N431 Care Plan #3

Lakeview College of Nursing

Lindsey Platt

Demographics (3 points)

Date of Admission 3/26/2020	**Patient Initials** B. M.	**Age** 38 years old	**Gender** F
Race/Ethnicity Caucasian	**Occupation** Nurse	**Marital Status** Married	**Allergies** Morphine sulfate, Ragweed
Code Status Full Code	**Height** 154.94 cm	**Weight** 55.9 kg	

Medical History (5 Points)

Past Medical History: Hypertension, UTIs, Kidney stones

Past Surgical History: Cesarean section, Cholecystectomy in 2012

Family History: Mother – diabetes, Brother – diabetes, Father – MI

Social History (tobacco/alcohol/drugs): current smoker – 1 pack per day – has been a smoker for 10 years, casual drinker (1-2x per month), never drug use

Assistive Devices: None

Living Situation: Lives at home with husband and 8 children

Education Level: Bachelor's degree in nursing (RN BSN)

Admission Assessment

Chief Complaint (2 points): redness, swelling, and pain to the RLE

History of present Illness (10 points): Patient is a 38-year-old female who presented to the ED with complaints of redness, swelling, and warmth to her right leg. Patient states that she was playing with her children outdoors and tripped over a rock, fell, and skinned her knee on the pavement. No alleviating factors. No precipitating factors. She was admitted with the hospitalist on 3/26 for a diagnosis of cellulitis.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Cellulitis

Secondary Diagnosis (if applicable): NA

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

"Cellulitis is a common infection of the skin and the soft tissues underneath. It happens when bacteria enter a break in the skin and spread. The result is infection, which may cause swelling, redness, pain, or warmth" (Gardner, 2019). Risk factors include trauma to the skin, diabetes, circulatory issues, cirrhosis or hepatitis, and other skin disorders such as eczema, psoriasis, or chickenpox. Causes of cellulitis include injuries that tear the skin, infections after surgery, long-term skin conditions such as eczema or psoriasis foreign objects in the skin, and/or bone infections underneath the skin. Cellulitis usually shows up on damaged skin such as inflamed wounds, dirty cuts, and areas with poor circulation. It needs to be treated by a doctor. Common symptoms include redness, swelling, warmth, pain, tenderness, and/or leaking of pus or fluid from the site. Diagnostic testing includes a blood test if the infection is suspected to have spread to your blood, an X-ray if there's a foreign object in the skin or the bone underneath is possibly infected and/or a culture. Your doctor will use a needle to draw fluid from the affected area and send it to the lab. Treatment includes resting the area, elevating the area to help reduce swelling and relieve discomfort as well as over the counter pain relievers like Tylenol or Motrin. If the infection isn't too bad, you can take antibiotics by mouth for a week to 14 days. You'll get IV antibiotics until the infection is under control (2 to 3 days), and then go home with oral medicines. You also may need surgery if doctors have to open and drain the wound but it is rare.

The patient stated she fell over a rock and scraped her knee. Her chief complaint was redness, swelling, and warmth to her right leg. Upon admission, she received a chest x-ray, an

EKG, right foot x-ray, and a venous doppler RLE. All findings are normal. As of labs, she has an elevated RBC, WBC, and creatinine associated with the infection. She is getting treated with clindamycin for cellulitis and hydrocodone/acetaminophen and hydromorphone for pain. Since she has other comorbidities such as hypertension, and a history of UTIs and kidney stones. She is also a current smoker which increases her risk of getting in infection.

Pathophysiology References (2) (APA):

Gardner, S. S. (2019, February 3). Cellulitis - Symptoms, Causes, Treatments, & More. Retrieved March 14, 2020, from https://www.webmd.com/skin-problems-and-treatments/guide/cellulitis#1

Swearingen, P. L. (2018). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Place of publication not identified: MOSBY.

