Analysis of the Geriatric Client

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Client Profile

Overview of Client

While at Noble's Pond, I took care of J.P. She was an 81 year old female who was admitted with coronary artery disease on July 7th, 2009. She also had several other medical diagnoses, consisting of: type II diabetes mellitus (uncomplicated), hypertension, hypothyroidism, hypercholesterolemia, anxiety, and irritable bowel syndrome. Her CODE status was DNRCC-Arrest, meaning she requested DNR comfort in the event if she went into cardiac or respiratory arrest. She was only allergic to sulfa. Her activity was a full-weight bearing status with assistance using her walker or wheelchair. She was on a low-sodium diet. J.P. had a Braden Score of 19, low fall risk, Katz Index of IADL of 4, and a score of 8 on the Geriatric Depression Scale. J.P. had some other definitive complaints besides her admission diagnosis, primarily about constant stabbing pain in her abdomen.

Admission Medical Diagnosis

Coronary artery disease. In coronary artery disease (CAD), atherosclerosis develops in the coronary arteries. This causes a blockage or narrowing of the arteries, which reduces blood flow to the area of the heart in which there is a defected artery. If the remaining blood flow is inadequate to meet the oxygen demands of the heart, then the area will become ischemic and injured. With ischemia and injury to the heart, the heart may fail to pump sufficient blood supply to other organs or tissues in the body, which overtime could lead to heart failure (Black, & Hawks, 2009). Coronary artery disease can occur because of many different factors.

Some of nonmodifiable risk factors of CAD include hereditary, increased age, and gender. J.P. has had 2 other siblings who passed away from heart failure. People who have had immediate family with heart disease are at a higher risk for developing CAD. This increased risk is related to genetic predisposition to hypertension, elevated lipid levels, diabetes, and obesity

(Black, & Hawks, 2009). J.P. also had 3 other siblings who had diabetes. J.P. had hypertension, was obese, diagnosed with high lipid levels, and had diabetes. CAD rates in women are 2 to 3 times higher after the development of menopause than women the same age who haven't developed menopause. All of these factors contribute to her CAD. Modifiable risk factors of CAD include smoking, hypertension, elevated cholesterol levels, physical inactivity, obesity, and diabetes (Black, & Hawks, 2009). J.P. has all of the modifiable risk factors except for smoking. For CAD manifestations to develop there must be a critical deficit in the blood supply to the heart in proportion to the demands for oxygen and nutrients, meaning a supply-and-demand imbalance must exist. Therefore the disease by itself does not necessarily produce subjective clinical manifestations (Black, & Hawks, 2009).

Primary goals for CAD include reducing risk factors and restoring blood supply to the heart. It is important to educate and encourage the client to reduce their risks by lowering dietary intake of fats and cholesterol, exercising, controlling diabetes, controlling hypertension, and keeping body weight near the ideal levels. It is also important to teach stress-reduction techniques such as progressive muscle relaxation and guided imagery (Black, & Hawks, 2009). It is important to monitor blood pressure levels in people with hypertension, and Hba1c levels in people with diabetes. In the event that the client would need to get surgery, her blood would need to be typed and cross-matched in case an emergency coronary artery bypass graft surgery would need to be performed. Antiplatelet medications, such as aspirin, and anticoagulants, such as heparin, can be used to prevent occlusion and restore blood flow. Other medications help restore blood flow include calcium-channel blockers or nitrates that will help reduce coronary spasms (Black, & Hawks, 2009). The client wass currently not on any of these medications. Although she was managing her other underlying problems, such as hypertension, diabetes, hypercholesterolemia, hypothyroidism, and anxiety, that contribute to CAD.

Other Medical Diagnoses

Type II Diabetes Mellitus. Diabetes is a chronic, progressive disease that is characterized by the body's inability to metabolize carbohydrates, fats, and proteins, leading to an increased level of glucose in the blood. Diabetes can be classified into different forms. J.P. has type II diabetes. Type II diabetes, also known as non-insulin-dependent diabetes, results from insulin secretory defect and insulin resistance, usually associated with obesity (Black, & Hawks, 2009). This can occur due to a desensitization of beta-cell response to hyperglycemia, but can be reversed by bringing glucose levels down to a normal level. Type II diabetes can also result due to insulin resistance, or when the activity of insulin is resistant in both the liver and peripheral tissues (Black, & Hawks, 2009). The major signs and symptoms of this disease are polyuria, or an increased frequency to urinate, polydipsia, increased thirst, and polyphagia, increased hunger (Black, & Hawks, 2009). This disease is most often asymptomatic and is diagnosed by lab tests, and testing the blood for glucose. J.P. was currently taking Glimepiride, Metformin, and Novolin R to help with managing her diabetes.

