N431 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 7/7/2020	**Patient Initials** R.Y.	**Age** 81	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Homemaker	**Marital Status** Married	**Allergies** Sulfa Antibiotics
Code Status DNR	**Height** 5'6"	**Weight** 88 lbs.	

Medical History (5 Points)

Past Medical History: Anxiety, Hypertension, Hypothyroid, Parkinson disease, Parkinson's disease dementia, Seasonal allergies, Spine degeneration, Severe protein-calorie malnutrition, Ineffective urethritis

Past Surgical History: Hip arthroplasty, Hysterectomy, Left shoulder surgery, Tonsillectomy

Family History: Heart Attack – Father

Social History (tobacco/alcohol/drugs): Never smoked, never used smokeless tobacco, no alcohol or drug use

Assistive Devices: Wheelchair

Living Situation: Lives at home with her husband.

Education Level: High school, with some college.

Admission Assessment

Chief Complaint (2 points): Severe lethargy

History of present Illness (10 points):

R.Y. is an 81-year-old Caucasian female with a past medical history of dementia, Parkinson's disease, and hypertension. She is at the hospital for toxic metabolic encephalopathy secondary to UTI. Her husband states that last evening, R.Y. seemed to be having hallucinations before bedtime. She shakes and nods her head to yes and no questions and opens her eyes to

touch. She follows simple commands and asked. Her husband states she has been like this for the past 2-3 days. She is not experiencing any pain, and the provider ordered urine and blood tests.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): UTI

Secondary Diagnosis (if applicable): Toxic metabolic encephalopathy

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

UTI and toxic metabolic encephalopathy

Urinary tract infections (UTI) is an infection in any part of the urinary system, mostly the lower urinary tract. UTI bacteria can infect the bloodstream causing urosepsis (Mayo Clinic, 2019). One of the causes of toxic metabolic encephalopathy is sepsis (Corner, 2015).

R.Y. complains of having pain during urination. She also complains of having a urinary frequency and a burning sensation when she urinates. Her husband states that her urine has been cloudy and has been incontinent. Signs and symptoms related to UTI related to R.Y. experiences the persistent urge to urinate, a burning sensation when urinating, dark appearing urine, and passing a small frequent small amount of urine (Mayo Clinic, 2019). R.Y. also has elevated blood pressure, having some hallucinations, and malnutrition. Signs and symptoms indicating that R.Y. may have toxic metabolic encephalopathy consists of hypertension, mental status alteration, and metabolic disturbances (Corner, 2015).

A urine sample for the lab was acquired to look for white blood cells, red blood cells, or bacteria (Mayo Clinic, 2019). When testing the blood sample, the doctor will look for a large number of white blood cells in the urine that indicates an infection (Mayo Clinic, 2019). R.Y. does not have the lab results at the moment.

R.Y. is ordered Thiamine IV for her toxic metabolic encephalopathy. This medication is for patients who have malnutrition and prevent vitamin B1 deficiency (Chalela & Kasner, 2020). If R.Y.'s lab results come back with high counts of WBC in her urine, then she will be administered antibiotics to treat the UTI (Mayo Clinic, 2019).

Pathophysiology References (2) (APA):

Chalela, J. A., & Kasner, S. E. (2020). *Acute toxic-metabolic encephalopathy in adults*. https://www.uptodate.com/contents/acute-toxic-metabolic-encephalopathy-in-adults#H11070711

Corner, C. (2015). *Encephalopathy*. https://acphospitalist.org/archives/2015/01/coding.htm#:~:text=Toxic%20encephalopathy%20describes%20acute%20mental,of%20toxic%20and%20metabolic%20factors.

