N441 Care Plan 1

Lakeview College of Nursing

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Demographics (5 points)

Date of Admission	**Patient Initial**	**Age**	**Gender**
3/7/2020	E.B.	71	Male
Race / Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Single	NKA
Code Status	**Height**	**Wight**	
Full Code	173 cm	103.4 kg	

Medical History (5 points)

Past Medical History:

- Prostate Cancer
- Metastatic bone cancer
- CAD
- Anemia
- GERD
- Hypercholesteremia
- Hypertension
- Hypothyroidism

Past Surgical History:

- Prostatectomy
- Cardiac catheterization & Stent, right heart @ 2018

Family History: Father side with hx of the heart disease.

Social History (Tobacco / Alcohol / Drugs, Patient Social Factors):

The patient is retired since 2005 from Air Force, living in a single home in Charleston, Illinois. Patient states he does not drink or smoke, nor uses any illicit drugs. He states used to drink occasionally before he diagnosed with cancer in 2007. The patient has a family history of

heart disease on his father's side. The patient joint Air Force two years after he graduated high school, and he never seeks for further education.

Admission Assessment

Chief Complaint (2 points):

- Pt arrived ER via EMS for weakness from nausea and diarrhea

History of Present Illness (10 Points):

The patient present in ER via EMS on March 7th complain of generalized weakness related to diarrhea that happened the day before. The patient states he was "feeling well two days ago and started the diarrhea yesterday for most of the day". He had nausea, but there is no vomiting or fever accompanied. The patient is having an increase of generalized weakness with low appetite and abdominal discomfort. As the patient states, "it feels like bloated," with lightheaded, blurred vision, chest pain, and the patient unable to get out of the bed. The patient is transferred to 2 south for observation in the evening; however, he suddenly developed tachycardia, hypotension, and febrile episode. His heart rate went from the 70s up to 130s, a temperature of 38.6C, with the blood pressure of 88/52, his lactic acid level of 2.9, his ECG shows the development of Atrial fibrillation. AT this time, the patient already received a total of 4L IV bolus to prevent shock. The patient then transferred to CCU for intensive care.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):

- Septic shock

Secondary Diagnosis (if applicable):

- Gastroenteritis

Pathophysiology of the Disease, APA Format (20 Points):

Sepsis is a systemic inflammatory response to an infection caused by various microorganisms, and it is a life-threatening condition followed by organ dysfunction due to a dysregulated host response to an infection (Lewis, 2011). Septic shock is a subset of sepsis and a state of organ failure due to impaired cellular function caused by inadequate tissue perfusion associated with sepsis (Lewis, 2011). Many microorganisms can cause sepsis, and up to 30% of the patients with sepsis may never have identifiable infection sites. Traditionally, gram-negative bacteria are commonly associated with sepsis. However, the studies show gram-positive bacteria, viral, and fungal infections can also cause sepsis (Hinkle & Cheever, 2018).

The body triggers inflammatory responses when microorganisms invade into body tissue, and it is a normal immune response. When it exaggerated by either excessive microorganisms or compromised immune systems, it leads to an increase in inflammation and coagulation but decreases in fibrinolysis (Lewis, 2011). As a result, these effects of the mediators produce damage to the endothelium, vasodilation, increased capillary permeability, the neutrophil and platelet aggregation adhesion to the endothelium, these physiological changes can lead to compromised tissue perfusion (Lewis, 2011).

The risk factors of septic shock, including immunosuppression, age (younger than one year, or older than 65 years), malnourishment, chronic illness, invasive procedure, and surgeries (Lewis, 2011). My patient has a high risk due to several factors. He was 71 years of age, immunocompromised due to cancer treatment, history of prostate cancer, and metastasized bone cancer, which made him prone to infection and septic shock.

