

Eminta Sunny
Nursing Concept Map
03/31/2023

Past Medical History

- LUNG CANCER
- CIRRHOSIS
- HYPOTHYROIDISM

Allergies:

SEVERE:

- PENICILLIN

MODERATE:

- HEPARIN
- IBUPROFEN
- CODEINE

CURRENT MEDICATIONS:

- BROAD-SPECTRUM ANTIBIOTICS IV
- FOLIC ACID
- FLUIDS: 0.9% SALINE
- LEVOTHYROXINE

Physical Assessment

GENERAL: SITTING UP IN SEMI-FOWLER POSITION. THE PATIENT SEEMS FRAIL.

NEUROLOGICAL: A&O 2(PERSON AND TIME). CONFUSED AT TIMES; SPEECH CLEAR.

CARDIAC: S1-S2, NORMAL SINUS RHYTHM

RESPIRATORY: PULMONARY EFFORT NORMAL. BILATERAL CLEAR BREATH SOUNDS

GI: DIET: GENERAL DIET, DIETARY NUTRITIONAL SUPPLEMENT. ABD SOFT, NONTENDER. BS SOUNDS ACTIVE IN 4 QUAD.

ELIMINATION: URINARY INCONTINENCE

PSYC/SOCIAL: SMOKES DAILY

ADLS: FALL PRECAUTION, CONSTANT OBSERVATION, FOUR WHEEL WALKER

Vital Signs :

TEMP: 97.1

HR: 79

RESP: 18

B/P: 160/75

SPO2: 96%

INITAL Lab Values:

CBC:

- LEUKOCYTOSIS: 30,000/mm3
- NEUTROPHILS: 25,00/MM3
- LACTIC ACID: 4.3 mmol/L
- SERUM PROCALCITONIN: 1.0 ng/mL

Patient History :

PATIENT INITIAL: R. L (FEMALE)

AGE: 77-YEARS OLD

AOD: 03/20/2023

AHCD: FULL CODE

Medical Diagnosis:

SEPSIS

Nursing Diagnosis :

ACUTE CONFUSION RELATED TO SEPSIS AS EVIDENCED BY DISORIENTATION.

Expected outcome:
 PATIENT WILL HAVE DECREASED CONFUSION BY DISCHARGE.

Subjective

PATIENT AFTER A NAP FREQNELY ASK "IS BREAKFAST HERE YET?" AFTER SHE ALREADY HAD BREAKFAST.

Objective

- FREQUENT MOOD CHANGES.
- NOT ABLE TO CONCENTRATE
- DECREASE LEVEL OF CONSCIOUSNESS

Interventions

- RE-ASSESS ATTENTION SPAN AND NEUROLOGICAL SYSTEM.
- ASSESS DIETARY INTAKE AND NUTRITIONAL STATUS.
- MONITOR I&O/ELIMINATION PATTERN AS ORDERED. ENCOURAGE A MINIMUM OF 30 OUNCES/DAY.
- MONITOR THE ENVIRONMENT FOR HAZARDS AND PROVIDE SAFETY MEASURES.
- ASSIST PATIENTS WITH PHYSICAL CONDITIONING AND HYGIENE AND HEALTH MAINTENANCE.

Evaluation :

THE GOAL WAS NOT MET. THE PATIENT WAS ALERT AND ORIENTED X 2 (PERSON AND PLACE). RE-ASSESS THE PATIENTS NEURO EXAM.

Nursing Diagnosis :

IMPAIRED PHYSICAL MOBILITY RELATED TO ACUTE PAIN, AS EVIDENCED BY VERBALIZED PAIN WHEN MOBILIZING.

Expected outcome:
 THE PATIENT WILL BE ABLE TO PERFORM SELF-CARE ACTIVITIES BOTH INDEPENDENTLY AND SAFELY BY DISCHARGE.

Subjective

PATIENT STATES, "IT HURTS WHEN I CHANGE POSTIONS"

Objective

- WEAKENED ABILITY IN FUNCTIONAL MOBILITY
- FATIGUE
- RANGE LIMITATIONS DURING MOVEMENT

Interventions

- ASSESS THE ORIGIN OF THE LIMITATION OF PHYSICAL MOVEMENT AND MONITOR VITAL SIGNS
- EVALUATE THE ASSISTANCE NEED TO PERFORM ADLS.
- ENSURE THE SAFETY OF THE ENVIRONMENT.
- ASSIST THE PATIENT WITH WALKING, MANEUVERING, AND AMBULATION FROM ONE LOCATION TO ANOTHER.
- PROVIDE BEDSIDE COMMODE

Evaluation :

THE GOAL WAS PARTIALLY MET. THE PATIENT WAS IN PAIN WHY TRANSFERRED TO THE BED COMMODE. THE PATIENT WAS ABLE TO PERFORM HYGIENIC CARE PROPERLY.

Nursing Diagnosis :

RISK FOR INFECTION RELATED TO THE COMPROMISED IMMUNE SYSTEM.

Expected outcome:
 THE PATIENT WILL REMAIN FREE FROM ANY NOSOCMIAL INFECTION WHILE IN THE HOSPITAL.

Subjective

PATIENT STATES, "I FEEL WEAK"

Objective

- BP ELEVATED
- ELEVATED BLOOD WORK
- PATIENT WIPES BACK TO FRONT

Interventions

- ASSESS THE VITAL SIGNS.
- ASSESS SITES OF INVASIVE DEVICES.
- MONITOR LABORATORY STUDIES.
- PERFORM HANDWASHING AND HAND HYGIENE.
- HAVE THE PATIENT ON OBSERVATION OR NEAR THE NURSES' STATION.
- PATIENT EDUCATION ON THE IMPORTANCE OF PROPER SKIN HYGIENE AND HYGIENE CARE
- ADMINISTER ANTIBIOTICS AS ORDERED.

Evaluation :

THE PATIENT WAS GIVEN EDUCATION ON HOW TO PERFORM HYGIENIC CARE. THE GOAL WAS MET. THE PATIENT WAS ABLE TO PERFORM HYGIENE CARE. SKIN ASSESSMENT WAS COMPLETE. THE PATIENT WAS FREE OF HOSPITAL-ASSOCIATED INFECTIONS AT THE END OF THE SHIFT.