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	4.0-5.2	8.8	No labs drawn	She has a history of HTN (Hinkle, 2018)
Hgb	F:12-15 M: 14-16	No labs drawn	No labs drawn	
Hct	F:42-52 M:35-47	No labs drawn	No labs drawn	
Platelets	140-440	No labs drawn	No labs drawn	
WBC	4.0-11.0	17.4	No labs drawn	Her body is fighting of infection (Hinkle, 2018)
Neutrophils	45-75%	No labs	No labs	

		drawn	drawn	
Lymphocytes	20-40%	No labs drawn	No labs drawn	
Monocytes	4-6%	No labs drawn	No labs drawn	
Eosinophils	<7%	No labs drawn	No labs drawn	
Bands	<3%	No labs drawn	No labs drawn	

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	138	No labs drawn	
K+	3.5-5.0	3.6	No labs drawn	
Cl-	98-107	No labs drawn	No labs drawn	
CO2	35-45	No labs drawn	No labs drawn	
Glucose	70-100	86	No labs drawn	
BUN	7-20	10	No labs drawn	
Creatinine	0.6 to 1.2	1.67	No labs drawn	She has a bacterial infection (Hinkle, 2018)
Albumin	3.4-5.4	No labs drawn	No labs drawn	
Calcium	8.5-10.5	No labs drawn	No labs drawn	
Mag	1.7-3.4	No labs drawn	No labs drawn	
Phosphate	2.5-4.5	No labs drawn	No labs drawn	
Bilirubin	<1.5	No labs drawn	No labs drawn	

Alk Phos	20-140	No labs drawn	No labs drawn	
AST	10-30	No labs drawn	No labs drawn	
ALT	10-40	No labs drawn	No labs drawn	
Amylase	23-85	No labs drawn	No labs drawn	
Lipase	60-160	No labs drawn	No labs drawn	
Lactic Acid	0.5-1.0	No labs drawn	No labs drawn	
Troponin	<0.3	No labs drawn	No labs drawn	
CK-MB	5-25	No labs drawn	No labs drawn	
Total CK	22-198	No labs drawn	No labs drawn	

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	0.86-1.16	No labs drawn	No labs drawn	
PT	11.9-14.9	No labs drawn	No labs drawn	
PTT	60-70	No labs drawn	No labs drawn	
D-Dimer	<250	No labs drawn	No labs drawn	
BNP	<450	No labs drawn	No labs drawn	
HDL	>60	No labs drawn	No labs drawn	
LDL	<130	No labs drawn	No labs drawn	
Cholesterol	<200	No labs drawn	No labs drawn	
Triglycerides	<150	No labs drawn	No labs drawn	

Hgb A1c	<7-8%	No labs drawn	No labs drawn	
TSH	0.4-4.0	No labs drawn	No labs drawn	

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 and clear	No labs drawn	No labs drawn	
pH	6.0	No labs drawn	No labs drawn	
Specific Gravity	1.010-1.025	No labs drawn	No labs drawn	
Glucose	0-0.8	No labs drawn	No labs drawn	
Protein	0-20	No labs drawn	No labs drawn	
Ketones	Negative	No labs drawn	No labs drawn	
WBC	0-5	No labs drawn	No labs drawn	
RBC	4	No labs drawn	No labs drawn	
Leukoesterase	2-5	No labs drawn	No labs drawn	

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	No labs drawn	No labs drawn	
PaO2	80-100	No labs drawn	No labs drawn	
PaCO2	33-45	No labs drawn	No labs drawn	
HCO3	22-26	No labs	No labs	

		drawn	drawn	
SaO2	90-100	No labs drawn	No labs drawn	

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	Labs not drawn	Labs not drawn	
Blood Culture	Negative	Labs not drawn	Labs not drawn	
Sputum Culture	Negative	Labs not drawn	Labs not drawn	
Stool Culture	Negative	Labs not drawn	Labs not drawn	

Lab Correlations Reference (APA):

Hinkle, J. L., Cheever, K. H., & Hinkle, J. L. (2018). *Brunner & Suddarths textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Upon admission, she received a chest x-ray, an EKG, right foot x-ray, and a venous doppler RLE. All findings are normal.