The clinical manifestation of septic shock, including elevated temperature 38.3C (101F) or higher, 36C (96.8F) or lower, tachycardia, tachypnea, warm flushed skin with bounding pulse, normal to hypotension, decreased urinary output, hyperglycemia, nausea, vomiting, diarrhea, dysrhythmia, and altered mental status, etc. (Hinkle & Cheever, 2018). The diagnostic tools, including white blood cell count 12,000 or higher, or less than 400, elevated lactate level, bilirubin level, plasma C-reactive protein, culture for blood and urine, etc. (Hinkle & Cheever, 2018). My patient exhibits these manifestations, he presents with fever of 38.6, heart rate of 130, the respiration rate of 22, nausea, diarrhea, his WBC was 29,000, bilirubin level of 1.1, elevated ALT and AST, lactic acid of 2.3, and he developed atrial fibrillation.

The treatments for septic shock are varied and depend on the stages of shock; however, the most important measure is prevention and early recognition of the signs and symptoms of the septic shock (Hinkle & Cheever, 2018). There are a few treatments for septic shock, and that including to treat underlying causes, fluid replacement therapy, pharmacological therapy, and nutritional therapy. First, the cause of the infection needs to be identified and eliminated, "current goals are to identify and treat patient in early sepsis within 3 hours to optimize patient outcome" (Hinkle & Cheever, 2018, p. 315). Second, fluid replacement must be initiated to correct the tissue's hypoperfusion states. "Reestablishing tissue perfusion through aggressive fluid resuscitation is key to the management of sepsis and septic shock" (Hinkle & Cheever, 2018, p. 316). Third, the common medications used to treat septic shock are antibiotics, broad-spectrum antibiotic agents started for patients who are still waiting for culture results (Hinkle & Cheever, 2018). My patient started IV zosyn, and penicillin antibiotic, for 3.375g/ 50ml every 6 hours. Other medications such as vasopressor, inotropic agents, proton pump inhibitors are used to support cardiac function, maintain blood pressure, and prevention of stress ulcers. My patient

had IV diltiazem 100mg for every 6 hours and metronidazole 500mg every 6 hours. Finally, "aggressive nutritional supplementation needs to be initiated within 24 to 48 hours of ICU admission to address the hypermetabolic state prevent with septic shock" (Hinkle & Cheever, 2018, p. 316). My patient was still able to eat and drink, and he did not need enteral feeding.

Reference:

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarths textbook of medical-surgical nursing*. Philadelphia: Wolters Kluwer.

Lewis, S. M. (2011). *Medical-surgical nursing: assessment and management of clinical problems*. St. Louis, MO: Elsevier/Mosby.

Laboratory Data (15 points)

CBC: Highlight all abnormal labs, explanation must contain in-text citation in APA format.

Lab Test	Nomal Range	Adm Value 3/7/20	Today Value	Reason for Abnormality
RBC	3.8-5.41	4.69	3.46	Decreased RBC indicates anemia (Corbett, 2008). The patient has chronic anemia due to history of chemotherapy and metastatic bone cancer.
Hgb	11.3-15.2	14.7	10.8	Decreased Hgb and Hct indicate reduced level of oxygen into the cells, it associated with decreased RBC and anemia (Corbett, 2008). The patient has chronic anemia due to chemotherapy and metastatic bone cancer.
Hct	33.2-45.3%	43.3	32	
Platelet	149-493K	89	37	Decreased platelets indicates reduced blood coagulability (Corbett, 2008). It associated with patient's metabolic disorder related to septic shock.
WBC	4-11.7K	29.6	27.9	Elevated white blood count indicates an active infection in the body (Corbett, 2008). The patient is suspected of septic shock, blood