Mayo Clinic. (2019). *Urinary tract infection (UTI)*. https://www.mayoclinic.org/diseases-conditions/urinary-tract-infection/symptoms-causes/syc-20353447

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	4.40-5.80	3.69	N/A	
Hgb	13.0-16.5	12.1	N/A	Low count, indication of anemia (Pagana et al., 2019).
Hct	38.0-50.0	35.6	N/A	
Platelets	140-440	162	N/A	
WBC	4.00-12.00	9.00	N/A	
Neutrophils	40.0-68.0%	N/A	N/A	

Lymphocytes	19.0-49.0%	N/A	N/A	
Monocytes	3.0-13.0%	N/A	N/A	
Eosinophils	0.0-8.0%	N/A	N/A	
Bands	0.0-4.0	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 mmol/L	145	N/A	
K+	3.5-5.0 mmol/L	3.3	N/A	
Cl-	98-108	108	N/A	
CO2	23-29	N/A	N/A	
Glucose	70-100 mg/ dL	117	N/A	Increased level due to taking melatonin over 3 months (Pagana et al., 2019).
BUN	8-25 mg/dL	15	N/A	
Creatinine	0.6-1.3 mg/ dL	0.85	N/A	
Albumin	3.5-5.2 gm/ dL	N/A	N/A	
Calcium	8.6-10 mg/dL	9.0	N/A	
Mag	1.5-2.6	N/A	N/A	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	<1.5 mg/dL	N/A	N/A	
Alk Phos	34-104	N/A	N/A	

AST	10-30 units/ L	N/A	N/A	
ALT	10-40	N/A	N/A	
Amylase	20-86	N/A	N/A	
Lipase	20-86	N/A	N/A	
Lactic Acid	0.5-1.0	N/A	N/A	
Troponin	0-0.4 ng/mL	N/A	N/A	
CK-MB	5-25 IU/L	N/A	N/A	
Total CK	22-198 U/L	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	2-3	1.1	N/A	Decreased INR due to severe protein-calorie malnutrition (Pagana et al., 2019).
PT	F: 9.5-11.3 s M: 9.6-11.8 s	13.1	N/A	Increased level due to taking aspirin (Pagana et al., 2019).
PTT	30-40 s	35	N/A	
D-Dimer	≤250 ng/mL	N/A	N/A	
BNP	<125	149	N/A	Increased level due to hypertension (Pagana et al., 2019).
HDL	40-59	N/A	N/A	
LDL	100-129	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	<150	N/A	N/A	
Hgb A1c	4-5.6%	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	Ambery Yellow clear	Dark yellow & cloudy	N/A	Dark and cloudy due to dehydration (Pagana et al., 2019).
pH	5.0-9.0	N/A	N/A	
Specific Gravity	1.001-1.025	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	-0.8 mg/dL	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0.4	N/A	N/A	
RBC	≤2	N/A	N/A	
Leukoesterase	Negative	N/A	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	7.35-7.45	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	(-) <10,000mL (+) >100,000mL	Results pending.	Results pending.	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Normal upper respiratory tract	N/A	N/A	
Stool Culture	Normal intestine flora	N/A	N/A	

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): No diagnosis imaging was ordered for this patient.

Diagnostic Test Correlation (5 points): No diagnosis imaging was ordered for this patient.

Diagnostic Test Reference (APA): N/A; no diagnosis imaging was ordered for this patient.

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

Home Medications (5 required)

Brand/Generic	Citalopram (Celexa)	Donepezil (Aricept)	Aspirin (Chewable Aspirin)	Melatonin (pineal hormone)	Memantine (Namenda)
Dose	10mg	10mg	81 mg	3mg	5 mg