Hypertension. Blood pressure is the tension or pressure exerted by blood against arterial walls. Hypertension is an excess amount of blood pressure in the arterial portion of systemic circulation. Hypertension causes an increase in workload on the heart, altering the structure of the vessels, and affects sensitive body tissues such as the kidneys, eyes, and central nervous system (Lemone, & Burke, 2004). Nonmodifiable factors contributing to hypertension include family history, age, and race. Some modifiable factors that contribute to hypertension include high sodium intake, low potassium intake, low calcium intake, low magnesium intake, obesity, excess alcohol consumption, smoking, and glucose intolerance (Lemone, & Burke, 2004). Early stages of hypertension are asymptomatic and normally marked only by an elevated blood pressure reading. Symptoms will result from the organ that is being damaged over time and may

include headache, nocturia, confusion, nausea, vomiting, and visual disturbances (Lemone, & Burke, 2004). Hypertension can be managed by living a healthier lifestyle and using medications like beta-adrenergic blockers, ACE inhibitors, calcium channel blockers, and diuretics. J.P. was currently taking Furosemide to help with her hypertension. J.P. was also on a low sodium diet to decrease any retention of fluid and to prevent her blood pressure from rising.

Hypothyroidism. Hypothyroidism results from a deficiency of thyroid hormone. This causes a decreased amount of oxygen to tissues, slows down the body metabolism, and decreases heat production in the body. A thyroid dysfunction may result from under activity of the thyroid gland or secondary to anterior pituitary dysfunction (Black & Hawks, 2009). For the thyroid gland to function properly it requires iodine to synthesize and secrete thyroid hormones. Thyroid hormone production depends on the secretion of TSH from the anterior pituitary and the ingestion of adequate protein and iodine. Insufficient amounts of thyroid hormone cause a decrease in lipid metabolism. This causes an increase in cholesterol and triglyceride levels, which can lead to arteriosclerosis and, J.P.'s admission diagnosis, coronary artery disease. It also plays a role in production of red blood cells and clients with hypothyroidism often show signs of anemia (Black & Hawks, 2009). J.P. did not have any thyroid lab results and was currently not taking any medication pertaining to her hypothyroidism.

Hypercholesterolemia. A lipid disorder, like hypercholesterolemia, occurs when there are too many fatty substances in the blood. Hypercholesterolemia occurs when the levels of cholesterol are elevated in the blood (UMMC, 2011). Cholesterol is a natural component of all cells in the body and is produced by the body with the all the amount of cholesterol you need. Excess cholesterol is added to the body by foods that are consumed and can cause harmful effects and plaque buildup in the arteries, which narrows the amount of blood flowing through the arteries (UMMC, 2011). Hypercholesterolemia increases a person's risk for other disorders

like atherosclerosis, hypertension, heart disease, and stroke. Normally there will be no signs and symptoms of high cholesterol. The only way to diagnose hypercholesterolemia is by getting a blood test to check the levels of cholesterol in your blood (UMMC, 2011). Healthy lifestyle changes and medications can be used to treat hypercholesterolemia. J.P. was currently taking Colestid and Simvastatin for her hypercholesterolemia and her cholesterol levels were currently within normal limits. This indicated that her lipid disorder was being managed and kept under control.

Anxiety. Anxiety occurs in many older adults. It is a feeling of discomfort, uneasiness, apprehension, or distress. Most people experience anxiety when they come across new life stressors or unknown situations (Tabloski, 2009). Some manifestations of anxiety include palpitations, chest pain, tachycardia, tachypnea, elevated blood pressure, and development of fear. With anxiety developing in a client, it is important for them to learn different skills to help cope and manage their stressors (Tabloski, 2009). Learning appropriate coping skills to help anxiety will also help the client to develop any further psychological disorders such as depression. Anxiety can be effectively treated with the use of anti-anxiety medications, psychotherapy, education, and hypnotism (Tabloski, 2009). J.P. was currently taking Effexor and Ativan for her anxiety.

Irritable bowel syndrome. This is non-life threatening, functional disorder of motility in the intestine. Irritable bowel syndrome (IBS) is thought to occur because of an abnormal communication between the enteric nervous system and central nervous system. Factors that contribute to the development of IBS include altered GI motility, visceral hypersensitivity, psychosocial factors, and neurotransmitter imbalances. Clinical manifestations of IBS can include: crampy abdominal pain, constipation, diarrhea, hypersecretion of colonic mucus, dyspeptic manifestation (flatulence, nausea, anorexia), and some level of anxiety or depression.

(Black, & Hawks, 2009). It's important to educate the client about consuming a diet with high-fiber, low-fat, and to avoid problematic foods. Reducing stress, engaging in regular exercise, and getting 8 hours of sleep per night will also help to restore the client's health. Antidiarrheals, antispasmodics, and antidepressants are helpful in managing IBS (Black, & Hawks, 2009). J.P. was currently taking Loperamide, Simethicone, and Bentyl, to help with her IBS. She was also taking Lexapro to control her depression that may be caused by this disorder.