Diagnostic Test Correlation (5 points): She got a chest x-ray to rule out pericardial effusion. It was negative for any acute abnormalities. This test will show us the space around the lungs to check for fluid or a pneumothorax and it can also show us heart-related lung issues. She got an EKG to rule out heart enlargement due to edema in her leg. This test can show us the electrical activity of your heart at rest. It provides information about your heart rate and rhythm,

and shows if there is enlargement of the heart due to high blood pressure (hypertension) or evidence of a previous heart attack (myocardial infarction). It shows NSR and no noted abnormalities. She received a x-ray of her right foot because she had redness and swelling and to rule out a fracture. It was negative for any acute abnormalities. This can show us any fractures or osteoporosis of the bone. She also got a venous doppler RLE because her skin was red, swollen, and warm. A doppler can show us any blockage in the veins by a blood clot or "thrombus" formation. It was negative for DVT.

Diagnostic Test Reference (APA):

Hinkle, J. L., Cheever, K. H., & Hinkle, J. L. (2018). *Brunner & Suddarths textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

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

Home Medications (5 required)

Brand/Generic	**Loratadine (Claritin)**	**Prenatal vitamin**	**Lisinopril (Zestril)**	**Tamsulosin (Flomax)**	**Acetaminophen (Tylenol)**
Dose	10 mg	2 chewable gummies	20 mg	0.4 mg	650 mg
Frequency	daily	daily	daily	daily	q6h PRN
Route	PO	PO	PO	PO	PO
Classification	Antihistamine	vitamin	Ace inhibitors antihypertensive	Alpha blockers	analgesic
Mechanism of Action	prevents histamine from binding to histamine receptor sites	Replaces vitamins and minerals due to pregnancies	Stops vasoconstriction (angiotensin I and II)	Blocks alpha1-adrenergic receptors inhibiting smooth muscle contraction improving the rate of urine flow	Inhibits prostaglandin synthesis in CNS and PNS (blocks pain impulse)
Reason Client Taking	allergies for skin, respiratory, eyes	prevents vitamin deficiency	control HTN	History of kidney stones, prevent recurrence	mild pain/fever
Contraindications (2)	fruit juice decreases absorption, hypersensitivity to desloratadine	Iron metabolism disorder, stomach ulcers	Pregnancy, increases serum concentration of dioxin and	Hypersensitivity to sulfonamides, renal failure	PUD, GI bleeds

			lithium, renal impairments		
Side Effects/Adverse Reactions (2)	Vomiting Headache Cough	Constipation, nausea	Angioedema Persistent cough hypotension	Headache, orthostatic hypotension	Abdominal pain, Heartburn
Nursing Considerations (2)	Avoid in pregnancy or urinary retention	Give regularly, this passes into breast milk,	Should not be given to a pt with unstable vitals or pts receiving therapy for chronic infection	Do not open, crush, or chew; they may need a bed alarm for orthostatic hypotension	Risk for stroke increases the longer ibuprofen is used; if IV ensure infusion pumps are programmed properly
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Can thicken and dry secretions, careful if client has asthma, bronchitis or pneumonia, CBC for renal or hepatic impairment	Vital signs, CBC	Monitor BP, potassium, cough, WBC	Monitor BP and renal function (CBC)	Vital signs, renal function
Client Teaching needs (2)	take with water, only take 1 of the drug class at a time. Careful when using multiple sedating drugs. Start 2-3 weeks before allergy season	do not take more than prescribed dose, take on empty stomach with full glass of water	take 1 hr before meals, get up slowly, no salt substitutes	Get up slowly, take on empty stomach 30 minutes after the same meal each day	Do not exceed recommended dose; recognize the signs of overdose: bleeding, fever, sore throat

Hospital Medications (5 required)

Brand/Generic	**Clindamycin (Cleocin)**	**Normal Saline**	**Hydrocodone / acetaminophen 5/325 (Vicoden)**	**Hydromorphone (Dilaudid)**	**Docusate (Colace)**
Dose	200 mg	100 mL/hr	325 mg	0.5 mg	100 mg
Frequency	q6h	once	q4h PRN	q4h PRN	BID PRN
Route	IV	IV	PO	IV	PO
Classification	Antibacterial and antiprotozoal antibiotic	Electrolyte replacement	Analgesic	Opioid analgesic	Stool softener
Mechanism of Action	Inhibits protein synthesis in susceptible bacteria which causes bacterial cells to die	Sodium regulates the membrane potential of cells and the active transport of molecules across cell membranes. Chloride is also responsible for	Inhibits prostaglandin synthesis in CNS and PNS (blocks pain impulse)	Bind with opioid receptors in the spinal cord and CNS altering the perception of and emotional response to pain	Decreases surface tension between oil and water in feces

