N431 Care Plan # 1

Lakeview College of Nursing

Tahija McClure

Demographics (3 points)

Date of Admission 9/10/2019	**Patient Initials** D.L	**Age** 66	**Gender** Male
Race/Ethnicity African American	**Occupation** Unemployed	**Marital Status** Single	**Allergies** No known drug or food allergies
Code Status Full Code	**Height** 175.2cm	**Weight** 78.400kg	

Medical History (5 Points)

Past Medical History:

- Benign essential hypertension
- Dementia
- Type 2 Diabetes
- Diastolic Heart Failure
- Dislipidemia
- Elevated Troponin
- Pneumonia involving the left lung
- Schizophrenia

Past Surgical History:

No Known Past Surgical History

Family History:

No Known Family History

Social History (tobacco/alcohol/drugs):

The patient denies use of alcohol and tobacco, which he quit more than 40 days ago

Assistive Devices:

Living Situation: The patient currently live in a nursing home

Education Level:

Admission Assessment

Chief Complaint (2 points): Pt was sent from palm terrace nursing home due to low temperature

History of present Illness (10 points):.

Patient who is a 66 year old male presented to the ED on 9/10/2019 from the nursing home due to low temperature.The nursing staff called EMS when the patient found to be hypothermic via rectal temperature of 34 degrees Celsius and bradycardia in the 40s. Upon arrival to the ED hypo treatment protocol and sepsis protocol begun. The patient had a lactic acid increase at 2.2 with no leukocytosis present the patient also had acute on chronic kidney injury with a creatinine of 1.97 and his baseline is 1.23 is a patient had hypoalbuminemia at 3.0 which improved from his previous 2.4. Upon examination the patient received a chest x-ray which showed a word thinning left lower lobe pleural effusion, and basilar opacities.The patient was started on healthcare-acquired Levaquin, zosyn and Vancomycin in the ED. The patient was admitted as an inpatient for sepsis due to possible pneumonia

Primary Diagnosis

Primary Diagnosis on Admission (2 points):.Pneumonia

Secondary Diagnosis (if applicable):.Sepsis

Pathophysiology of the Disease, APA format (20 points):

Sepsis is a dysregulated response to infection resulting in acute organ dysfunction or tissue hypoperfusion. Sepsis infection triggers pro-inflammatory and anti-inflammatory mechanism. An imbalance lead to tissue damage and increased susceptibility to secondary infections(Lippincott

advisor, 2019). With sepsis organ dysfunction occurs, partially due to impaired tissue oxygen. vascular endothelium is damaged, leading to cell death. altered coagulation leads to impaired tissue oxygenation, microthrombi, endothelial dysfunction, which may lead to disseminated intravascular coagulation (Lippincott advisor, 2019). System vasodilation and hypotension lead to tissue hypoperfusion.Causes of sepsis can be related to community-acquired and health care-Associated infection, gram-positive and gram-negative bacterial infection, fungal infections, pneumonia which is the most common, and urinary tract and abdominal infection(Lippincott advisor, 2019).Signs and symptoms or physical findings that might be related to sepsis is a temperature greater than 100. 4 degrees Fahrenheit, tachycardia, tachypnea , sepsis specific to infection source, altered mental status, decreased capillary refill time or mottling, pain and purulent drainage in a surgical wound and acute oliguria(Lippincott advisor,2019). Diagnostic procedures that may be done to confirm a diagnosis of sepsis or to assist in identifying the source of infection may include, specimen collection for wound, urine, blood, cerebrospinal fluid, or sputum culture. Imaging tests include Computerized tomography (CT).Ultrasound or Magnetic resonance imaging (MRI)(Mayo Clinic, 2018). Since my patients diagnosis of sepsis with secondary to pneumonia they ordered an x-ray which is also a good way to confirm pneumonia my patient x-ray showed that there was a large left pleural effusion, increased from prior chest x-ray, no right pleural effusion, there was no pneumothorax, the heart size was stable and there was left basilar opacity and the right lung was clear. Treatment involving this disease may involve antibiotics, intravenous fluids, and vasopressors. Other medications you may receive include low doses of corticosteroids, insulin to help maintain stable blood sugar levels, drugs that modify the immune system responses, and painkillers or sedatives(Mayo Clinic, 2018).