Surgery History

J.P. had cataract surgery, bilateral laser eye surgery, and cholecystectomy prior to her admission at Noble's Pond but has not had any surgeries since her admission.

Assessment Data

Health Perception/Health Management

Subjective data. J.P. denied she smoked, or ever has used tobacco or other drugs. J.P. denied the use of alcohol. She stated she exercised on a regular basis because she "is always walking back and forth to go to the bathroom so often, but other than that I don't get much exercise." J.P. used her walker and wheelchair for assistance when getting out of bed and kept her side rails up when she was in the bed. She explained how she always tried to stay safe to the best of her ability because she does not want to fall or injure herself.

Objective data. The client was very alert and answered questions very well in detail. According to the Hendrich II Fall Risk Model, J.P. scored a 1 on the Get Up & Go Test. This indicated that J.P. had a low risk for falling and was able to push herself up successfully in one attempt. J.P. also took the Kats Index of Independence in Activities of Daily Living (IADL). She scored a 4 out 6. This indicated that she was mostly independent. She needed someone to depend on and assist her with bathing. She was incontinent of her bladder meaning she had to depend on

some kind of assistance. She was independent with dressing, toileting, transferring, and feeding herself.

Indirect data. The client's chart listed a personal history of hypertension, sinus trouble, hay fever, cataract surgery, bilateral laser eye surgery, anemia, diabetic (for 40 years), gastric paresis, kidney stones, cholecystectomy, patella fracture, left carotid stenosis, left hip fracture from falling. The client's chart also listed that she is up to date with all of her immunizations and recently received the Mantoux and influenza immunization. In the chart her orders indicated she needed to have 1 side rail up bilaterally as enabler every shift, night, days, and evenings.

Interpretation. Possible nursing diagnoses: Ineffective Activity Planning.

Nutritional-Metabolic

Subjective data. J.P. stated that she had always had a very good appetite and could feed herself. She denied any feelings of nausea or vomiting.

Objective data. Her skin was warm, pink, dry, and intact with no edema. Her skin turgor was less than 3 seconds. She had a brisk capillary refill on all fingers and toes that was less than 3 seconds. Her nails and hair both looked clean and within normal limits. She had no pruritis, bruising, or lesions on her skin. Her temperature, taken orally, was 98.4 degree Fahrenheit. She had pink and moist mucous membranes with no lesions or ulcerations in the mouth. She had no dentures or partials. According to the Braden Risk Assessment Scale, the client received a total score of 19. This showed that J.P. had a low risk of developing a pressure ulcer.

Indirect data. In her chart it said she was 5 feet tall and weighed 163 pounds. Her chart stated she could feed herself and at meal times did not need assistance when eating or drinking. Her orders indicated she needed: a skin assessment every week on Wednesdays; pressure reduction mattress to bed to maintain skin integrity every shift 10pm, 6am, 2 pm; elevate heels

off bed at all times every shift 10pm, 6am, 2pm; encourage resident to turn and reposition every 2 hours every shift 10pm, 6am, 2pm; and may see the house podiatrist as needed.

Interpretation. Due to her being overweight and diabetic for 40 years she could have a risk for impaired skin integrity, so it is imperative that her skin is assessed and prevented from developing pressure ulcers. Even though her Braden Score is very good, it is important to prevent any pressure ulcer formation in elderly client with diabetes, because their body has a decreased ability to heal wounds.

Elimination

Subjective data. J.P. stated that her stool had been hard, formed, had about one bowel movement a week, and had been constipated for a few weeks. She said she "has incontinence and it is all the time, I go to the bathroom all the time to urinate." She denied any dysuria or hematuria, but explained that she frequently had to urinate many times throughout the day. J.P. said her incontinence was more present during the day than at night, but did have to get up a few times during the night too. J.P. said "I do wear incontinence briefs for protection, but I don't like the feeling of going in them, so I tend to get up all the time and empty my bladder." Client stated she constantly always had pain in her abdomen. When assessing her abdomen she exclaimed, "The pain in my stomach is so severe, I am really worried. Please be careful when touching my stomach. It hurts so much. The doctor said that the pain in my stomach is due to a ruptured hernia or an ulcer and said that I will be getting an x-ray soon to look at it." She made it clear she was very nervous about me touching her stomach because she was in pain.

Objective data. Her abdomen was soft, rounded, and had hypoactive bowel sounds in all 4 quadrants. She had pain in her stomach rated 10 out of 10, and was nervous when I was palpating that her pain would increase. Client showed grimacing when palpating stomach.

Indirect data. No Indirect data was obtained at this time.

Interpretation. Acute pain, Anxiety, Constipation, Urge Incontinence.

Activity-Exercise

Subjective data. Client stated she was independent with eating, dressing, bed mobility, transferring, and ambulating. While bathing the client said she needed assistance from others.