				culture is obtained to identify the microorganism.
Neutrophil	45.3-79%	73	80	Increased neutrophils accompany with decreased lymphocytes indicate bacterial infection, inflammatory response, tissue necrosis, and severe physical stress (Corbett, 2008).
Lymphocyte	11.8-45.9	1.8		
Monocyte	4.4-12	6.2		
Eosinophil	0-6.3	0.1		
Bands				
Chemistry: Highlight the Abnormal				
Na	135-145	139	138	
K	3.5-5	3.9	2.8	Decreased K level indicates excessive K loss or excessive fluid loss, and metabolic disorder also cause K imbalance (Corbett, 2008). The patient was under massive fluid replacement therapy, may accompanied with metabolic disorder.
Cl	98-107	105	109	
CO2	22-26	25	19	
Glucose	70-99	153	101	Elevated glucose level can be seen in Pt with liver dysfunction. However, it also can be seen with Pt after meal (Corbett, 2008).
BUN	6-20	18	6	
Creatine	0.5-0.9	1.06	0.78	
Albumin	3.5-5.2	4.3		
Ca	8.6-10.4	8.6		
Mg	1.6-2.4	1.7	1.4	Decreased Mg level indicates inadequate Mg intake and absorption, or increased excretion due to hypercalcemia, or drugs such as furosemide use (Corbett, 2008). The patient admitted with severe fluid imbalance due to sepsis.
Phosphate				
Bilirubin	0-1.2	1.1		
Alk Phos	35-105	62		
TSH	0.4-4.5			
AST	0-32	14		
ALT	0-33	11		
Amylase				
Lipase				
Lactic Acid	0.5-2.4	2.9		
Cholesterol	200>			
HDL	45<			
LDL	130>			
Triglycerol	35-160			
Lactic Acid	0.5-2.4			
Other Test: Highlight Abnormals				

INR	1			
PT	9.5-11.8			
PTT	30-40			
D-Dimer	250>			
BNP	500>			
A1C	5.7>			
Urinalysis:				
C & C	Clear/Yellow	Yellow & Hazy		
pH	4.5-8	5		
S. Gravity	1.005-1.035	1.019		
Glucose	0	Neg		
Protein	0	Neg		
Ketones	0	Neg		
WBC	5>	Neg		
RBC	0-3	5		Increased RBC in urine indicates infection, trauma, tumor, or kidney stones (Corbett, 2008).
Leukoesterase	Negative	Neg		
Arterial Blood Gas:				
pH	7.35-7.45			
PaO2	80-100			
PaCO2	35-45			
HCO3	22-26			
SaO2	95%<			
Culture:				
Urine	Negative	Neg		
Blood	Negative	Neg	Pending	
Sputum	Negative			
Stool	Negative			

Lab Correlations Reference (APA):

Corbett, J. V. (2008). *Laboratory tests and diagnostic procedures: with nursing diagnoses*. Harlow: Prentice Hall.

Other Diagnostic Tests (EKG, Echocardiogram, Xrays, CT scan, etc) (5 points)

- **ECG**

The electrocardiography is a graphic image of electrical currents of the heart. The 12-lead ECG is used to diagnose dysrhythmia, conduction abnormalities, and chamber enlargement, as well as myocardial ischemia, injury, or infarction (Hinkle & Cheever, 2018). The patient's ECG indicates sinus tachycardia @130 with A-fib.

- **Abdominal CT scan**

  An abdominal computer tomography scan uses an X-ray to provide a cross-sectional image of the abdominal cavity; a contrast media may or may not used to enhance the visualization. CT scans can be used to identify the tumor, infarctions, and structural abnormalities (Hinkle & Cheever, 2018). My patient's result indicates an inflammation of the stomach, and he diagnosed with gastroenteritis.

Diagnostic Test Correation, APA format Reference (5 points):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarths textbook of medical-surgical nursing*. Philadelphia: Wolters Kluwer.

