N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/10/2019	P.C.	72	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Secretary	Single	Amiodarone Chlorthalidone Clindamycin Dilaudid Hydrochlorothiazide
Code Status	**Height**	**Weight**	
Full	5’3”	47 kg	

Medical History (5 Points)

Past Medical History: TIA/Stroke/Pleural effusion/A-fib/Osteoporosis/Meralgia Paresthetica/HTN/colon resection/High cholesterol/Hiatal hernia/depression/COPD/CKD/CAD/Brain aneurysm/Back pain/AAA

Past Surgical History: Ureter stent replacement/Upper GI endoscopy/Dialysis cath/hysterectomy/Gallbladder surgery/Foot surgery/Femoral bypass

Family History: Mom; Kidney stones/cancer; Dad: kidney stones/heart attack; Brother: Kidney stones

Social History (tobacco/alcohol/drugs): current everyday smoker/no current alcohol use/ no drug use

Assistive Devices: uses walker as needed

Living Situation: Assisted-living facility

Education Level: high school diploma

Admission Assessment

Chief Complaint (2 points): Severe pain

History of present Illness (10 points): A 72 year old woman presents with severe pain. She states the pain is all over but is mostly concerned with her neck and lower back. Patient was seen in the ER for similar symptoms two days ago and was unable to be dialyzed at that time due to her pain levels. Patient is a known case of end stage renal disease and on hemodialysis. She has a catheter to the right chest and is in the same condition that she was in the ER due to her pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): UTI

Secondary Diagnosis (if applicable): chronic pain/fever

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

A urinary tract infection is an infection of the lower urinary tract. The lower urinary tract includes the ureters, bladder, urethra, and prostate. Some urinary tract infections can ascend into the area where the kidneys are located causing conditions such as pyelonephritis. The most common organism associated with UTIs is known as Escherichia coli. Pyelonephritis and urosepsis are the most dangerous complications of untreated UTIs, which can be fatal.

Some risk factors for developing a UTI include bladder distention, female gender, stool incontinence, certain disease processes, calculi, stasis, and alkalotic urine. Expected findings include lower back/abdominal discomfort, nausea, urinary frequency/urgency, urinary retention, perineal itching, fever, cloudy or foul-smelling urine, and urethral discharge. For older adult patients, it is especially common to see confusion, incontinence, loss of appetite, nocturia, and dysuria. One might also notice signs of urosepsis which are decreased blood pressure, increased heart rate, increased respirations, and fever.

To diagnose this infection, providers will normally order a urinalysis and urine culture and sensitivity. Positive results will show different things such as bacteria, WBCs, RBCs, leukocyte esterase and nitrates in the urine, which was seen in the patient's urinalysis. Healthcare professionals will also perform tests to rule out a sexually transmitted infection. When the UTI becomes more complicated, diagnostic procedures such as a CT scan or Ultrasonography can be used.

As far as nursing care is concerned, the major take home to treating a UTI is following the proper medication regimen, increasing fluids, ensuring proper hygiene is being implemented, and assisting in relief measures such as rest/sitz baths.

Patient education should include drinking three liters of fluid per day, bathing daily, emptying their bladder every 3-4 hours, and urinating before and after intercourse. Patients should also be encouraged to drink cranberry juice. Education specific to females include wiping from front to back, avoiding bubble baths and feminine products, avoid sitting in wet bathing suits and avoid wearing tight clothing.

Pathophysiology References (2) (APA):

Henry, N. J. E., & McMichael, M. (2016). Content Mastery Series Review Module: RN Adult Medical Surgical Nursing (10.0 ed.). ATI Nursing Education.
Hinkle, J.L., & Cheever, K. H. (2018). Brunner & Suddarth's Textbook of Medical-Surgical Nursing (14 ed.). Philadelphia, PA: Wolters Kluwer.