Objective data. She used her walker or wheelchair when ambulating. She had a limped gait. I mean that when she got up to walk it was like her weight would shift from side to side with each step she took. Her range of motion was within normal limits. Her posture was within normal limits, showing no signs of kyphosis, lordosis, or scoliosis. J.P. had no deformities, amputations, or prostethesis. Her vital signs consisted of: apical pulse regular at 86 beats per minute; respiration rate of 18 per minute; sitting blood pressure of 135/72 mmHg; temperature of 98.4 degrees Fahrenheit; and a pulse ox of 97 % at room air. Her radial pulse was +2 bilaterally, popliteal pulse was +2 bilaterally, post-tibial pedal pulse was +2 bilaterally, and dorsalis pedal pulse was +2 bilaterally. Like I said before, her capillary refill, skin, nails, and hair were within normal limits. Her chest was symmetrical with no irregularities. She had no cough. J.P's lungs sounded clear anteriorally and posteriorally, bilaterally.

Indirect data. Orders in her chart indicated J.P. needed vital signs every month on the 15th and blood pressures every Wednesday.

Interpretation. Potential problem for Impaired Walking

Sleep-Rest

Subjective data. J.P. stated she received 10 hours of sleep per night. She normally rested frequently throughout the day, because she did not feel rested after sleeping at night. She stated that she did wake up during the night due to her stomach pain, or bad dreams.

Objective data. No objective data was obtained at this time.

Indirect data. No Indirect data was obtained at this time.

Interpretation. Disturbed Sleep Pattern

Cognitive-Perceptual

Subjective data. J.P. complained, "It's hot in here. Do you think it's hot?" about three or four times throughout the assessment. She also said, "You have a pretty smile" and "Why did you pick me?" three or four times throughout the assessment too. She denied any numbness or tingling in her extremities. Her pain was rated 10 out of 10, with complaints of stabbing, severe pain in her stomach that occurs all the time. She said she was hard of hearing in her right ear.

Objective data. The client was alert and oriented to person, place, and time. She was in a good mood throughout her assessment with a full affect. She had said some of the phrases above several times and couldn't remember that she had said them before. Her pupils were brisk to 3mm bilaterally, with PERRLA. Her reflexes were within normal limits. J.P.'s hand grasps and pedal pushes were both strong bilaterally. She would frequently move the left side of her head towards me when I was talking to her, because she stated her hearing in her right ear was impaired. Her touch and smell were within normal limits. Her speech was clear and she had an easy ability to make decisions.

Indirect data. No Indirect data was obtained at this time.

Interpretation. Impaired Memory. Acute Pain.

Self-Perceptions/ Self-Concept

Subjective data. She rated her level of anxiety a 6 out of 10 related to her stomach, because she did not know what was wrong with it. J.P. stated she was "neutral" when asked how she viewed herself, but she wasn't negative of her body image, just not sure about what could be going on inside her body. According to the Geriatric Depression Scale, J.P. scored an 8 indicating she was suggestive of depression. Had she of gotten a score of 10 or higher she would have always been indicated with depression.

Objective data. Her hygiene and dress were appropriate. She had a calm appearance, accept for when talking about her stomach she would grimace. Client had good eye contact and answered questions readily.

Indirect data. No Indirect data was obtained at this time.

Interpretation. Anxiety. Readiness for Enhanced Self-Concept.

Role-Relationship

Subjective data. J.P. had a roommate who she said she had become very good friends with. She had never been married and had no children. Her last job was at the CYC, central states station in Massillon. She is currently retired. Her support system consists of her family. She is a sibling of 10 totaling 4 brother and 6 sisters. All that is left is her 1 brother and herself. Her brother and sister-in-law visit her most often. J.P. said she keeps herself busy by attending the facilities activity sessions like crafts and church services.

Objective data. No objective data was obtained at this time.

Indirect data. In J.P.'s chart, it stated that her family history consisted of: diabetes in 3 siblings, liver disease in 1 sibling, heart disease in 2 siblings, arthritis in 1 sibling, throat cancer in 1 sibling, and cataracts in 1 sibling.

Interpretation. No interpretation is needed.

Sexuality-Reproductive

Subjective data. J.P. stated she cannot remember her last menstrual period or when she started menopause. She denied that she had any sexually transmitted diseases. She was never married and has never had any kids. She denied ever being pregnant.

Objective data. No objective data was obtained at this time.

Indirect data. No Indirect data was obtained at this time.

Interpretation. No interpretation is needed.

Coping-Stress Tolerance

Subjective data. J.P. said whenever she is stressed she normally cries. Her primary stressors include her constant stomach pain and being confined to a nursing home. She deals with her stress by praying or talking about her stresses with her roommate. She hasn't had any major losses within this past year.

Objective data. No objective data was obtained at this time.

Indirect data. No Indirect data was obtained at this time.

Interpretation. Readiness for Enhanced Coping.

Value-Belief

Subjective data. J.P. stated she was a Catholic who attended Sunday church. She denied any concerns towards her ability to practice her religion.