Frequency	Daily	Nightly	Daily	Nightly	2x Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	SSRI	Cholinergic	NSAID	Sedative	NMDA receptor antagonist
Mechanism of Action	Inhibits the reuptake of serotonin in the CNS.	Improves cholinergic function by making more acetylcholine available.	Produce analgesia and inhibiting production of prostaglandins.	Promotes sleep and possesses antioxidant activity.	Binds to CNS NMDA receptor sites, preventing binding of glutamate, and excitatory neurotransmitter.
Reason Client Taking	To treat mood and anxiety disorders.	To treat dementia.	To relieve mild to moderate pain.	To improve sleep pattern.	To decrease symptoms of dementia/ cognitive decline.
Contraindications (2)	- Bradycardia - Hypokalemia	- Hypersensitivity -Use cautiously when currently taking NSAIDs	-Bleeding disorders - Hypersensitivity	- Hypersensitivity -Pregnancy and lactation	-increases risk of UTI - Hypersensitivity
Side Effects/Adverse Reactions (2)	-Insomnia -Anorexia	-Headache -Nausea	-Dyspepsia -Anemia	-Hypotension -Drowsiness	-Hypertension -Urinary frequency
Nursing Considerations (2)	-Monitor mood changes during therapy. -Assess for suicidal tendencies.	-Administer in the evening just before going to bed. -Do not split, crush, or chew; may increase rate of absorption.	-Use lowest effective dose for shortest period of time. -Administer after meals or with food or an anti-acid to minimize gastric irriation.	-Assess sleep patterns throughout therapy. -Administer at bedtime as directed.	-Dose increases should occur no more frequently than weekly. -May be administered without regard to food.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor electrolytes (potassium and magnesium).	May cause anemia, monitor blood levels.	Monitor PT, hct, hepatic function, serum salicylate, and uric acid.	Monitor blood glucose, coagulation panel, hormone panel, and lipid panel	May cause anemia, monitor blood levels.
Client Teaching	-Caution pt.	-Inform pt. and	-Take with a	- Instruct pt. to	-Caution pt.

needs (2)	to change position slowly to minimize dizziness. -Advise pt., family, caregivers to look for suicidality.	family that it may take weeks before improvement in baseline behavior is observed. -Emphasize the importance of follow-up exams to monitor progress.	full glass of water and to remain in an upright position for 15-30min after administration. -Advise pt. to report tinnitus; unusual bleeding of gums; bruising; black, tarry stools; or fever lasting longer than 3 days.	take at bedtime as directed. -Causes drowsiness. Caution pt. to avoid activities requiring alertness until response to medication is known.	and caregiver that medication may cause dizziness. -Teach pt. and caregivers that improvement in cognitive functioning may take months; degenerative process is not reversed.

Hospital Medications (5 required)

Brand/Generic	Potassium phosphate (monobasic)	Levothyroxine sodium (Synthroid)	Ondansetron (Zofran)	Hydralazine (Apresoline)	Thiamine (vitamin B-1)
Dose	500 mg	38 mcg	4 mg	10 mg	1oo mg
Frequency	4x daily with meals & nightly	IV	IV	IV	IV
Route	G-tube	Daily	Once PRN	Every 6 hrs.	Daily
Classification	Anti-urolithic	Hormones	Antiemetic	Antihypertensive	Vitamins
Mechanism of Action	Serves as a buffer for the excretion of hydrogen ions by the kidney.	Replacement of or supplementation of thyroid hormones.	Blocks the effects of serotonin at 5-HT3 – receptor sites.	Direct-acting peripheral arteriolar vasodilator.	Required for carbohydrate metabolism.
Reason Client Taking	For growth and repair of cells and tissues.	To restore hormonal balance.	To decrease incidence of nausea and vomiting following surgery.	To lower BP.	To treat or prevent vitamin B1 deficiency.