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	**3.8-5.41**	**3.32**	**3.12**	**Low red blood cells can result from different disease processes such as chronic renal disease (Capriotti and Frizzell, 2016.)**
Hgb	**11.3-15.2**	**9.1**	**8.6**	**Low hemoglobin levels can be**

				correlated to kidney failure (Capriotti and Frizzell, 2016.)
Hct	**33.2-45.3**	**27.5**	**26.3**	**Low hematocrit levels can result from decreased red blood cells (Capriotti and Frizzell, 2016).**
Platelets	**150,000-400,000**	**301**	**280**	
WBC	**4.0-11.7**	**10.80**	**8.90**	
Neutrophils	**45.3-79**	**77.2**	**69.3**	**Increased neutrophils can result from an infection such as a UTI (Capriotti and Frizzell, 2016).**
Lymphocytes	**11.8-45.9**	**9.1**	**154**	**Decreased lymphocytes can result from certain drugs, undernutrition, and infection (Capriotti and Frizzell, 2016).**
Monocytes	**4.4-12.0**	**12.9**	**14.7**	**Increased monocytes can result from inflammation from an infection (Capriotti and Frizzell, 2016).**
Eosinophils	**0-6.3**	**0.1**	**0.1**	
Bands	**0-5**	**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**	**135**	**135**	
K+	**3.5-5.1**	**4.4**	**4.1**	
Cl-	**98-107**	**105**	**103**	
CO2	**22-29**	**27**	**25**	
Glucose	**70-99**	**89**	**93**	
BUN	**6-20**	**69**	**77**	**BUN levels can increase as a result of kidney disease/damage (Hinkle and Cheever, 2018).**

Creatinine	**0.50-0.90**	**4.75**	**4.78**	**Creatinine levels can increase as a result of kidney disease/damage (Hinkle and Cheever, 2018).**
Albumin	**3.5-5.2**	**2.7**	**2.3**	**Low levels of albumin can result from malnutrition, inflammation, and kidney/liver damage (Hinkle and Cheever, 2018).**
Calcium	**8.6-10.4**	**7.7**	**7.3**	**Low levels of calcium can result from renal failure, certain drugs, and hypomagnesia (Hinkle and Cheever, 2018).**
Mag	**1.5-2.5**	**n/a**	**n/a**	
Phosphate	**2.5-4.5**	**n/a**	**n/a**	
Bilirubin	**0.0-1.2**	**n/a**	**n/a**	
Alk Phos	**35-105**	**77**	**68**	
AST	**0-32**	**15**	**15**	
ALT	**0-33**	**8**	**7**	
Amylase	**23-85**	**n/a**	**n/a**	
Lipase	**13-60**	**n/a**	**n/a**	
Lactic Acid	**0.5-1.0**	**n/a**	**n/a**	
Troponin	**<0.04**	**n/a**	**n/a**	
CK-MB	**5-25**	**n/a**	**n/a**	
Total CK	**22-198**	**n/a**	**n/a**	

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	**0.8-1.1**	**n/a**	**n/a**	
PT	**11-12.5**	**n/a**	**n/a**	
PTT	**60-70**	**n/a**	**n/a**	
D-Dimer	**< 0.5**	**n/a**	**n/a**	
BNP	**< 125**	**n/a**	**n/a**	
HDL	**40-59**	**n/a**	**n/a**	
LDL	**< 130**	**n/a**	**n/a**	
Cholesterol	**< 200**	**n/a**	**n/a**	
Triglycerides	**< 150 mg/dl**	**n/a**	**n/a**	
Hgb A1c	**< 6.5%**	**n/a**	**n/a**	
TSH	**0.4-4.0**	**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**	**Yellow**	**n/a**	
pH	**5.9-8.0**	**5.0**	**n/a**	
Specific Gravity	**1.005-1.034**	**1.011**	**n/a**	
Glucose	**negative**	**neg**	**n/a**	
Protein	**negative**	**1+!**	**n/a**	**Proteinurea is most commonly related to kidney disease/damage (Hinkle and Cheever, 2018).**
Ketones	**negative**	**neg**	**n/a**	
WBC	**4.0-11.7**	**11-20!**	**n/a**	**The most common cause of leukocytes in the urine is a urinary tract infection (Hinkle and Cheever, 2018).**
RBC	**3.80-5.41**	**0-2**	**n/a**	
Leukoesterase	**Negative**	**mod!**	**n/a**	**Leukoesterase in the urine is a common sign of a urinary tract**

				infection (Hinkle and Cheever, 2018).

