL. Output: Foley – 575 mL Rectal Tube – 200 mL
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:**	Patient is alert and oriented x4. Patient has slightly impaired range of motion on right upper extremities. Patient has severely impaired range of motion on left upper extremity. Patient is currently bedbound, was unable to stand today.

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**	Patient was able to sit on the side of the bed for about 10 minutes with physical therapy. Yes, to fall risk. Fall risk score is 91. Patient can tolerate moving in bed, unable to stand at this moment. Needs assistance with equipment and to stand and walk.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	No visible signs of drainage from eyes. PERRLA is bilaterally intact. Generalized weakness present. Strength is unequal for upper and lower extremities. Left side is severely impaired. Right side is slightly impaired. Patient is alert and oriented x4. Speech is clear and concise. No sensory deficits.
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):**	Patients current coping method is to watch tv, at home he drank vodka. Patient is at an adult developmental level. Patient does not like to talk about religion he does not believe in spiritual needs. Patient can talk about home life; his brother helps him out at home with grocery shopping and laundry. Patient does not talk to ex-wife. Does have two daughters who he currently talks to and is very close.

Discharge Planning

Discharge location: Patient will be discharged to Accolade. Accolade is a nursing home the patient got accepted to and will be receiving rehab.

Home health needs: Patient is unable to go back home. If the patient was able to go back home. He would need 24-hour care and medical equipment such as a wheelchair, Hoyer, if unable to move around.

Equipment needs: Patient would need a wheelchair to go home in and a Hoyer lift to help get into the shower.

Follow-up plan: Patient needs a follow-up with PCP and recheck lab values. The patient needs to follow up with a nephrologist for the acute kidney injury. Patient needs to check with PCP about alcohol cessation programs and/or information about cessation.

Education needs: Patient needs to be educated on the importance of self-care and ambulating; if unable to move, patient needs to be educated on the importance of repositioning themselves in bed. Patient needs education about cessation of alcohol.

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. Impaired skin integrity related to being bedridden as evidenced by open wounds on coccyx and lower extremities (Phelps, 2023).	I chose impaired skin integrity because the patient already has open wounds and with the patient not being able to ambulate well, they are at higher risk for more breakdown.	Patient will be able to ambulate at least 5 feet prior to discharge.	1. Reposition patient very 2 hours (Phelps, 2023). 2. Help patient perform active range of motion and sitting on the side of the bed (Phelps, 2023).	Patient was able to sit on the side of the bed for a couple of minutes. Patient was unable to stand with physical therapy.
2. Ineffective renal tissue	I chose ineffective	Patient will show	1. Obtain accurate intake and output	Patient was able to

perfusion related to acute kidney injury as evidenced by elevated labs (BUN and Creatinine) (Phelps, 2023).	renal tissue perfusion because the patient was admitted for an acute kidney injury which results in having ineffective tissue perfusion.	better renal perfusion with having normal labs and increased urine output.	for fluid intake and output for stools and emesis (Phelps, 2023). 2. Educate patient on diet recommendations and follow the renal diet (Phelps, 2023).	cooperate with the renal diet and with the patient having a foley and rectal tube we were able to obtain accurate measurements.
3. Excess fluid volume related to acute kidney injury as evidenced by edema in lower extremities (Phelps, 2023).	I chose excess fluid volume because the patient was admitted for an acute kidney injury and has edema in their lower legs.	Patient will no longer show any signs of edema in lower extremities by ambulating and elevating lower extremities by discharge..	1. Reposition patient every 2 hours and elevate lower extremities (Phelps, 2023). 2. Assist patient is deep breathing exercises along with the use of an incentive spirometer (Phelps, 2023).	Patient was able to use the incentive spirometer by themselves with reminders and was able to tolerate having legs elevated on a pillow for about 10 minutes.

Nursing Process Prioritization	**Rationale**
1. Impaired skin integrity related to being bedridden as evidenced by open wounds on coccyx and lower extremities (Phelps, 2023).	There is not a lot of evidence if the wounds are healing. They are still red and open. There was a consult made to wound to help come up with a plan to help with the healing process.
2. Ineffective renal tissue perfusion related to acute kidney injury as evidenced by elevated labs (BUN and Creatinine)	Patient is voiding at least 30 mL/hour. BUN is in a normal range compared to what it was on admission.

(Phelps, 2023).	
3. Excess fluid volume related to acute kidney injury as evidenced by edema in lower extremities (Phelps, 2023).	The edema is better compared to how it was on admission. There is still evidence of edema, it was pitting edema grade +2 and now it is grade +1.

Other References (APA):

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