Objective data. No objective data was obtained at this time.

Indirect data. No Indirect data was obtained at this time.

Interpretation. No interpretation is needed.

Lab Information

Taken 2/2/11

Laboratory Data	Client Results	Normal Values	Analysis
ALT	14	10-35	J.P.'s lab result is within normal limits.
Albumin	3.3 (L)	3.5-5.0	Decreased albumin may occur from malnutrition or a low protein diet. These levels can also be low due to liver disease, overhydration, or inflammatory disease. J.P. may not be eating the right foods, or may not be taking in enough protein for her body. Because of her diabetes, she may have some impaired nutrition. Drugs like aspirin that J.P. was currently taking can alter albumin levels.
Bilirubin	0.15	0.10-0.50	J.P.'s lab result is within normal limits.
Total Protein	5.7 (L)	6.4-8.3	Total protein is made up of prealbumin, albumin, and globulins. Therefore, if one of those serum lab results is abnormal, the total protein level will be abnormal as well. Since J.P.'s Albumin level is decreased, her Total protein level was decreased as well.
HDL	43		J.P.'s lab result is within normal limits.
LDL	71		J.P.'s lab result is within normal limits.

**All of the laboratory information above was obtained from Mosby's manual of Diagnostics and Laboratory Tests.*

Medication Table

Drug & (Classification)	Action	Side effects	Route/Dosage	Nursing Responsibilities	Reason for Taking Medication
Promethazine (anitemeitc, antihistamine, sedative, phenothiazine)	Relief of symptoms of histamine excess usually seen in allergic conditions. Diminished nausea or vomiting. Sedation.	Confusion, sedation, dizziness, extrapyramidal reactions, nervousness, neuroleptic malignant syndrome, blurred vision, diplopia, tinnitus, bradycardia, hypertension, hypotension, tachycardia, constipation, drug-induced hepatitis, dry mouth, photosensitivity, severe tissue necrosis upon infiltration at site, rashes, blood dyscrasias.	25mg PO daily	Assess for allergy symptoms before and periodically throughout therapy. Monitor blood pressure, pulse, and respiratory rate frequently in clients receiving IV doses. Assess client for nausea and vomiting before and after administration. Assess for adverse anticholinergic effects (delirium, acute confusion, dizziness, dry mouth, blurred vision, urinary retention, constipation, tachycardia). Administer with food, water, or milk to minimize GI irritation. Tablets may be crushed and mixed with food or fluids for clients with difficulty swallowing. Advise client to change positions slowly to minimize orthostatic hypotension. Caution client to avoid concurrent use of alcohol and other CNS depressants with this medication. Instruct client to notify health care professional if sore throat, fever, jaundice, or uncontrolled movements are noted.	Client is allergic to Sulfa and is taking Furosemide and Glimepiride, which are 2 drugs that require the client to be assessed for an allergy to sulfa. This medication will help her with her allergy.
Tylenol	Analgesia.	Hepatic failure,	650 PO daily	Assess for allergy. Assess type,	Mild Pain.

(antipyretic, nonopioid analgesic)	Antipyresis.	renal failure, neutropenia, pancytopenia, leukopenia, rash, urticaria		location, intensity prior to and 30–60 min following administration. Administer with full glass of water. Inform clients with diabetes that acetaminophen may alter results of blood glucose monitoring. Caution client to check labels on all OTC products. Advise clients to avoid taking more than one product containing acetaminophen at a time to prevent toxicity.	
Novolin R (antidiabetic hormone, pancreatic)	Control of hyperglycemia	Hypoglycemia, lipodystrophy, pruritis, erythema, swelling, allergic reactions including anaphylaxis.	100u/mL once a day on Monday & Thursday	Assess for allergy. Assess client periodically for symptoms of hypoglycemia and hyperglycemia during therapy. Monitor body weight periodically. Changes in weight may necessitate changes in insulin dose. Overdose is manifested by symptoms of hypoglycemia. Mild hypoglycemia may be treated by ingestion of oral glucose. Severe hypoglycemia is a life-threatening emergency; treatment includes IV glucose, glucagon, or epinephrine. Instruct client on proper technique for administration: type of insulin, equipment, storage, and place to discard syringes. Discuss importance of not changing brands of insulin or syringes, selection and rotation of injection sites, and compliance with therapeutic regimen. Opened, unused insulin vials should be discarded 1 month after opening.	Type II Diabetes