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	**7.35-7.45**	**n/a**	**n/a**	
PaO2	**75-100**	**n/a**	**n/a**	
PaCO2	**35-45**	**n/a**	**n/a**	
HCO3	**22-26**	**n/a**	**n/a**	
SaO2	**92-100**	**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):

Hinkle, J.L., & Cheever, K. H. (2018). ***Brunner and Suddarth's Textbook of Medical-Surgical Nursing*** **(14th ed.). Philadelphia, Pa: Wolter's Kluwer Health Lippincott Williams & Wilkins.**

Capriotti, T., & Frizzell, J. P. (2016). ***Pathophysiology: Introductory concepts and clinical perspectives.*** **Philadelphia: F. A. Davis company.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

The patient received an EKG during her admission at the hospital. This noninvasive procedure can potentially assist with the diagnosis of heart problems by recording electrical impulses (Hinkle and Cheever, 2018). Most patients will undergo an EKG to set up a baseline. Further tests can be ran and examined to make a comparison to the original test that can indicate progression or regression.

Diagnostic Test Correlation (5 points):

The test results showed a sinus rhythm with premature atrial complexes as well as a septal infarction. No other abnormalities were indicated. Normal EKG readings would show no infarction as well as complexes within their normal limits.

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). ***Brunner and Suddarth's Textbook of Medical-Surgical Nursing*** **(14th ed.). Philadelphia, Pa: Wolter's Kluwer Health Lippincott Williams & Wilkins.**

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

Hospital Medications (5 required)

Brand/Generic	**Norvasc (amlodipine)**	**Lipitor (atorvastatin)**	**Colestid (cholestipol)**	**Bentyl (dicyclomine)**	**Cymbalta (Duloxetine**
Dose	**10 mg**	**10 mg**	**1 g**	**10 mg**	**60 mg**
Frequency	**QD**	**QD**	**Q2H**	**QD**	**QD**

Route	oral	oral	oral	oral	oral
Classification	Dihydropyridine	antihyperlipidemic	antihyperlipidemic	anticholinergic, antispasmodic	antidepressant, pain reliever
Mechanism of Action	binds to dihydopyridine and nondihydropyridine cell membrane receptor sites on myocardial and vascular smooth muscle cells and inhibits influx of extracellular calcium ions across slow calcium channels	reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown	combines with bile acids in the intestine, preventing their absorption and forming an insoluble complex that's excreted in feces	inhibits actylcholine's muscarinic actions at postganglionic parasympathetic receptors in secretory glands, smooth muscles, and the CNS	inhibits dopamine, neuronal serotonin, and norepinephrine reuptake to potentiate noradrenergic and serotonergic activity in the CNS
Reason Client Taking	to control hypertension	to control lipid levels	to treat hypercholesterolemia	to treat irritable bowel syndrome	to treat major depressive disorder
Contraindications (2)	alsikren therapy -- hypersensitivity	active hepatic disease -- unexplained persistent rise in transaminase level	coplete biliary obstruction -- hypersensitivity	gi obstruction -- hiatal hernia	hepatic insufficiency -- uncontrolled angle-closure glaucoma
Side Effects/Adverse Reactions (2)	dysphagia -- myalgia	amblyopia -- epistaxis	headache -- abdominal distention	lethargy -- palpitations	bleeding episodes, cough

Nursing Considerations (2)	**monitor blood pressure while adjusting dosages -- assess patient frequently for chest pain when starting or increasing the dose**	**use cautiously in patients who consume substantial quantities of alcohol or have a history of liver disease -- may be used with colestipol or cholestyramine for additive antihyperlipidemic effects**	**mix with at least 90 ml of fluid before giving it to prevent accidental inhalation or esophageal distress -- adverse GI reactions are more common in patients over age 60**	**do not give drug by IV route -- assess patient on long term therapy for chronic constipation and fecal impaction**	**give cautiously to patients with a history of mania, which it may activate -- watch closely for evidence of suicidal thinking or behavior**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**blood pressure -- liver enzymes**	**liver enzymes -- blood glucose**	**cholesterol levels -- fluid intake**	**assess heart rate before administration**	**blood pressure -- serum sodium -- liver panel**
Client Teaching needs (2)	**take with food to reduce GI upset -- immediately notify prescriber of dizziness, arm or leg swelling, difficulty breathing, hives, or rash**	**take drug at the same time each day to maintain its effects -- consult prescriber before taking OTC niacin because of increased risk for rhabdomyolysis**	**colestipol does not reduce the importance of dietary changes -- keep appointments for follow up blood tests**	**do not take an antacid or antidiarrheal within 2 hours of dicyclomine -- blurred vision, dizziness, or drowsiness may occur**	**take capsule whole -- do not stop abruptly because adverse reactions may occur**