Pathophysiology References (2) (APA):

Sepsis - Symptoms and causes. (2019). Retrieved 14 September 2019, from

https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214

Sepsis - Lippincott Advisor. (2019). Retrieved 15 September 2019, from

http://advisor.lww.com/1na/pages/printPage.jsp

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.6	**2.35**	**2.64**	**Anemia is a common problem encountered in patients with sepsis. Several mechanisms contribute to acute reduction in hemoglobin and hct levels in the setting of sepsis, including reduced production of red blood cells induced by the systemic inflammatory response, as well as increased destruction of red cells due to hemolysis and bleeding**

				(Maury, Bitternan&Ghanem-Zoubi, 2016).
Hgb	11.3-15.2	**8.0**	**8.9**	**Anemia is a common problem encountered in patients with sepsis. Several mechanisms contribute to acute reduction in hemoglobin and hct levels in the setting of sepsis, including reduced production of red blood cells induced by the systemic inflammatory response, as well as increased destruction of red cells due to hemolysis and bleeding (Maury, Bitternan&Ghanem-Zoubi, 2016).**
Hct	33.4%-45.3%	**23.4**	**26.7**	**Anemia is a common problem encountered in patients with sepsis. Several mechanisms contribute to acute reduction in hemoglobin and hct levels in the setting of sepsis, including reduced production of red blood cells induced by the systemic inflammatory response, as well as increased destruction of red cells due to hemolysis and bleeding (Maury, Bitternan&Ghanem-Zoubi, 2016).**
Platelets	150,000-400,000	**150**	**159**	
WBC	4,000-11,000	**7.1**	**6.2**	
Neutrophils	45.3-79	**53.8**	**47.5**	
Lymphocytes	11.8-45.9	**28.5**	**38.5**	
Monocytes	4.4-12.0	**17.1**	**13.4**	
Eosinophils	0.0-6.3	**0.2**	**0.3**	
Bands	N/A	**N/A**	**N/A**	

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	**142**	**143**	
K+	3.5-5	**3.9**	**3.8**	
Cl-	98-107	**106**	**104**	
CO2	22-29	**28**	**30**	
Glucose	70-100	**87**	**78**	
BUN	8-25	**18**	**20**	
Creatinine	0.6-1.3	**1.55**	**1.97**	My patients Acute on chronic kidney injury caused his creatinine levels to be elevated from his baseline level
Albumin	3.5-5.2	**2.6**	**3.0**	Problems with the kidneys may cause them to release large amounts of protein into the urine. This can take albumin from the blood, leading to hypoalbuminemia (Elaine, 2018). My patient upon arrival to ED had acute on chronic kidney injury which may have cause low levels of albumin.
Calcium	8.6-10	**8.7**	**8.7**	
Mag	1.5-2	**N/A**	**1.9**	
Phosphate	0.8-1.5	**N/A**	**N/A**	
Bilirubin	< 1.5	**0.2**	**0.2**	
Alk Phos	50-100	**86**	**98**	
AST	10-30	**11**	**16**	

ALT	10-40	**11**	**14**	
Amylase	30-125	**N/A**	**N/A**	
Lipase	10-150	**N/A**	**N/A**	
Lactic Acid	0.5-1.0	**0.7**	**2.3**	Lactic acid levels get higher when strenuous exercise or other conditions—such as heart failure, a severe infection (sepsis), or shock —lower the flow of blood and oxygen throughout the body(UofMHealth, 2019).
Troponin	0.00 to 0.04 ng/ml	**N/A**	**0.011**	
CK-MB	0.5-2.4	**N/A**	**2.2**	
Total CK	Men:38-174 Women:96-140	**N/A**	**44**	

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.9-1.2	**N/A**	**N/A**	
PT	11-14 sec	**N/A**	**N/A**	
PTT	20-40 sec	**N/A**	**N/A**	
D-Dimer	< 250	**N/A**	**N/A**	
BNP	0.5-30	**N/A**	**N/A**	
HDL	**N/A**	**N/A**	**N/A**	
LDL	**N/A**	**N/A**	**N/A**	
Cholesterol	**N/A**	**N/A**	**N/A**	
Triglycerides	**N/A**	**N/A**	**N/A**	