Contraindications (2)	-Hyperkalemia -Hypocalcemia	-Hyperthyroidism -Hypersensitivity	-Congenital long QT syndrome -Hypersensitivity	-Hypersensitivity -Products containing tartrazine should be avoided in pts. with known tolerance.	-Hypersensitivity -Alcohol intolerance
Side Effects/Adverse Reactions (2)	-Confusion -Diarrhea	-Insomnia -Weight loss	-Dry mouth -Drowsiness	-Tachycardia -Sodium retention	-Restlessness -Vasodilation
Nursing Considerations (2)	-Too rapid or bolus IV administration of potassium has resulted in fatalities. -Do not administer IM.	-Shake well to dissolve completely. -Administer solution immediately after preparation; discard unused portion.	-Administer undiluted immediately before induction of an anesthesia. -Administer over at least 30 sec and preferably over 2-5 min.	-May be administered concurrently with diuretics or beta blockers to permit lower doses and minimize side effects. -Administer undiluted. Use solution as quickly as possible after drawing through needle into syringe.	-Assess for signs and symptoms of thiamine deficiency. -Assess pt.'s nutritional status.
Key Nursing Assessment(s)/Lab (s) Prior to Administration	Monitor serum phosphate, potassium, and calcium levels. Monitor renal function and urinary pH.	Monitor thyroid function, blood and urine glucose.	Monitor ECG, bilirubin, AST and ALT levels.	Monitor CBC, electrolytes, and ANA titer.	Monitor serum theophylline, uric acid, and urobilinogen concentrations.
Client Teaching needs (2)	-Advise pt. of the importance of maintaining a high fluid intake to prevent kidney stones.	-Instruct pt. to take medication as directed at the same time each day. -Explain to pt. that medication does not cure hypothyroidis	Instruct pt. to take medication as directed. -Advise pt. to notify healthcare provider immediately if symptoms of	-Encourage pt. to comply with additional interventions for hypertension. -Pt. should weigh themselves twice weekly	-Encourage pt. to comply with dietary recommendations of healthcare provider. -Teach pt. that foods high in thiamine include cereals,

	-Instruct pt. to report diarrhea, weakness, fatigue, muscle cramps, or tremors promptly.	m.	irregular heartbeat or involuntary of eyes, face, or limbs occur.	and assess feet and ankles for fluid retention.	meats, and fresh vegetables; loss is variable during cooking.

Medications Reference (APA):

2019 Nurse's Drug Handbook (2019). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Appears inattentive and disoriented; slightly distress; looks her age; clean; Appears frail and lethargic.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	 Skin is within the patient's norm Fair skin; warm & dry; She is not diaphoretic. Temperature is within the average range. There is good skin turgor. No rashes, bruises, wounds, or scars. No peripheral edema is noted **Braden Score:** 10
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head & neck are symmetrical; trachea is midline without deviation; Auricle is moist and pink without lesions; sclera is white; conjunctiva is clear; lids are moist & pink; septum is midline; sinuses are nontender; dentition is good
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):**	Normal rate; S1 & S2 without murmurs, gallops, or rubs; pulses are 2+ throughout; capillary refill less than 3 seconds.

Peripheral Pulses: **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular even & nonlabored, symmetrical, no wheezes or crackles noted.
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 ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Does not eat a regular balanced diet at home. Has very poor nutrition. Currently, pt. is NPO. H: 5'6" W: 88 lbs. Bowel sounds are normoactive. Last BM: One day ago. Abdomen is soft, distended, and nontender. No pain, no masses. No incisions, scars, drains, or wounds.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☒ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Dark Yellow Cloudy and has a slight odor. Urine output is 200mL. Genitals appear pink and dry.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐**	CV II-XII are intact; Reflexes are 1-2+ throughout; Poor coordination; No pain, paralysis; No paresthesia; Not pallor; Warm temperature No swelling or increased pressure; Need supportive devices: wheelchair; Needs assistance with her ADLs.

Fall Risk: Y ☒ N☐ **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk ☒**	**Fall Score:** 32
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Alert, but confused and oriented x1; Gets agitates; Speech is somewhat articulate; Normal sensation; 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):**	Married with one son. Both her husband and son are her support system. Her husband is involved with her care. Ego integrity, wisdom & the ability to participate in life with a sense of satisfaction.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0945	86	190/93	18	98.7°F	99%
1254	98	140/62	18	97.9°F	99%

Vital Sign Trends:

Patient's vital signs are within her normal range. She remains hypertensive.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0945	Numeric	Abdomen	6	Sharp	Administered Tylenol

1254	Numeric	N/A	0	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	22
Location of IV:	Right lower arm; 0.45 NS @ 100 mL/hr.
Date on IV:	6/23
Patency of IV:	Infusing
Signs of erythema, drainage, etc.:	No signs of erythema or drainage.
IV dressing assessment:	Clean, dry, intact, and inclusive.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Urine – 350 mL IV – 100mL/hr	Urine – 200 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was cooperative but was very hungry. Patient is not allowed to eat because she is NPO due to surgery.