Home Medications (5 required)

Brand/Generic	Coreg (carvedilol)	Lasix (furosemide)	Synthroid (levothyroxine)	Carafate (sucralfate)	Singulair (montelukast)
Dose	25 mg	20 mg	50 mcg	1 gm	10 mg
Frequency	BID	QD	QD	QID	QD
Route	oral	oral	oral	oral	oral
Classification	antihypertensive	antihypertensive, diuretic	thyroid hormone replacement	antiulcer	antiallergen, antiasthmatic
Mechanism of Action	reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload	inhibits sodium and water reabsorption in the loop of Henle and increases urine formation	replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis	may react with hydrochloric acid in the stomach to form a complex that buffers acid	antagonizes receptors for cysteinyl leukotrienes, produced by arachidonic acid metabolism and released from eosinophils, mast cells, and other cells
Reason Client Taking	to treat hypertension	to manage hypertension	to treat mild hypothyroidism	to prevent recurrence of duodenal ulcer	to prevent or treat asthma
Contraindications	severe	anuria --	acute MI --	renal	hypersens

(2)	**bradycardia -- severe hepatic impairment**	**hypersensitivity**	**uncorrected adrenal insufficiency**	**failure -- taking aluminum-containing drugs**	**itivity -- phenobarbital drug therapy**
Side Effects/Adverse Reactions (2)	**angina -- back pain**	**hyperglycemia -- blurred vision**	**muscle weakness -- weight gain**	**crystalluria -- blisters**	**headache -- pruritis**
Nursing Considerations (2)	**know that if patient has heart failure, expect to also give digoxin, a diuretic, and an ACE inhibitor -- in patients with DM it may mask signs of hypoglycemia**	**if patient is at a high risk for hypokalemia, give potassium supplements along with furosemide -- expect to discontinue if oliguria persists for more than 24 hours**	**expect to give drug IV if patient can't take tablets -- monitor PT of a patient who is receiving anticoagulants; they may require a dosage adjustment**	**monitor fluid intake and output during therapy -- monitor patient's blood glucose level and signs/sx.'s of hypoglycemia**	**this medication is not for acute asthma attack or status asthmaticus -- watch patient closely for suicidal tendencies during therapy**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**blood glucose -- blood pressure**	**serum potassium -- weights -- baseline vitals -- CBC**	**thyroid function tests**	**cbc -- body tissue or fluid specimen**	**abg's -- cardiac enzymes**
Client Teaching needs (2)	**drug may cause orthostatic hypotension, take precautions -- seek emergency care if patient develops hives or swelling**	**change positions slowly to minimize effects of orthostatic hypotension -- take at the same time each day to maintain therapeutic effects**	**patient will most likely need to take the drug for life -- take with a full glass of water to avoid choking**	**notify prescriber if urine turns reddish brown, it may indicate crystalluria -- avoid prolonged exposure to sunlight and to wear**	**use a peak flow meter to determine personal best expiratory volume -- report increased bleeding tendency or severe**

				sunscreen and protective clothing when outdoors	**skin reaction**

Medications Reference (APA):

Cella, D. D. (2017). *Nurse's Drug Handbook* (Sixteenth ed.) Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is alert and oriented x4 with the ability to communicate her needs to the health care team. Patient shows signs of acute distress d/t her current pain levels. Patient is slightly disheveled but overall displays appropriate hygeine.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:**	**Patient's skin appeared healthy with slight bruising on both arms. Patient's skin appeared to tent slightly upon assessment. Patient did not appear to have discoloration of the lower extremities upon assessment. No rashes/bruising/drains noted. Braden score was a 12.**

Wounds: . **Braden Score: 12** **Drains present: Y☐ N X** **Type:**	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Patient's head, ears, eyes, and teeth appeared healthy. No obvious signs of leakage or drainage. Oral mucosa is pink and moist.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N X** **Edema Y ☐ N X** **Location of Edema:**	Patient's heart sounds were regular with no murmur heard upon auscultation. Peripheral pulses were strong and palpable. Capillary refill was WDL. Patient did not present with neck vein distention or edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Patient did not show use of accessory muscles while breathing. Patient's lung sounds were clear bilaterally with no wheezes or crackles.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N X** **Nasogastric: Y ☐ N X** **Size:** **Feeding tubes/PEG tube Y ☐ N X** **Type:**	**Patient follows a regular diet at home, and was currently following a regular diet prior to discharge. Patient's height is 5'3" and weight is 47 kg. Patient's bowel sounds were normoactive and her last BM was during the night she was admitted. No masses were present upon palpitation, and patient did not complain of pain in her abdominal area. No distention, incision, scars, drains, or wounds were present. No ostomy, nasogastric, or feeding tubes were present.**