Omeprazole (antiulcer agent, proton pump inhibitor)	Diminished accumulation of acid in the gastric lumen. Healing of duodenal ulcers.	Dizziness, drowsiness, fatigue, headache, weakness, chest pain, abdominal pain, acid regurgitation, constipation, diarrhea, flatulence, nausea, vomiting, itching, rash, allergic reactions.	20mg PO BID	Assess for allergy. Assess client routinely for epigastric or abdominal pain and frank or occult blood in the stool, emesis, or gastric aspirate. May cause occasional drowsiness or dizziness. Caution client to avoid driving or other activities requiring alertness until response to medication is known. Advise client to consult health care professional before taking any Rx, OTC, or herbal products. Advise client to avoid alcohol, products containing aspirin or NSAIDs, and foods that may cause an increase in GI irritation. Advise client to report onset of black, tarry stools; diarrhea; abdominal pain; or persistent headache to health care professional promptly.	Stomach pain. Possible ulcer formation in GI tract.
Aspirin (antipyretics, nonopioid analgesic, salicylate)	Analgesia. Reduction of inflammation. Reduction of fever. Decreased incidence of transient ischemic attacks and MI.	Tinnitus, GI bleeding, dyspepsia, epigastric distress, nausea, abdominal pain, anorexia, hepatotoxicity, vomiting, anemia, hemolysis, rash, urticaria, allergic reactions including anaphylaxis and	81mg PO daily	Assess for allergy. Clients who have asthma, allergies, and nasal polyps or who are allergic to tartrazine are at an increased risk for developing hypersensitivity reactions. Assess pain and limitation of movement; note type, location, and intensity before and at the peak (see Time/Action Profile) after administration. Assess fever and note associated signs (diaphoresis, tachycardia, malaise, chills). Monitor for the onset of tinnitus, headache, hyperventilation, agitation, mental confusion, lethargy, diarrhea, and sweating. If these symptoms appear,	Pain

		laryngeal edema.		withhold medication and notify physician immediately	
Furosemide (loop diuretic)	Diuresis and subsequent mobilization of excess fluid (edema, pleural effusions). Decreased blood pressure.	hypotension, anorexia, constipation, diarrhea, hyperglycemia, hyperuricemia, dehydration, hypocalcemia, hypochloremia, hypokalemia, hypomagnesemia, hyponatremia, hypovolemia, metabolic alkalosis, aplastic anemia, agranulocytosis, hemolytic anemia, leukopenia.	40mg PO daily	Assess for allergy. Assess fluid status. Monitor daily weight, intake and output ratios, amount and location of edema, lung sounds, skin turgor, and mucous membranes. Notify physician or other health care professional if thirst, dry mouth, lethargy, weakness, hypotension, or oliguria occurs. Monitor blood pressure and pulse before and during administration. Monitor frequency of prescription refills to determine compliance in clients treated for hypertension. Diuretic use is associated with increased risk for falls in older adults. Assess falls risk and implement fall prevention strategies. Assess for allergy to sulfonamides.	Hypertension
Miralax (osmotic)	Evacuation of the GI tract without water or electrolyte imbalance.	Abdominal bloating, cramping, flatulence, nausea.	17g/dose (powder) i capful PO daily	Assess for allergy. Assess client for abdominal distention, presence of bowel sounds, and usual pattern of bowel function. Assess color, consistency, and amount of stool produced. Inform client that 2–4 days may be required to produce a bowel movement. PEG should not be used for more than 2 wk. Prolonged, frequent, or excessive use may result in electrolyte imbalance and laxative dependence.	Complaints of constipation.

Colestid (lipid-lowering agents)	Decreased plasma cholesterol and LDL. Decreased pruritis	Irritation of tongue, constipation, fecal impaction, hemorrhoids, perianal irritation, hyperchloremic acidosis, vitamin A, D, and K deficiency.	1g PO daily in the morning	Assess for allergy. Obtain a diet history, especially in regard to fat consumption. Assess severity of itching and skin integrity. Dose may be decreased when relief of pruritis occurs**.** Assess frequency, amount, and consistency of stools.	Hyperlipidemia
Effexor (antidepressant, antianxiety agent)	Decrease in depressive moods. Decreased anxiety. Decrease in panic attacks.	Neuroleptic malignant syndrome, seizures, suicidal thoughts, abnormal dreams, anxiety, dizziness, headache, insomnia, nervousness, weakness	25mg PO daily in morning	Assess for allergy. Assess mental status and mood changes. Inform health care professional if client demonstrates significant increase in anxiety, nervousness, or insomnia. Assess suicidal tendencies, especially in early therapy. Monitor blood pressure before and periodically during therapy. Sustained hypertension may be dose-related; decrease dose or discontinue therapy if this occurs. Monitor appetite and nutritional intake. Weigh weekly. Report continued weight loss. Adjust diet as tolerated to support nutritional status. Assess for serotonin syndrome	Anxiety.
KCL (mineral and electrolyte supplements)	Treatment or prevention of potassium depletion.	Confusion, restlessness, weakness, arrhythmias, abdominal pain, diarrhea, flatulence,	20mEq PO once every morning	Assess for allergy. Assess for signs and symptoms of hypokalemia and hyperkalemia. Administer with or after meals to decrease GI irritation. Instruct client to avoid salt substitutes or low-salt milk or food unless approved by health care professional. Client should	Prevention from electrolyte imbalance. Client is taking diuretics, which can cause potassium