Procedures/testing done: Urine and blood test

Complaints/Issues: Patient complaints that she is hungry. (She is NPO).

Vital signs (stable/unstable): Vital signs are stable, but BP remains elevated.

Tolerating diet, activity, etc.: Tolerates diet and activity.

Physician notifications: Poor nutrition and failure to thrive.

Future plans for patient: Will place patient on a mechanical soft diet and see how she does. Evaluate for PEG due to patient's poor nutrition. Patient may also need a PEG to take her medication.

Discharge Planning (2 points)

Discharge location: To a nursing home long-term care, possibly with hospice.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Wheelchair

Follow up plan: There are no follow-up plans indicated.

Education needs: Acute confusion education; Fall injury risk education; & Skin injury risk education.

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

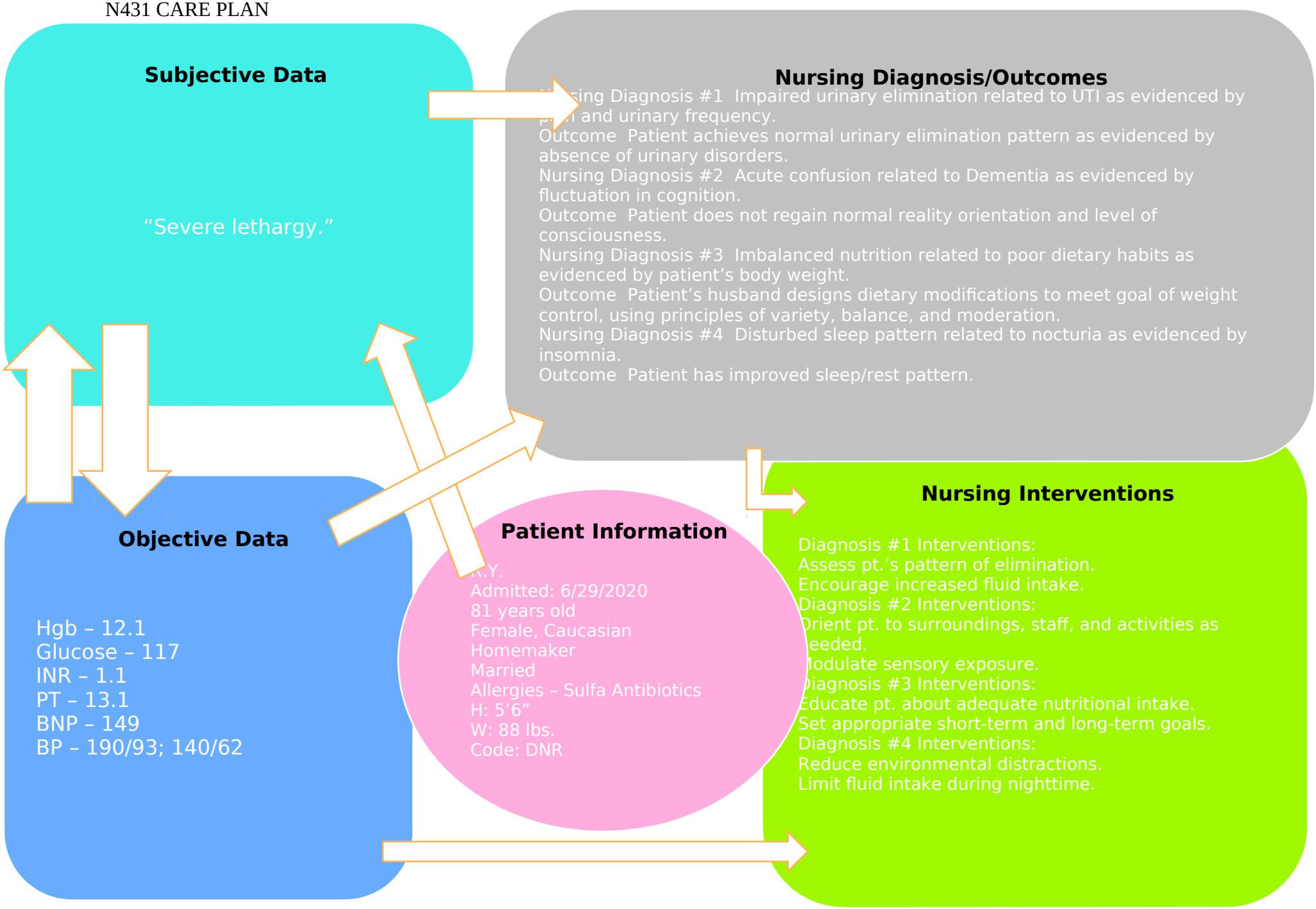
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired urinary elimination related to UTI as evidenced by pain and urinary frequency.	The patient complaints of frequent and painful urination.	1. Assess patient's pattern of elimination. 2. Encourage increased fluid intake.	Patient achieves normal urinary elimination pattern as evidenced by absence of urinary disorders.
2. Acute confusion related to Dementia as evidenced by fluctuation in cognition.	The patient has Parkinson's Disease dementia.	1. Orient pt. to surroundings, staff, necessary activities as needed. 2. Modulate sensory exposure. Provide a calm environment; eliminate extraneous	Patient does not regain normal reality orientation and level of consciousness.