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N X** **Dialysis: Y X N ☐** **Inspection of genitals:** **Catheter: Y ☐ N X** **Type:** **Size:**	**Patient's urine was yellow and hazy. Minimal output was noted during her time of care. No indication of discomfort upon urinating was made. Patient is on dialysis but was not using a catheter. Patient wore depends.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y X N ☐** **Fall Risk: Y X N☐** **Fall Score: 45** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment X** **Needs support to stand and walk X**	Patient uses mild assistance with her ADL's. Patient makes use of a walker to help her ambulate. Patient is a fall risk and is not supposed to leave her bad without assistance. Neurovascular status is WNL. ROM is limited without assistance but patient can move as tolerated when necessary. Fall score: 45
NEUROLOGICAL (2 points): **MAEW: Y ☐ N X** **PERLA: Y X N☐** **Strength Equal: Y ☐ N X if no -** **Legs X Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.**Patient's upper extremities are able to move well and have bilaterally equal strength. Patient lacks strength and ROM in her lower extremities but can move them as tolerated. Patient is showing signs of acute distress d/t her current pain levels. Patient's response to PERRLA is WNL and has no signs of neurological defects. Speech is not garbled. A&O x4.**
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):**	Patient enjoys relaxing with her family as a way of coping. Her education ended after she graduated highschool. Psychological and developmental skills coincide. Patient does not practice any specific religion. Patient has two sisters that have been in to see her, and they support her plan of care.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0800	**88**	**157/54**	**12**	**97.2**	**93%**
.*unable to get because patient was scheduled for an early dialysis and did not come back					

Vital Sign Trends: Patient had a known history of hypertension. Due to her scheduled dialysis appointment, all blood pressure medications were to be withheld for the time being. This could have contributed to a rise in her pressure, but was still an insignificant finding to her personal baseline. All other values were WNL.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**10**	**back**	**severe- need intervention**	**constant aching**	**PRN pain med**
0900	**10**	**back**	**severe- need intervention**	**constant aching**	**PRN pain med**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	No IV

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
90 ml	**0 ml**

Nursing Care

Summary of Care (2 points)

Overview of care: Overall, I spent roughly two and a half hours with the patient due to the fact she had to be transferred to dialysis early in the morning. The majority of her care consisted of distributing her medications, changing her depends, ordering breakfast, and repositioning her to relieve pain.

Procedures/testing done: Patient was transferred to dialysis and had received an EKG on admission.

Complaints/Issues: The only complaint from the patient was the constant pain throughout her body, generally her lower back through her legs.

Vital signs (stable/unstable): Vital signs were stable. Her blood pressure ran slightly high but this was not a major concern because the patient had a known history of hypertension and was not permitted to take her blood pressure medications before dialysis.

Tolerating diet, activity, etc.: Patient was tolerating a regular diet and ate 75% of her breakfast. She was unable to get up out of bed at the time being.

Physician notifications: No notifications were made from the provider during the time of care.

Future plans for patient: The patient will be discharged to her assisted living facility. There she will be prescribed antibiotics to treat the UTI, and most likely pain medications to control her chronic pain. Proper personal hygiene should be implemented as well as minor ROM exercises to remain active.

Discharge Planning (2 points)

Discharge location: assisted living facility - Bowman Estate's

Home health needs (if applicable): Patient needs mild assistance with her ADL's, more of a supervision tactic.

Equipment needs (if applicable): The only assistive device used by the patient is a walker.

Follow up plan: As a follow up plan, patient will attend regular appointments including dialysis and follow her medication regimen properly.