Current Medication (10 points, 1 per completed med)

Home Medication					
Brand/Generic	ASA -Aspirin	atorvastatin -Lipitor	levothyroxine -Synthroid	docusate sodium -Colace	lisinopril -Zestril
Dose	81mg	40mg	50mcg	50mg	2.5mg
Route	PO, daily	PO, daily	PO, daily	PO, daily	PO, daily
Classification	Non-opioid Analgesic	Antilipidemic	Thyroid hormones	Stool softener	Antihypertensive ACE Inhibitor
Action	Block prostaglandin synthesis	Inhibits HMG-CoA Reductase production	Replacement of endogenous	Decreasing surface tention	Block RAAS

			thyroid hormones.	between oil and water in feces.	
Reason	Low dose used for blood thinner. Prevention of blood clots.	Patient has hyperlipidemia, to reduce the cholesterol level.	Manage and control of hypothyroidism.	To prevent constipation that may cause excessive cardiac work load	Lower blood pressure
Contra-indication	Pregnancy No children use Hemophilia Bleeding d/o	Liver d/o Antibiotics use Pregnancy/ Lactation Grapefruits	Hypersensitivity, Recent MI, hyperthyroidism	Pregnancy Hypersensitivity	No w/ NSAID Lithium
S/E, A/R	GI bleeding Ulceration	Hepatotoxic Myopathy	Nervousness, headache, insomnia, irritability	Syncope Palpitation Abd cramp distention	Hypotension Dry cough Angioedema Hyperkalemia
Nursing Intervention	Monitor s/s of the bleeding tendency	Monitor: AST / ALT CK level	Assess for the apical pulse and BP before and during therapy. Monitor: s/s of Hyperthyroidism.	Monitor: abuse F/E imbalance	Monitor: s/s of VS, BMP, CBC, I&O, ECG, Facial edema
Patient Teaching	Not w/ alcohol Take w/ food (Davis' s, P1287)	Take with meal @ night time (Davis' s, P629)	Educate Pt about s/s of hyperthyroidism, report when having SOB, palpitation. (Davis' s, P1169)	Increasing fiber fluid intake, encourage exercise (Davis' s, P442)	d/c NSAID Avoid K rich foods d/c/slowly (Davis' s, P170)
Hospital Medications					
Brand/Generic	Vancomycin-Vancocin	ondansetron-Zofran	metronidazole - Flagyl	ketorolac-Toradol	diltiazem-Cardizem
Dose	1250mg	4mg/2ml	500mg/ 100ml	30mg/1ml	100mg/ 100ml
Route	IV Pig, Q12hrs	IV Push, Q6 hrs, PRN	IV Pig, Q6 hrs	IV push, Q6hrs, PRN	IV Pig, Q12hrs
Classification	Antibiotics	Antiemetics	Anti-infective	NSAIDs	Antiarrhythmics
Action	Binds to bacterial cell wall, result in cell death.	Blocks effects of serotonin activities in CNS.	Disrupts DNA and protein synthesis in susceptible organisms.	Inhibits prostaglandin synthesis, producing peripherally mediated analgesics.	Inhibits Ca transport into myocardial and vascular smooth muscle cells, result in relaxation of cardiac muscles.
Reason	Treatment or prophylactic use for septic infection	Pt had nausea when he arrived at ED.	Pt had suspected septic shock, and still waiting	Pt had stomach pain when arrived to ED.	Manage and control of Pt's hypertension and A-fib.

			for blood culture result.		
Contra-indication	Hypersensitivity, liver or renal impairment	Hypersensitivity liver impairment, abdominal surgery.	Hypersensitivity, Hx of seizure, other neurological disorders.	Hypersensitivity, cross sensitivities with other NSAIDs.	Hypersensitivity 2nd or 3rd AV Blocks, recent MI or pulmonary congestion.
S/E, A/R	Anaphylaxis, nephrotoxicity, phlebitis, ototoxicity	Headache, dizziness, constipation, diarrhea, abdominal pain.	Seizure, headache, dizziness, anorexia, diarrhea, abdominal pain.	Drowsiness, dizziness, headache, GI bleeding, diarrhea.	Arrhythmia, CHF, peripheral edema, bradycardia, chest pain.
Nursing Intervention	Monitor: S/S of infection, IV sites, obtain culture, I & O, liver panel, renal function.	Assess for nausea, vomiting, abdominal distention. Monitor for liver enzymes level.	Assess for infection, monitor VS, WBC, obtain blood, urine cultures.	Monitor for allergic reaction during therapy, frequent pain assessment.	Monitor: ECG continuously, BP, HR, I&O throughout the therapy. Assess for s/s of CHF.
Patient Teaching	Instruct Pt to report: hearing loss, N/V, tinnitus, vertigo, jaundice. (Davis's, P1215)	Instruct Pt to take as directed. Report if involuntary movement of eyes, face, or limbs occurs. (Davis's, P911)	Instruct Pt to take as directed. Report if development of SOB, facial swelling, wheezing occurs. (Davis' s, P716)	Instruct Pt to report allergic reaction such as SOB, swelling of face or neck. (Davis' s, P587)	Advice Pt do not take grape fruits juice with it, caution Pt to change position slowly. (Davis' s, P418)