		noise and stimuli.	
3. Imbalanced nutrition related to poor dietary habits as evidenced by patient's body weight.	The patient has severe protein-calorie malnutrition and weighs 88 lbs.	1. Educate pt. about adequate nutritional intake. 2. Set appropriate short-term and long-term goals.	Patient's husband designs dietary modifications to meet goal of weight control, using principles of variety, balance, and moderation.
4. Disturbed sleep pattern related to nocturia as evidenced by insomnia.	Patient needs to drink melatonin at night and has urinary frequency.	1. Reduce environmental distractions such as noise and light. 2. Limit fluid intake during nighttime.	Patient has improved sleep/rest pattern.

Other References (APA):

Swearingen P., & Wright, J. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Concept Map (20 Points):


Subjective Data
"Severe lethargy."
Nursing Diagnosis/Outcomes
sing Diagnosis #1 Impaired urinary elimination related to UTI as evidenced by
and urinary frequency.
Outcome Patient achieves normal urinary elimination pattern as evidenced by absence of urinary disorders.
Nursing Diagnosis #2 Acute confusion related to Dementia as evidenced by fluctuation in cognition.
Outcome Patient does not regain normal reality orientation and level of consciousness.
Nursing Diagnosis #3 Imbalanced nutrition related to poor dietary habits as evidenced by patient's body weight.
Outcome Patient's husband designs dietary modifications to meet goal of weight control, using principles of variety, balance, and moderation.
Nursing Diagnosis #4 Disturbed sleep pattern related to nocturia as evidenced by insomnia.
Outcome Patient has improved sleep/rest pattern.
Objective Data
Hgb – 12.1
Glucose – 117
INR – 1.1
PT – 13.1
BNP – 149
BP – 190/93; 140/62
Patient Information
R.Y.
Admitted: 6/29/2020
81 years old
Female, Caucasian
Homemaker
Married
Allergies – Sulfa Antibiotics
H: 5'6"
W: 88 lbs.
Code: DNR
Nursing Interventions
Diagnosis #1 Interventions:
Assess pt.'s pattern of elimination.
Encourage increased fluid intake.
Diagnosis #2 Interventions:
Orient pt. to surroundings, staff, and activities as needed.
Modulate sensory exposure.
Diagnosis #3 Interventions:
Educate pt. about adequate nutritional intake.
Set appropriate short-term and long-term goals.
Diagnosis #4 Interventions:
Reduce environmental distractions.
Limit fluid intake during nighttime.