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**A 71-year-old female with unspecified syncope.**

**Patient: C.O**

**NURSING DIAGNOSIS**

**Risk for fall**

**Related to unspecified syncope.**

**No prior history of syncope, cardiac or neurological issues**



**ASSESSMENT**

**Patient alert and oriented X3**

**Patient lungs sounds were clear bilaterally.**

**Patient S1 and S2 sounds are normal.**

**Document data**

**Patients have no history of syncope.**

**No document prior medical history**

**Pt vitals were in range.**

**BP136/80 P69 RR18 TEMP 97.4**

**Patient schedule to have MRI of the brain to rule out Strokes/TIA**



### **Nursing Intervention**

**Adjust bed in the lowest position.**

**Necessary items within reach of patient.**

**Ensure adequate fluid intake to prevent dehydration.**

**Monitor patient level of consciousness.**

### **EXPECTED OUTCOME**

**No expected Syncope**

**Identifying the cause and treatment to prevent further episodes.**

**No injury**

**Patient will describe her intention to maintain safety precaution.**

**Educate patient to change position slowly.**



### **EVALUATION**

**Patient goal was not met because I left before discharge.**