

Eminta Sunny
Health Assessment
Patient Nursing Assessment
04-21-2023

Comprehensive Nursing Assessment

Patient Information:

Patient's Name: A.R
Age: 77 years old
Gender: Female
Date of Birth: 07-23-1945
Date of Admission: 03-20-2023

Admitting Diagnoses: Sepsis

Comprehensive Nursing Assessment Done: 03-21-2023

Source of History: The daughter (name unknown)
A.R. reports pain and seems confused.

History of Present Illness:

The daughter called EMS on March 20th, 2023, stating the patient was confused and had worsening abdominal pain over the past day. The daughter confirmed the patient had been more malaise and action more lethargic. The patient presented with fever, confusion, and back pain.

Past History: The patient has extensive malignancy history, including liver cirrhosis with hepatic mass in 2014. The patient has a history of lung cancer. The patient was diagnosed with hypothyroidism in 2008.

Allergy: Severe anaphylactic reaction to penicillin. Moderate allergic reaction to heparin, ibuprofen, and codeine.

Medications:

Name of Medication	Dose	Route	Frequency	Reason
Acetaminophen	650 mg. 10mg/ml	Infusion	Every four hours	Acute Pain
Folic Acid	1 mg	Tablet	Once every AM	Prevent folic acid deficiency
Levothyroxine	50 mcg	Tablet	Once every AM	Hypothyroidism
Metronidazole	500 mg	Tablet	Three times a day	Antibiotic
Pantoprazole	40 mg	Tablet	Once every AM	Lower stomach acid

Family History: A.R. is the only daughter; her parents are both deceased due to old age. Married and has two daughters. Currently lives with daughter—no family history of chronic diseases.

Health Patterns:

Self-concept: N/A

Value-belief: Roman Catholic

Habits: Denies use of the illicit drug. No alcohol. Cigarettes: Smokes 2 PPD for an unknown time, never tried to quit.

Exercise: No sustained physical exercise. Mobility aids present; walker.

Diet: General diet. Increased supplements

Sleep-rest: No disturbance in sleep, 8-9 hours throughout the night. Naps during AM for 1-2 hours. No sleeping aid is needed.

Relationship: Previously married. Spouse deceased, Date unknown

Coping-stress-response: N/A

Review of systems:

General: Reports abdominal pain, unable to move in bed. Reports more tiredness and illness. Malaise.

Head, Eyes, Ears, Throat: Patient reports difficulty with hearing. No earaches, no discharge. No problem with vision or double vision. No mouth pain, bleeding gums, toothaches, sores, or lesions. Reports no frequent or severe headaches, no head injury, dizziness, syncope, or vertigo.

Neck: No pain, limitation, lumps, or swollen glands.

Breast: No pain, lump, nipple discharge, rash, swelling, or trauma. Does not do breast self-examination.

Respiratory: History of lung cancer; no chest pain with breathing; no wheezing. Smokes cigarettes 2 PPD for unknown years.

Cardiovascular: Patient reports dyspnea with exertion. No chest pain, palpitation, cyanosis.

Gastrointestinal: Appetite good with no recent change. History of liver cirrhosis and mass in 2014. Pain was reported during movement. Bowel movement 3/week, soft, brown; no rectal bleeding or pain. No use of vitamins, antacids, or laxatives.

Urinary: Patient reports urinary incontinence. The urine color is yellow. No history of kidney disease.

Genital: No menstrual cycle. No vaginal itching.

Musculoskeletal: No history of arthritis or gout. Joint pain is present, and limitations of joints. No muscle pain or weakness.

Neurologic: No seizure disorder, stroke, or fainting. Weakness and tremor problems with coordination. No difficulty in talking or swallowing. Not aware of memory problem

Hematologic: No bleeding problems in the skin: no excessive bruising. Not aware of exposure to toxins

Endocrine: Hypothyroidism present. No increased hunger, thirst, or urination; reports cold intolerance.

Physical Exam:

General Survey: A.R. is a 77 – year- old Caucasian female, not currently under the influence of alcohol or other drugs. Unable to ambulate without difficulty. She appears to be in distress. Alert and Oriented to person and place. Restlessness.

HEENT: Normocephalic, no lesions, lumps, scaling parasites, or tenderness. Face: symmetric, no weakness, no involuntary movements. Wrinkles and dry skin are present.

Visual acuity and field: decreased due to age. Arcus senilis is present in both eyes. EOM is intact, with no nystagmus. No ptosis, lid lag, discharge, or crusting. Corneal light reflexes are symmetric, with no strabismus.