Lab Refenrence (APA Format):

Deglin, J. H., & Vallerand, A. H. (2009). *Davis drug guide for nurses*. Philadelphia: F.A. Davis.

Assessment

Physical Assessment (18 Points)

GENERAL(1 points): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is presents lying on bed TV. He is A&O x5, very cooperative but with generalized weakness, as evidenced by his voice was very soft. Pt's allover appearance is clean and relaxed.
INTEGUMENTARY (2 points): **Skin color:**	The patient is a Caucasian male and presents with a fair to pale skin tone. The skin has

Character: **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden scale : 17** **Drains present: Y N** **Type**	normal elasticity and texture, warm to touch. No rashes or scars present. Pt has normal skin turgor, no s/s of dehydration. Pt has bruises on left and right arms due to unsuccessful IV insertions. He also has redness on the coccyx and both bony heels, possible stage I pressure ulcers. Braden score of 17, risk for skin integrity.
HEENT (2 points): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth**	The Head is midline with no deviation. The hair is short, grey in color. Ears show no drainage, and he does not wear hearing aids. Pt uses glasses regularly. Pilpuls are round and reactive to light. Nose shows no deviated septum, turbinate equal bilaterally. He is wearing nasal cannula 2L/min. Oral mucosa is pink and moist, with no notable abnormalities. His teeth are intact, and he does not wear dentures.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable)** **Peripheral Pulses:** **Capillary refill:** 3> **Neck Vein Distention: Y N** **Edema: Y N** **Location of Edema:**	Pt currently monitored by ECG, Pt was noted to be normal sinus with tachycardia. HR fluctuates between the 70s to 150s. ECG shows the development of A-fib. Heart sound auscultated x5, no abnormality noted. Pt denies chest pain. Pedal pulse was equal bilaterally, no edema noted. Negative for neck vein distension. Cap refill was less than 3 seconds.
RESPIRATORY (2 points): **Accessory muscle use: Y N** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measure:**	The patient does not use accessory muscles when breathing. Pt denies SOB and denies sputum production. Lung sound auscultated, clear throughout bilaterally, no crackle, rhonchi, wheezes noted. Pt does use supplemental O2 with the nasal cannula of 2L/min. Trachea in the midline, no deviation.
GASTROINTESTINAL (2 points): **Diet at home:** Regular diet **Current Diet:** Heat healthy diet **Height:** 173 cm	The patient eats a regular diet at home and currently eats a heart-healthy diet at the hospital. He states that he tries to eat more vegetables and fruits in the home. Pt's