Hgb A1c	**N/A**	**N/A**	**N/A**	
TSH	**N/A**	**N/A**	**N/A**	
		N/A	**N/A**	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow, clear	**Yellow**	**N/A**	
pH	5.0-8	**5.0**	**N/A**	
Specific Gravity	1.005-1.024	**1.018**	**N/A**	
Glucose	Normal	**negative**	**N/A**	
Protein	Negative-Normal	**negative**	**N/A**	
Ketones	Negative	**negative**	**N/A**	
WBC	< 5	**2**	**N/A**	
RBC	0-3	**1**	**N/A**	
Leukoesterase	Negative	**negative**	**N/A**	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.34-7.45**	**N/A**	**N/A**	
PaO2	**80-100**	**N/A**	**N/A**	
PaCO2	**35-45**	**N/A**	**N/A**	
HCO3	**22-26**	**N/A**	**N/A**	
SaO2	**95-100**	**N/A**	**N/A**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	**N/A**	
Blood Culture	Negative	**N/A**	**N/A**	
Sputum Culture	Negative	**N/A**	**N/A**	
Stool Culture	Negative	**N/A**	**N/A**	

Lab Correlations Reference (APA):

Laboratory Values: NCLEX-RN. (n.d.). Retrieved from https://www.registerednursing.org/nclex/laboratory-values/

Diagnostic Imaging

All Other Diagnostic Tests (5 points): No other diagnostic imaging test were completed

Diagnostic Test Correlation (5 points): No other diagnostic imaging test were completed

Diagnostic Test Reference (APA):

Current Medications (10 points, 1 point per completed med)
10 different medications must be completed

Home Medications (5 required)

Brand/Generic	Aspirin	Atorvastatin/ Lipitor	Metoprolol/ Lopressor	Gabapentin	Cardizem /Diltiazem
Dose	**81mg**	**20mg**	**50mg**	**100mg**	**60mg, 120mg= 2tabs**
Frequency	**Once Daily**	**Once Daily**	**Once Daily**	**Once Daily**	**Once Daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**

Classification	Platelet Inhibitor, Anit-inflammatory agent, Antipyretic, Analgesic	Antihyperlipidemic, HMG-CoA reductase inhibitor	Antihypertensive	Anticonvulsant	Antihypertensive
Mechanism of Action	Prevents the platelets, the part of the blood that forms clots from sticking together, wither forming new clots or making existing ones worse. Inhibits a chemical (prostaglandin) that causes localized vasodilation, reducing inflammation and fever.	Inhibits HMG-CoA which increases LDL receptors on hepatocytes which then remove LDL from the blood Prevents the accumulation of fat in the blood vessels	Lowers B/P by B-blocking effects. Reduces elevated renin plasma levels.	Gabapentin is a GABA neurotransmitter analog; however, it does not inhibit GABA uptake or degradation. It appears to interact with GABA cortical neurons, but its relationship to functional activity as an anti convulsant is unknown.	Block influx of calcium ions into cardiac muscle: prevents spasm of coronary arteries. Arterial and venous vasodilator .Reduces preload and afterload. Reduces myocardial oxygen demand.
Reason Client Taking		Hx Dislipidemia	Hx Hypertension		Hx Hypertension
Contraindications (2)	**Ulcers** **Recent bleeding**	Atorvastatin is contraindicated in patients with active hepatic disease (including cholestasis,	Sinus Bradycardia Acute Heart Failure	Hypersensitivity to tartrazine, hepatic impairment Bleeding disorders.	Hypotension Sick sinus syndrome

		hepatic encephalopathy, hepatitis, and jaundice) Alcoholism			
Side Effects/Adverse Reactions (2)	Vomiting Prolonged Bleeding	Photosensitivity Dyspepsia	Hypotension Dizziness	Drowsiness Ataxia	Bradycardia Chest Pain
Nursing Considerations (2)	Give drug with food or after meals if GI upset occurs. Give drug with a full glass of water to reduce the risk of tablet or capsule lodging in the esophagus.	Evaluate cholesterol and triglyceride levels; Monitor liver function tests;	Monitor B/P and HR during beginning treatment. Monitor ECG directly when giving IV during initial treatment.	Monitor for changes in behavior that may be indicative of suicidal ideation Monitor therapeutic effectiveness; may not occur until several weeks following initiation of therapy, in those treated for seizure disorders , assess frequency of seizures	Assess for rash periodically during therapy. May cause Stevens-Johnson syndrome. Discontinue therapy if severe or if accompanied with fever, general malaise, fatigue, muscle or joint aches, blisters, oral lesions, conjunctivitis, hepatitis and/or eosinophilia. Angina