Education needs: Patient should be taught preventative measures to avoid contracting another UTI. She should understand the importance of sticking to her medication regimen and be educated on the pertinent information regarding her medications. Finally, the patient should be taught non pharmacological therapeutic techniques to manage chronic pain.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per	Evaluation

● Include full nursing diagnosis with “related to” and “as evidenced by” components	● Explain why the nursing diagnosis was chosen	**dx)**	● How did the patient/family respond to the nurse’s actions? ● Client response, status of goals and outcomes, modifications to plan.
Risk for hyperthermia related to inflammation as evidence by presence of infection.	**This diagnosis was chosen because the patient was suffering from an infection and chronic pain. Although her WBC’s and temperatures remained WNL, it is important to monitor them to make sure they stay that way.**	**1. Encourage adequate fluid intake.** **2. Assess for signs of increased temperature.**	**1. The patient responded well to both interventions. There were no family members present during her time of care.** **2. Patient verbalized understanding the importance of increasing fluids (as tolerated) and made an effort to do so. Patient understood what changes in status could indicate a rise in temperature ie. (sweating, feeling warm) and assured us that she would notify if she experienced those things. Regular temperature was monitored as well. No modifications were necessary at the time.**
Impaired urinary	**This diagnosis was chosen**	**1. assess patient’s voiding patterns**	**1. Patient responded well to**

elimination related to hesitancy as evidence by decreased urinary output, history of AKI, and complaints of dysuria.	**because this specific patient not only has a UTI, but also chronic renal impairment and is treated with dialysis. Therefore, her output levels are significantly low.**	**2. Encourage voiding every 2-3 hours**	**both interventions.** **2. Patient was compliant when voiding patterns were assessed. However, patient has a very minimal output so voiding every 2-3 hours might need to be increased to 4-6. Hopefully, with an increase in fluids, progress will be noted. No modifications necessary.**
Acute pain related to inflammation of the urinary tract as evidence by pain levels of a 10, nonverbal and verbal indicators present during time of care.	**This diagnosis was chosen because the patient appeared to be in a severe amount of pain for her tolerance levels.**	**1. suggest use of non pharmacological techniques as appropriate.** **2**.instruct to avoid coffee, tea, sodas, and alcohol	**1. Patient responded well to both interventions.** **2. The major non pharmacological intervention used was repositioning. Although it took a fair amount of time, the patient was able to find something that worked for her and her pain. As far as stimulants to avoid, patient verbalized understanding of the teaching and did not have further questions. No modifications necessary.**
Risk for	**This diagnosis**	**1. Reduce**	**1. Patient**

disturbed sleep pattern related to pain as evidence by restlessness/irritability.	**was chosen because the patient was in a severe amount of pain and was constantly moving to get comfortable, thus hindering the amoutn of time she had to rest.**	**environmental distraction such as noise and light.** **2. encourage limiting the intake of chocolate and caffeine before bedtime**	**responded well to both interventions.** **2. Although the time of care was during the day so these interventions could not necessarily be implemented, the patient verbalized understanding of both teaching points and insisted she would vocalize what she needed to her nurse to increase her rest periods. No modifications needed.**

Other References (APA): N/A

Concept Map (20 Points):

Nursing Diagnosis/Outcomes: Map was not showing up properly

Risk for disturbed sleep pattern related to pain as evidence by restlessness/irritability. Patient will report at least 6 hours of undisturbed sleep throughout hospitalization.

Acute pain related to inflammation of the urinary tract as evidence by pain levels of a 10, nonverbal and verbal indicators present during time of care. Patient will not report a pain level greater than 5 throughout hospitalization. If so, intervention will be implemented as soon as possible.

Impaired urinary elimination related to hesitancy as evidence by decreased urinary output, history of AKI, and complaints of dysuria. Patient will increase fluids and have a normal output level for her body before discharge.