Weight: 103.6 kg **Auscultation Bowel sounds:** x4 quadrants **Last BM:** 3/9 **Palpation:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y N** **Nasogastric: Y N** **Feeding tubes/PEG tube Y N** **Type:**	abdominal inspection is completed, the skin is intact and warm to touch, with no lesion or rash, BS auscultated x 4 quadrants, soft to touch. No mass or tenderness, distension upon palpation. However, Pt complains of "feeling of little bloating" in the upper gastric region, the pain level of 3/10. He denies intervention. His last BM was 3/9.
GENITOURINARY (2 Points): **Color:** yellow **Character:** clear **Quantity of urine:** Void X 1 **Pain:** **Dialysis Y N** **Inspection of genitals** **Catheter: Y N** **Type**	The patient is able to ambulate to the bathroom with assistance due to fall risk, and he denies difficulty, urgency, pain upon urination. He does not have dialysis or catheters. No genital abnormality noted. No abnormal odor noted.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** decreased **ADL Assistance: Y N** **Fall Risk: Y N** **Fall score: 35** **Activity/Mobility Status:** w/ assistance **Independent (up ad lib)** **Needs assistance with equipment Y N** **Needs support to stand and walk**	The patient is able to get out of the bed and ambulate with assistance due to generalized weakness. Neurovascular status inspected, no pain, no color change, no numbness or tingling, no paralysis, and distal pulses equal bilaterally. He has free of ROM, and he does not use assistive devices. He does need ADL assistance, and he is fall risk with a fall score of 35.
NEUROLOGICAL (2 points): **MAEW: Y N** **PERLA: Y N** **Strength Equal: Y N** **if no - Legs Arms Both** **Orientation:** **Mental Status:** **Speech:**	The patient is able to stand and ambulate, PERRLA is noted. He is A&O x5, very cooperative with generalized weakness. He is able to answer all my questions with no difficulties, strength is equal in both extremities, and sensory sensation is intact.

Sensory: **LOC:**	
PSYCHOSOCIAL/CULTURAL (2 points): **Coping methods,** **Educational level** **Developmental level,** **Ethnicity,** **Religion & what it means to pt.** **Occupation (previous if retired)** **Personal/Family Data (Think about home environment, family structure, and available family support)**	Pt is 71 years old Caucasian male, single and retired, living in a single home in Charleston, IL. He married once and divorced in the 1970s without any kids, and he is single ever since. He states he does not practice any religion currently, although he is alone he is got his close friend Bill, they spent a lot of time together to hang out, and share the concerns or problems in life. He worked for Air Force for the entire life, and he receives a pension check every month.

Vital Signs, 2 sets (5 points)

Time	Pulse	BP	RR	Temp	O2
0800	108	128/75	19	38.1 C	95%
1200	110	134/63	21	38.1C	96%

The patient is admitted due to nausea and diarrhea associated with tendency of sepsis, he has elevated WBC level of 29, development of A-fib associated with decreased K and Mg level, and elevated HR, RR are clinical manifestation of septic shock, fever is associated with sepsis infection.

Pain Assessment, 2 sets (2 Points)

Time	Scale	Location	Severity	Characteristic	Intervention
0800	0-10	Upper gastric	3	Bloating	Pt denied
1200	0-10	Upper gastric	2	Bloating	Pt denied

IV Assessment

Site location, Patency / Condition & Date	Fluid Type / Rate or Saline Lock
Size of IV: 20	0.9% NaCl: 125ml/hr

Location of IV: Left Upper Arm **Date on IV:** 3/10/2019 **Patency of IV:** IV site is stable and patent. **Signs of erythema, drainage, etc.:** No s/s of infiltration, phlebitis, or other complications. **IV dressing assessment:** IV dressing is intact.	KCl: 50ml/hr Diltiazem: 5ml/hr
Other lines (PICC, Port, Central line, etc.)	
Type: **Site:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS cap in place:** **CLABSI prevention measure:**	N/A

Input & Output

Input	Output
2906 ml	765 ml

Nursing Care

Summary of care (2 points):

Overview of care:

The patient has admitted ED in 3/7 due to generalized weakness associated with nausea and diarrhea, CT scan confirmed with gastroenteritis, and suspect of septic shock. Pt developed A-fib while in 2-south, and transferred to CCU. Massive fluid replacement and prophylactic antibiotics were initiated. Pt's VS is still unstable; HR fluctuates from the 70s to 150s, tachypneic, and fever due to elevated WBC of 29,000. His K level went down to 2.8 this morning, and Mg level went down to 1.4. IV KCl is initiated at 1000, IV

Mg will be followed after KCl. He complains of little bloating in the stomach but denies any intervention. He was able to get out of the bed to use the bathroom, but he needs assistance due to the weakness. He ordered breakfast for cereal and coffee this morning, and he finished all.