		nausea, vomiting, GI ulceration, stenotic lesions		be advised to read all labels to prevent excess potassium intake. Instruct client to report dark, tarry, or bloody stools; weakness; unusual fatigue; or tingling of extremities. Notify health care professional if nausea, vomiting, diarrhea, or stomach discomfort persists.	depletion.
Glimepiride (antidiabetic, sulfonylurea)	Lowers blood sugar.	Dizziness, drowsiness, weakness, constipation, diarrhea, drug-induced hepatitis, dyspepsia, increased appetite, nausea, vomiting, hypoglycemia, hyponatremia, hemolytic anemia.	4mg PO BID	Assess for allergy. Observe client for signs and symptoms of hypoglycemic reactions. Clients on concurrent beta-blocker therapy may have very subtle signs of hypoglycemia. Assess client for allergy to sulfonamides.	Type II Diabetes
Metformin (antidiabetic, biguanides)	Maintenance of blood glucose	Abdominal bloating, diarrhea, nausea, vomiting, unpleasant metallic taste, hypoglycemia, lactic acidosis.	500mg PO BID	Assess for allergy. When combined with oral sulfonylureas, observe for signs and symptoms of hypoglycemic reactions. Clients stabilized on a diabetic regimen that is exposed to stress, fever, trauma, infection, or surgery may require administration of insulin.	Type II Diabetes
Ativan (analgesic	Sedation, decreased	Dizziness, drowsiness,	0.5mg PO TID	Assess for allergy. Assess geriatric clients carefully for CNS reactions as	Anxiety.

adjuncts, antianxiety agents, sedative, benzodiazepine)	anxiety.	lethargy, hangover, headache, ataxia, slurred speech, forgetfulness, confusion, mental depression, paradoxical excitation, blurred vision, respiratory depression, apnea, cardiac arrest, bradycardia, hypotension, constipation, diarrhea, nausea, vomiting, weight gain		they are more sensitive to these effects. Assess falls risk. Assess degree and manifestations of anxiety and mental status prior to and periodically throughout therapy. Prolonged high-dose therapy may lead to psychological or physical dependence. Restrict amount of drug available to client.	
Lexapro (antidepressant)	Antidepressant action	Neuroleptic syndrome, suicidal syndrome, insomnia, dizziness, drowsiness, fatigue, diarrhea, nausea, abdominal pain, constipation, dry mouth,	20mg PO daily	Assess for allergy. Monitor mood changes and level of anxiety during therapy. Assess for suicidal tendencies, especially during early therapy. Restrict amount of drug available to client. Risk may be increased in children, adolescents, and adults C24 yr. After starting therapy, children, adolescents, and young adults should be seen by health care professional at least weekly for 4 wk, every 3 wk for next 4 wk, and on advice of health care professional	Depressive moods from Irritable Bowel Syndrome.

		indigestion, syndrome on inappropriate secretion of antidiuretic hormone, hyponatremia, serotonin syndrome, increased appetite.		thereafter. Assess for serotonin syndrome.	
Simvastatin (lipid-lowering agents)	Lowering of total and LDL cholesterol and triglycerides. Slightly increases HDL cholesterol. Slows the progression of coronary atherosclerosis with resultant decrease in coronary heart disease-related events	Dizziness, headache, insomnia, weakness, abdominal cramps, constipation, diarrhea, heartburn, drug-induced hepatitis, dyspepsia, elevated liver enzymes, nausea, pancreatitis, rashes, pruritis, rhabdomoysis, hypersensitivity reactions.	40mg PO daily	Assess for allergy. Obtain a diet history, especially with regard to fat consumption. Advise client that this medication should be used in conjunction with diet restrictions (fat, cholesterol, carbohydrates, alcohol), exercise, and cessation of smoking. Instruct client to notify health care professional if unexplained muscle pain, tenderness, or weakness occurs, especially if accompanied by fever or malaise.	Hyperlipidemia. Coronary Artery disease.
PRN MEDS					