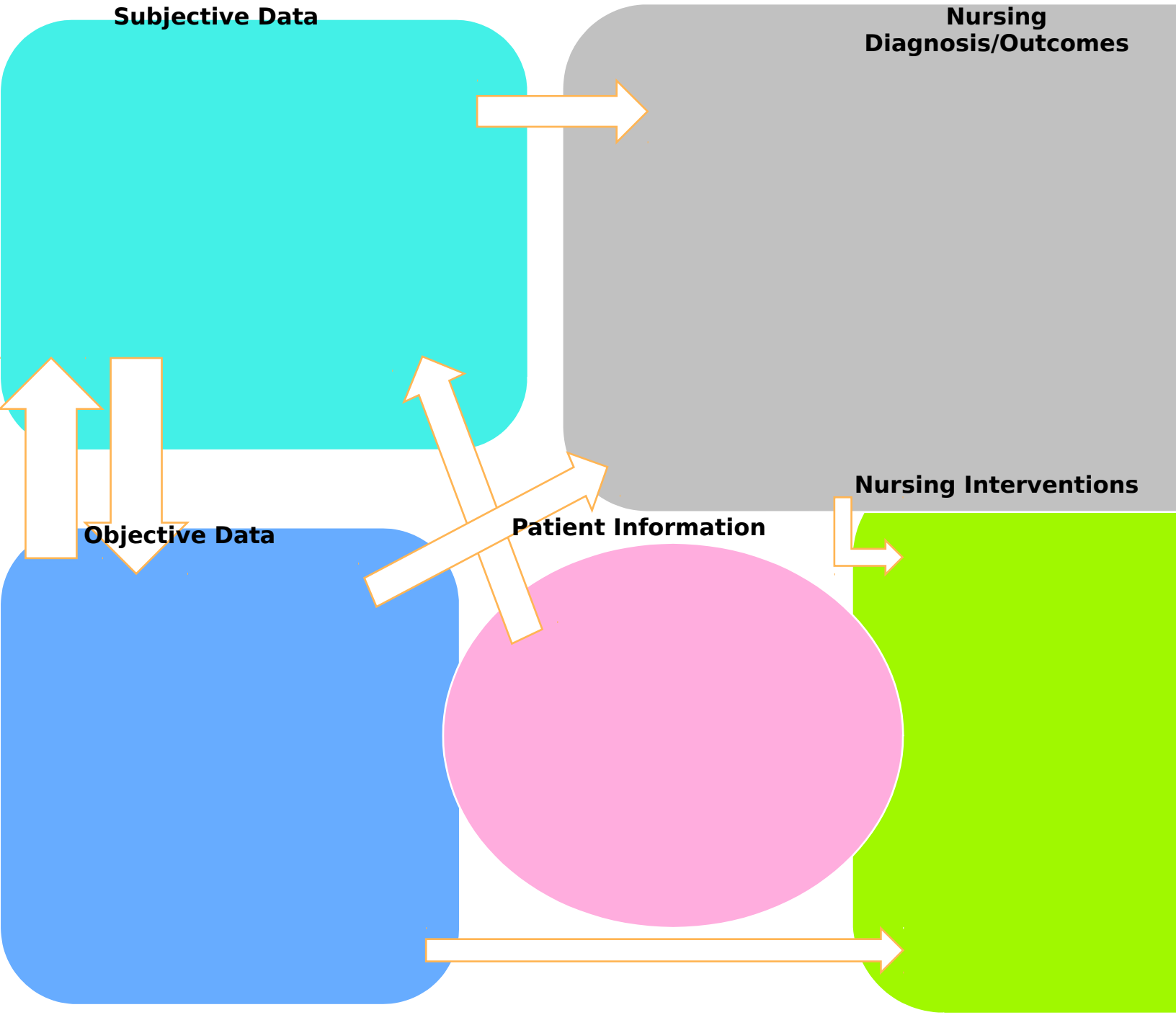
Risk for hyperthermia related to inflammation as evidence by presence of infection.
Patient's temperatures will be continuously monitored and maintained throughout stay.

Nursing interventions:
Reduce environmental distraction such as noise and light.
encourage limiting the intake of chocolate and caffeine before bedtime
suggest use of non pharmacological techniques as appropriate.
instruct to avoid coffee, tea, sodas, and alcohol
assess patient's voiding patterns
Encourage voiding every 2-3 hours
Encourage adequate fluid intake.
Assess for signs of increased temperature.

Subjective Data:
pain at a level 10
pain in the lower back
complaints of dysuria

Objective:
moaning/wincing
WBC,RBC, Leukoesterase, and protein in the urine
Increased BUN and creatnine
decreased output

Patient Information:
A 72 year old woman presents with severe pain. She states the pain is all over but is mostly concerned with her neck and lower back. Patient was seen in the ER for similar symptoms two days ago and was unable to be dialyzed at that time due to her pain levels. Patient is a known case of end stage renal disease and on hemodialysis. She has a catheter to the right chest and is in the same condition that she was in the ER due to her pain.


Subjective Data
Nursing Diagnosis/Outcomes
Nursing Interventions
Objective Data
Patient Information