		maintaining fluid balance, but it is also essential in the maintenance of acid-base balance			
Reason Client Taking	cellulitis	Replace water and electrolytes lost	moderate pain	severe pain	Constipation
Contraindications (2)	History of antibiotic-associated colitis or regional enteritis	congestive heart failure, severe renal impairment	PUD, GI bleeds	Acute asthma, GI obstruction	Fecal impaction, hypersensitivity
Side Effects/Adverse Reactions (2)	Eye pain, diarrhea	Injection side swelling, infection from IV site	Abdominal pain, Heartburn	Diaphoresis, blurred vision	Abdominal cramping, throat irritation
Nursing Considerations (2)	Culture and sensitivity testing must be done before giving the first dose	Do not use if it is cloudy or discolored, store at room temperature	Risk for stroke increases the longer ibuprofen is used; if IV ensure infusion pumps are programmed properly	watch for serotonin syndrome, watch for dependence	Watch for electrolyte imbalance, long term use can lead to constipation
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver enzymes	Vital signs and electrolyte levels	Vital signs, renal function	Monitor I+O, respiratory rate and BP	Vital signs, electrolytes, I+O
Client Teaching needs (2)	Complete course of therapy, take with at least 8 oz of water to prevent esophageal irritation	You may have a taste of salt in your mouth, the hospital will be monitoring your output	Do not exceed recommended dose; recognize the signs of overdose: bleeding, fever, sore throat	Can lead to abuse or addiction, no alcohol	Do not use if they are vomiting or have nausea, increase fiber intake

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2018 Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A+Ox4. Appears well-nourished. No signs of distress. Affect was appropriate, calm, and cooperative. RASS score of 0.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin appeared pink, warm and dry. Temperature was between 36.5-36.8 degrees Celsius within normal limits. No rashes, bruises, or wounds. Skin turgor was normal, capillary refill less than 3 seconds Braden score of 22 making her without skin risk. No drains present Redness, swelling, and warmth to the RLE.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head appeared normocephalic. Patent airway. Her trachea is midline. No ear pain, nasal congestion, or sore throat. Extraocular motions are intact. No recent visual problems. Her temporal membranes are clear bilaterally. Nasal passages are clear and moist. She does not wear dentures or glasses.
CARDIOVASCULAR (2 points): **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:**	Heart sounds appeared normal. S1 and S2 sounds were heard without any S3 or S4 sounds. Normal rate and rhythm. No murmurs, gallops, or rubs. Peripheral radial pulses were normal 3+ bilaterally. Peripheral dorsalis pedis pulses were normal 3+ bilaterally. Nail bed color is normal for ethnicity. Capillary refill less than 3 seconds. Lower extremities showed 2+ edema bilaterally. No neck vein distention.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Lungs sounds heard to auscultation bilaterally in all 5 lobe fields. No accessory muscle use needed. Respiratory rate was 16.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:**	Regular diet at home and in the hospital. 154.94 cm tall, 55.9 kg Bowel sounds active in all four quadrants No pain upon palpation

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:**	No distention, incisions, scars, drains, or wounds Last BM was today, 3/30 No ostomy, NG, or feeding tubes Abdomen appeared flat and non-tender.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Voiding without difficulties. Urine is yellow and clear. No odor. Her total output was 1750 mL. She uses a bed pan since she is oxygen dependent. No bladder distension or pain with urination. No dialysis No catheter
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☐**	Active ROM Currently on no supportive devices. She can get up independently. She does turn herself in the bed. Fall risk of 20 making her a low fall risk
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:**	A+Ox4 Moves all extremities Pupils equal, round, and reactive to light Strength was equal in all extremities bilaterally. Affect and communication was appropriate for developmental age. Normal cognition. Speech is clear.