					Assess location, duration, intensity, and precipitating factors of patient's anginal pain.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor for bleeding** **Labs:PT, PTT, INR**	Liver Function Test	Patients blood pressure should be taken prior to giving this med	Assess vertigo or dizziness that might affect gait, balance, and other functional activities	Monitor BP and pulse prior to therapy, during dose titration, and periodically during therapy. Monitor ECG periodically during prolonged therapy. May cause prolonged PR interval.
Client Teaching needs (2)	**Monitor for blood in stools**	Avoid drinking more than 200mL/day of grapefruit juice during therapy. Diet low in Fat, Cholesterol, Carbs, &	Advise patient to notify the provider if their heart rate drops below 60 or is significantly lower than usual	Avoid CNS depressants (ETOH) Avoid activities requiring mental alertness or coordination	Caution patient to change positions slowly to minimize orthostatic hypotension. May cause drowsiness or

		Alcohol, exercise & cessation of smoking.	Caution patient not to abruptly stop the drug		dizziness. Advise patient to avoid driving or other activities requiring alertness until response to the medication is known

Hospital Medications (5 required)

Brand/Generic	**Albuterol/ Proventil**	**Enoxaparin /Lovenox**	**Levofloxacin/ Levaquin**	**Piperacillin / tazobactam (Zosyn)**	**Vancomycin/Vancocin**
Dose	2.5 mg = 3ml	40mg=0.4ml	750mg	4.5g=100ml	2g=40ml
Frequency	Q4H	Once Daily	Q48H	Q6H	Q24H
Route	Inhalation	Sub-Q	IV piggyback	IV piggyback	IV piggyback
Classification	Bronchodilator	Anticoagulant	Anti-infective	Anti-infective	Anti-Infective
Mechanism of Action	B agonist(primarily B2) relaxes bronchial smooth muscle,resulting in bronchodilat	Potentiates the inhibitory effect of antithrombin on factor Xa and thrombin	interference with the enzyme DNA gyrase, which is needed for bacterial DNA synthesis;	Antibacterial combination product consisting of the semisynthetic piperacillin and the	Binds to bacterial cell wall, resulting in cell death

	ion Also relaxes vascular and uterine smooth muscle; decreases air way resistance		bactericidal effect	beta-lactamase inhibitor tazobactam. Tazobactam component does not decrease the activity of the piperacillin component against susceptible organisms.	
Reason Client Taking		Hospital protocol for every patient to prevent dvt's	Pneumonia/ Sepsis	Pneumonia / Sepsis	Bacteria in the blood (Sepsis)/ Pneumonia
Contraindications (2)	Known hypersensitivity reactions to albuterol. Use caution in PTs with diabetes, hyperthyroidism, cerebrovascular disease, and COPD.	Bacterial endocarditis Bleeding disorders	Renal disorder Client receiving Theophylline	Hypersensitivity to piperacillin, tazobactam, penicillins, cephalosporins, or beta-lactamase inhibitors such as clavulanic acid and sulbactam.	Hypersensitivity to corn or corn products Hypersensitivity to vancomycin or its components
Side Effects/Adverse Reactions (2)	Tachycardia Tremors	Thrombocytopenia Headache	Nausea Photosensitivity	Diarrhea thrombocytopenia	Tachycardia Hypotension
Nursing Considerations (2)	Observe for wheezing Shake inhaler well and allow at	Monitor patient for hypersensitivity reactions (chills,	Observe for s/s of anaphylaxis. Discontinue	Observe patient for signs and symptoms of anaphylaxis	Must monitor blood levels to ensure therapeutic

	least 1 min between inhalation	fever, urticaria). Monitor CBC, platelet count, and stools for occult blood periodically during therapy. I	drug & notify MD or other HCP immediately if these problems occur. Keep epinephrine, antihistamine, and resuscitation equipment close by in case of an anaphylactic reaction.	(rash, pruritus, laryngeal edema, wheezing). Discontinue the drug and notify health care professional	peak and trough levels and prevent toxicity Rapid infusions may cause hypotension
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess Bp, lung sounds, and pulses before domain and during peak	Assess for signs of bleeding and hemorrhage (bleeding gums; nosebleed; unusual bruising; black, tarry stools; hematuria; fall in hematocrit or blood pressure; guaiac-positive stools); bleeding from the surgical site.	Assess for infection prior to and during therapy	Assess patient for infection (vital signs; appearance of wound, sputum, urine, and stool; WBC) at beginning	
Client Teaching needs (2)	Instruct pt in proper use of metered-dose inhaler Rinse mouth with water	Advise patients to report any symptoms of unusual bleeding or bruising,	Encourage pt to maintain a fluid intake of at least 1500-2000 ml/day to	Advise patient to report rash and signs of superinfection (black furry	Complete full course of vancomycin as prescribed