No deformities or tenderness to palpation in the nose. Nares present. Mucosa pink; no lesions. Septum midline; no perforation.

Ears: No mass, lesions, scaling, discharge, or tenderness to palpation. Canal clear. Whispered words not heard bilaterally. Normal voice hearing decreased.

Mucosa and gingivae pink; no lesions or bleeding. No teeth, no dentures present. Tongue symmetric, protruding midline, no tremor. Gag reflex present.

Neck and Lymph nodes: Neck supple with full ROM. Symmetric; no masses, tenderness, or lymphadenopathy. Trachea midline.

Thorax and Lungs: Pulmonary effort normal on room air. Chest expansion symmetric. Basilar rales were heard in the lungs during the auscultation but disappeared after the patient was instructed to cough—bilateral clear breath sounds on auscultation. No cyanosis

Cardiovascular: S1 and S2 regular. Normal sinus rhythm. No thrills present. No edema present.

Breasts: No abnormalities present. Symmetric; no retraction, discharge, or lesions. No masses or tenderness.

Abdomen: Flat, symmetric. Increased fat deposition over the abdomen and hip area. Skin wrinkled, no lesions—weakened abdominal muscles. No hernias were present. No tenderness is present—no enlargements of the spleen.

Genitalia: N/A

Extremities/Peripheral Vascular: The patient is on fall precaution. Fall Risk Assessment: 85. No Edema or varicosities present. No calf tenderness. Crepitation of joints present. No redness, no cyanosis. All peripheral pulses present, 3+ and equal bilaterally.

Musculoskeletal: Postural changes present. Decrease in height, shortening of the trunk with longer long extremities. Kyphosis present. Slight flexion of hips and knees. Presence of bony prominences. Full ROM; movements slow. Muscle strength- able to maintain flexion against resistance and without tenderness.

Neurologic:

Mental Status: Alert and Oriented to person and place. Confusion to time. Able to communicate. Speech is slow but intact. The patient is confused; behavior is inappropriate at times.

Cranial Nerves: N/A

Cerebellar: Fall precaution. More Fall Scale: 85. Decreased rapid alter movements, slow and not smooth. Patients have difficulty walking without assistance.

Sensory: Decreased tactile sensation. Position test decreased.

Reflexes: Senile tremors present. The grip strength is intact. DTR is intact and less brisk. Plantar reflex absent.

Laboratory Data:

TEST	PATIENT RESULT	NORMAL RANGE
CBC:		
• Hgb	8.7gm/dL	14.0-18.0
• Hct	27.8%	42.0-52.0
• WBC	3.73 K/mcL	4.8-10.8
• RBC	2.96 M/mcl	4.7-6.1
Chemistries		
• Na	140 mEq/L	136-145
• K	3.6 mEq/L	3.5-5.1
• Cl	111 mEq/L	98-107
• Ca	7.6 mg/dL	8.6-10.2
• BUN	9.0 mg/dL	8-23
• Creatinine	<0.47 mg/dL	0.8-1.3

Information Gathered After initial comprehensive Nursing Assessment:

- **03/25/2023: IR guided drainage of right psoas abscess**
- **03/31/2025: Surgical swab Culture: Growth of rare anaerobic gram-positive rods resembling Robinsoiella peoriensis (Information gathered after initial comprehensive nursing assessment which was done 03/21/2023)**

Nursing Assessment/Plan:

- **Acute confusion related to sepsis as evidenced by disorientation.**
- **Impaired physical mobility related to acute pain as evidenced by verbalizing pain when mobilizing.**

Interventions:

Acute Confusion Intervention	Impaired physical mobility intervention
<ul style="list-style-type: none"> • Reassess attention span and neurological system. • Assess dietary intake and nutritional status. • Monitor lab work as ordered by MD. • Monitor input and out elimination pattern as ordered. Encourage a minimum of 30 ounces a day. • Monitor the environment for hazards and provide safety measures, such as bedside commodes, bed alarm, placing the bed in the slowest position, and bed locked. 	<ul style="list-style-type: none"> • Assess the origin of the limitation of physical movements and monitor vital signs. • Evaluate the assistance needed 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. • Patient education on safety environments at home to family, such as having light hallways, removing throw rugs, and use of

<ul style="list-style-type: none">• Assist patients with physical conditioning and hygiene, and health maintenance.	shower assistance bar.
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Evaluation:

- **Confusion Evaluation: The goal was not met; the patient was alert and oriented x2 (person and place). Re-assesses the patient's neurological exam.**
- **Physically mobility Evaluation: The goal was partially met; the patient was in pain while transferred to the bed commode. The patient was able to perform hygiene care properly.**