Speech: **Sensory:** **LOC:**	No lightheadedness or focal weakness No slurred speech or sensory deficits No LOC
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):**	States she copes with stress by online shopping. Lives at home with husband and 8 children who are supportive of her. She has a bachelor's degree in nursing. She does not practice any religion.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	76	126/68	16	36.5	98%
1100	68	118/62	16	36.8	97%

Vital Sign Trends:

Her vital signs were stable and afebrile. She is on a Tylenol to keep her temperature within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	Generalized	6/10	generalized pain	Tylenol administered
1100	Numeric	Generalized	2/10	generalized pain	no intervention at this time

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:**	20G left AC inserted on admission (3/26) No complications, patent, dressing clean/dry/intact

Signs of erythema, drainage, etc.: **IV dressing assessment:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
NS at 100 mL/hr for 4 hours Tea PO 240 mL with breakfast Apple juice 120 mL with breakfast	Urine 1750 mL total voided Stool x2

Nursing Care

Summary of Care (2 points)

Overview of care: We will continue to monitor her infection and wound.

Procedures/testing done: none today

Complaints/Issues: No stated complaints or issues besides generalized pain that was treated with Tylenol.

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: She is on a regular diet and activity and is tolerating them well.

Physician notifications: None today

Future plans for patient: Discharge

Discharge Planning (2 points)

Discharge location: Patient plans to discharge back home with her husband and children.

Home health needs (if applicable): NA

Equipment needs (if applicable): NA

Follow up plan: Will follow up with PCP in 1 week following discharge.

Education needs: No noted discharge needs or case management concerns

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. Infection related to cellulitis as evidenced by redness, swelling, and warmth of RLE.	She has a bacterial infection of cellulitis	1.Administer Clindamycin as prescribed 2.Monitor WBCs	She responded well to antibiotics, her WBC count was elevated upon arrival and she remained afebrile.
2. Inadequate tissue perfusion related to infection as evidenced by edema in the RLE	Her chief compliant was swelling and redness in her right leg.	1. Assess peripheral pulses 2.Monitor for edema	She had some welling and edema on her right leg. She received a doppler on admission that was negative for any clots.
3. Pain related to cellulitis as evidenced by her stating her pain as a 6/10	She stated her pain as a 6/10	1.Administer Tylenol as prescribed 2. Reassess pain an hour after administering the analgesic	Her pain was relieved with Tylenol.
4. Risk for delayed wound healing related to cellulitis as evidenced by being an active mother of 8	She lives an active lifestyle with her children that could delay her healing.	1. Keep the infected area clean and dry. 2. Limit activity	The wound was kept clean and dry and activities were clumped together to limit her on the infected leg

Other References (APA):

Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Ball, B. S., Holman, H. C., Lemon,

T. (2016). *Rn adult medical surgical nursing: review module*. Assessment Technologies Institute.

Concept Map (20 Points):

N431 Care Plan

Subjective Data

pain

Nursing Diagnosis/Outcomes

Infection related to cellulitis as evidenced by redness, swelling, and warmth of RLE.
Outcome: The patient will be free from infection by discharge
Inadequate tissue perfusion related to infection as evidenced by edema in the RLE
Outcome: The patient will decrease the edema in her legs before discharge
Pain related to cellulitis as evidenced by her stating her pain as a 6/10
Outcome: The patient will keep her pain at a tolerable level by discharge
Risk for delayed wound healing related to cellulitis as evidenced by being an active mother of 8
Outcome: The patient will clump activities together and try to stay off her affected leg during this shift

Objective Data

Labs are relevant to infection
Patient can ambulate independently
EKG, chest x-ray, right foot x-ray, and venous doppler of RLE were negative for all abnormalities
Net output of 1,098
Edema of RLE

Patient Information

Patient is a 38-year-old female who presented at the emergency department for redness, swelling, and warmth to the RLE. She was admitted and diagnosed with cellulitis.

Nursing Interventions

Monitor vital signs: Pulse oximetry, blood pressure, heart rate, and respiration rate. Report significant findings
Auscultate breath sounds frequently.
Assess patient's pain.
Monitor for signs of bleeding
Administer PRN pain medication, if prescribed.
Provide frequent breaks and rest periods in between activities
Speak in a loud, therapeutic manner
Establish honest, therapeutic communication in an empathetic manner
Explain all interventions, diagnostics and medications

N431 Care Plan

N431 Care Plan