	after each inhalation to prevent dry mouth	dizziness, itching, rashes, fever, swelling, or difficulty breathing to health care professional immediately. Instruct patients not to take aspirin, naproxen, or ibuprofen without consulting a health care professional while on enoxaparin therapy.	prevent crystalluria. Instruct pt to notify HCP if fever & diarrhea develop, especially if stool contains blood, pus, or mucus.	overgrowth on tongue, vaginal itching or discharge, loose or foul-smelling stools) and allergy. Caution patient to notify health care professional if fever and diarrhea occur, especially if stool contains blood, pus, or mucus. Advise patient not to treat diarrhea without consulting a healthcare professional.	Notify the provider if you develop severe or persistent diarrhea

Medications Reference (APA):

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is awake in bed. He is alert and oriented to his normal
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 15** **Drains present: Y☐ N ☐** **Type:**	Patient's skin was warm and dry no rashes or lesions.The patient's skin turgor with less than 3 seconds. The patient's skin was intact with no visible rashes, bruises or wounds. The patient doesn't have any drains present and has a braden score of 15
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The hair is normal cephalic and a traumatic without tenderness, visible or palpable masses, depression, or scarf. Hair is of normal texture and evenly distributed.Patience and panic membranes pearly Gray bilaterally.Patient pupils were equal, round , reactive to light and accommodation.Oral mucosa is pink and moist. Tongue is normal in appearance without lesions and with good symmetrical movement. The pharynx is normal in appearance without tonsillar swelling or exudates. No adenopathy is noted.

CARDIOVASCULAR (2 points): **Heart sounds: S1, S2 heart sounds noted no murmurs rubs or gallops present** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: +3 pedal pulses bilaterally** **Capillary refill: capillary refill is less than 3 seconds** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Upon physical examination, heart sounds were auscultated. S1, S2 heart sounds were noted With no murmurs gallops or rubs. pedal pulses assessed and were bilaterally present, 3+. Patient's capillary refill was less than two seconds. Patient shows no signs of neck vein distention or edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient showed no use of accessory muscles and lungs were clear upon auscultation no crackles, wheezes or rhonchi noted
GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet** **Height:175.2 cm** **Weight: 78.400 kg** **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's normal diet at home is a regular diet. Patient's current diet is a regular diet. Bowel sounds were auscultated and present in all four quadrants. Patient reports no pain upon palpation. No tenderness was noted. No masses or abdominal noted. No noted scars, drains, or wounds. Patient has no ostomy, nasogastric tube, PEG tubes, or drains. Patient's last bowel movement was 02/10/2019.

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Patient has no use of dialysis and does not have a catheter present. Upon his last urination, patient denies any hesitancy or urgency. Patient's urine does not have an abnormal color or abnormal odor.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient has active range of motion bilaterally. Patient is a fall risk. Patient doesn't get out of bed much but is up with assistance and to the bathroom x1 or the patient uses a urinal. Patient has assistance as a precaution. Patient occasionally uses a walker as an assistive device Morse Fall Risk: 85
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is awake in bed but appeared to be fatigued. He is A&O to his normal since he is a demented patient who also has a hx of schizophrenia. Patient speaks English Patient MAEW and his PERLA was intact. His strength is equal bilaterally. Patient does not show any signs of neurological damage. The patient doesn't have any religion preference and live in a nursing home
PSYCHOSOCIAL/CULTURAL (2 points): **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 doesn't have any religion preference and lives in a nursing home

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

1300	70	150/60	20	36.7	95%
1600	72	145/59	18	37.0	96%

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1330	0-10	No Pain	No Pain	No Pain	No intervention were made the pt reported no pain
1620	0-10	No Pain	No Pain	No Pain	No intervention were made the pt reported no pain

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:22 **Location of IV:** right peripheral **Date on IV: 9/10/19** **Patency of IV:** Catheter is patent **Signs of erythema, drainage, etc.:**No phlebitis, infiltration or drainage present **IV dressing assessment**	Sodium Chloride 0.9% 100ml/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
230	150

Nursing Care

Summary of Care (2 points)

Overview of care,Procedures/testing done, Complaints/Issues,Vital signs

(stable/unstable),Tolerating diet, activity, etc.,Physician notifications, Future plans for patient:

Patient was fatigued throughout the morning. Patient had no complaints of pain throughout the shift and his vital signs remained stable throughout the shift. Patient's abnormal lab values are due his current illness, and his past medical history. Patient was given his afternoon med by me as supervised my the nurse.Patient had no pressing concerns and was given a bed bath and ambulated before debridement of my clinical hours. Patient tolerated his diet well and future plans are to promote education to the patient on the prevention of pneumonia/ sepsis infections.