Procedure / testing done:

The patient is in close monitoring of ECG change, and hemodynamic status. No procedure is scheduled.

Complain / issues: Pt complains pain level of 3/10 discomfort and bloating feeling in the stomach. He denies any intervention.

Vital signs (stable/ unstable): Pt's VS were not stable this morning.

Tolerating diet, activities, etc.: Pt complete 100% of breakfast, and walked to the bathroom to void.

Physician notification: N/A

Future plans for patient: Pt needs to monitor ECG and VS closely to maintain electrolytes and fluid balance.

Discharge Planning (2 points)

Discharge location: at hospital

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Pt needs to contact his primary doctor for further evaluation.

Education needs:

Upon discharge, the patient will be going back to his home in Charleston, and his friend Bill will be there to get him back. The patient would benefit from a cardiac-healthy diet

that high in protein and fiber, low in carbohydrate, sodium, and fat. He needs to be educated in infection control to maintain a bacteria-free environment to stay away from infection, as well as the proper food handling and meal preparation. He needs to follow the schedule medication every day and stick with it. The patient would follow the scheduled check-up for the long-term management of his medical condition. His home environment needs to be assessed as well to minimize the risk of falls.

***The following must be listed in order for priority and must be NANDA approved Diagnosis (18 Points total, 3 Points for each complete diagnosis with 2 interventions & rationales, 3 Points for correct priortization.)**

Nursing Diagnosis	Rationale	Intervention (2 per dx)	Evaluation
1. Fatigue and weakness related to decreased tissue perfusion as evidenced by patient diagnosed w/ sepsis and experiencing tachycardia and tachypnea from fluid and electrolyte imbalance (Lewis, 2011)	This is related to Pt's chief complain of generalized weakness due to diarrhea and nausea.	1. O2 supplementation with 2L, in nasal canula 2. Encourage alternate rest and activity periods to reserve the energy	Pt's VS are still not stable, he is still tachycardiac, and tachypneic. The interventions were not successful.
2. Electrolyte imbalance related to excessive diarrhea and metabolic	This is related to Pt's disturbed metabolic status associated with infection and sepsis, cause his	1. Monitor closely for ECG change 2. Monitor for S/S of hyperkalemia and hypermagnesemia	Pt was initiated with KCl at 1000, under close monitor of EC

disturbance as evidenced by patient's decreased K and Mg levels this morning (Lewis, 2011)	electrolytes went abnormal. Pt's K level was 2.8, Mg level was 1.4.		
3. Impaired skin integrity related to decreased immobility as evidenced by the patient's Braden score of 17 (Lewis, 2011)	This is related to Pt's decreased immobility due to fatigue and weakness, and Pt is already presenting redness in his bony prominences of coccyx and both heels.	1. Frequent assessment of skin integrity. 2. Encourage of fluids intake, IV NaCl.	Pt does not show S/S of progress of pressure ulcers.
3. Risk for fall due to generalized weakness associated with present illness (Lewis, 2011)	This is related to Pt's weakness from being ill for more than four days. He requires an assistant to stand and ambulate.	1. Wearing wristband to notify all the health care team. 2. Use call light, or bed alarm to stand or transfer.	Pt maintained wristband and used call light every time get out of the bed.
4. Risk for bleeding due to patient's decreased platelets counts (Lewis, 2011)	This is related to Pt's platelet counts was 37 this morning.	1. Minimize the chance to puncture the patient. 2. Encourage use of soft brush, and an electric razor for shaving.	Pt shows no S/S of bleeding by the end of the shift.

Reference:

Lewis, S. M. (2011). *Medical-surgical nursing. assessment and management of clinical problems*. St. Louis, MO: Elsevier/Mosby.