Discharge Planning (2 points)

Discharge location: Palm Terrace Nursing Home

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan:

- Ask for information about where and when to go for follow-up visits:
- For continuing care, treatments, or home services, ask for more information.

Education needs:

  - Wash your hands often with soap and water. Carry germ-killing gel with you. You can use the gel to clean your hands when there is no soap and water available.
  - Do not touch your eyes, nose, or mouth unless you have washed your hands first.
  - Always cover your mouth when you cough. Cough into a tissue or your

shirtsleeve so you do not spread germs from your hands.

- Try to avoid people who have a cold or the flu. If you are sick, stay away from others as much as possible.

Contact your healthcare provider if:

- You have questions or concerns about your condition or care.
- You develop a fever

Seek care immediately or call 911 if:

- You have increased swelling in your legs, feet, or abdomen.
- You are short of breath or you cough up blood.
- You have a fast heart rate and your chest hurts.
- You feel so dizzy that you have trouble standing up.
- Your lips or fingernails are blue.

Nursing Diagnosis (15 points)
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	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Risk for	Acute infectious	1.Monitor the	It's expected that the

hyperthermia r/t inflammatory process	disease processes are often suggested by temperature that's 102°F and higher.	client's temperature 2. Adjust environmental factors as indicated. Remove excess clothing as necessary.	patient and family has complete understanding of the nursing actions and that the client temperatures stay within normal ranges
2. risk for deficient fluid volume r/t Increase in vascular compartment, massive vasodilation	Tachycardia, hypotension, and fever can signal the body's response to fluid loss.	1. Assess vital signs. 2.Observe for excessively dry skin and mucous membranes	It's expected that the patient and family has complete understanding of the nursing actions and that the client remains free from fluid loss maintains optimal fluid volume
3. Risk for infection r/t immuno supression	The most common causes of sepsis are respiratory tract and urinary tract infection, pneumonia followed by abdominal and soft tissue infections. Acute infectious disease processes are often suggested by temperature that's 102°F and higher	1. Assess client for a possible source of infection (e.g., burning urination, localized abdominal pain, burns, open wounds or cellulitis, presence of invasive catheters, or lines). 2. Teach proper hand washing using antibacterial soap before and after each care activity.	It's expected that the patient and family has complete understanding of the nursing actions and that the client remain free from further infection and follow precaution to prevent and acquiring infections
4. Deficient Knowledge r/t cognitive	Discussing the disease and clinical	1. Review disease process and future expectations.	It's expected that the patient and family has complete understanding of

limitations	expectations provides a knowledge base from which client can make informed choices	2.Review individual risk factors, mode of transmission, and portal of entry of infections.	the nursing actions and that the client understand treatment and clinical manifestations related to diagnosis

Other References (APA):

Sepsis (Discharge Care) - What You Need to Know. (2019). Retrieved 14 September 2019, from https://www.drugs.com/cg/sepsis-discharge-care.html

6 Sepsis and Septicemia Nursing Care Plans. (2019). Retrieved 14 September 2019, from https://nurseslabs.com/sepsis-nursing-care-plans/

Lactic Acid | Michigan Medicine. (2017). Retrieved 14 September 2019, from https://www.uofmhealth.org/health-library/hw7871

Concept Map (20 Points):

Subjective Data

My patient did not show any subjective signs that was pertinent to sepsis just a low rectal temperature upon arrival to the ED, which is objective data

Nursing Diagnosis/Outcomes

risk for deficient fluid volume r/t Increase in vascular compartment, massive vasodilation the expected outcome for my patient client remain free from further infection and follow precaution to prevent and acquiring infections

Objective Data

Elevated Lactic Acid Level
Increasing Creatinine Level
Low Temperature

Patient Information

Pat

year

nted to the ED on 9/10/2019 from the nursing home due to low temperature.The nursing staff called EMS when the patient found to be hypothermic via rectal temperature of 34 degrees Celsius and bradycardia

Nursing Interventions

Optimize fluid volume status
Assess/monitor cardiac output
Prevent Infection
Assess/monitor/ and manage body temperature