Loperamide (antidiarrheal)	Relief of diarrhea.	Drowsiness, dizziness, constipation, abdominal pain/distention/discomfort, dry mouth, nausea, vomiting, allergic reactions.	1mg/5mL PO PRN	Assess for allergy. Assess frequency and consistency of stools and bowel sounds prior to and during therapy. Assess fluid and electrolyte balance and skin turgor for dehydration.	Irritable Bowel syndrome.
Guaifenesin (expectorant, allergy/cold/ cough remedy)	Mobilization and subsequent expectoration of mucus.	Dizziness, headache, nausea, diarrhea, stomach pain, vomiting, rashes, urticaria.	10cc (200mg) PO every 3 hours PRN	Assess for allergy. Assess lung sounds, frequency and type of cough, and character of bronchial secretions periodically during therapy. Maintain fluid intake of 1500–2000 mL/day to decrease viscosity of secretions. Instruct client to cough effectively. Client should sit upright and take several deep breaths before attempting to cough.	Sinus trouble.
Vicodin (opioid analgesic, antitussive)	Decrease in severity of moderate pain. Suppression of the cough reflex.	Confusion, dizziness, sedation, euphoria, hallucinations, headache, unusual dreams, respiratory depression, hypotension, bradycardia, constipation, dyspepsia,	5-500mg tab PO TID PRN	Assess for allergy. Assess blood pressure, pulse, and respirations before and periodically during administration. If respiratory rate is <10/min, assess level of sedation. Physical stimulation may be sufficient to prevent significant hypoventilation. Dose may need to be decreased by 25–50%. Initial drowsiness will diminish with continued use. Assess bowel function routinely. Prevention of constipation should be instituted with increased intake of fluids and bulk, and laxatives	Severe Pain.

		nausea, vomiting, urinary retention, sweating, physical dependence, psychological dependence, tolerance.		to minimize constipating effects. Stimulant laxatives should be administered routinely if opioid use exceeds 2–3 days, unless contraindicated**.** Assess type, location, and intensity of pain prior to and 1 hr (peak) following administration. When titrating opioid doses, increases of 25–50% should be administered until there is either a 50% reduction in the client's pain rating on a numerical or visual analogue scale or the client reports satisfactory pain relief. A repeat dose can be safely administered at the time of the peak if previous dose is ineffective and side effects are minimal. Narcan is the antidote. Assess cough and lung sounds during antitussive use.	
Simethicone (antiflatulant)	Passage of gas through the GI tract by belching or passing flatus.	None significant	125mg PO BID PRN	Assess for allergy. Assess client for abdominal pain, distention, and bowel sounds prior to and periodically throughout course of therapy. Frequency of belching and passage of flatus should also be assessed.	Irritable Bowel Syndrome.
Bentyl (anticholinergic)	Decreases GI motility.	Confusion, drowsiness, blurred vision, increased intraocular pressure, palpitations, tachycardia,	10mg capsule PO TID PRN	Assess for allergy. Assess client for symptoms of irritable bowel syndrome before and periodically during therapy. Assess client routinely for abdominal distention and auscultate for bowel sounds. If constipation becomes a problem, increasing fluids and adding bulk to the diet may help alleviate the	Irritable Bowel Syndrome.

		paralytic ileus, constipation, heartburn, decreased salivation, dry mouth, nausea, vomiting, urinary hesitancy, urinary retention, decreased sweating, allergic reactions including anaphylaxis.		constipating effects of the drug. Monitor intake and output ratios; may cause urinary retention. Severe anticholinergic symptoms may be reversed with physostigmine or neostigmine.	

**All of the medication information above was obtained from Davis' drug guide for nurses.*

Concept Care Map

Medications

-Promethazine
-Tylenol
-Novolin R
-Omeprazole
-Aspirin
-Furosemide
-Miralax
-Colestid
-Effexor
-KCL
-Glimepiride
-Metformin
-Ativan
-Lexapro
-Simvastatin
-Loperamide
-Guaifenesin
-Vicodin
-Simethicone
-Bentyl

IV Sites/Fluids/Rate

None

Past Medical /Surgical History

-Type II Diabetes Mellitus
-Hypertension
-Hypothyroidism
-Hypercholesterolemia
-Anxiety
-Irritable bowel syndrome.
-Cholecystectomy
-Cataract surgery
-Bilateral laser eye surgery

Student Name: Courtney Wiener **Client Initials:** J.P. **Date:** 2/11/11

Age: 81 **Gender:** F **Room** 109-A **Admit Date:** 7/17/09

CODE Status: DNRCC-Arrest **Allergies:** Sulfa

Diet: Low-sodium **Activity:** FWB with assist of walker/wheelchair **Braden Score:** 19

Admitting Diagnoses/Chief Complaint

Coronary Artery Disease

Assessment Data

T: 98.4°F, P:86, R:18, BP: 135/72, POX:97% RA. Pain 10/10.
Pt c/o constant stabbing pain in abdomen. A&Ox3, PERRLA.
Face symmetrical. No JVD present. Temporal and Carotid pulses +2 bilat.
Pt communicated without difficulty, clear speech, and proper eye contact.
LOC WNL. Skin was warm, dry, and intact. Skin turgor < 3 sec, Cap refill < 3sec.
No edema present. Pink, moist, mucous membranes.
Pt had impaired hearing of right ear. Chest shape WNL & symmetrical.
Apical pulse 86 with regular rhythm. Lungs clear anteriorly & posteriorly bilateral.
No cough. Hypoactive BS x 4. Abdomen soft, rounded. Pt c/o stabbing pain and tenderness with palpation. Pt stated she was worried for me to palpate because she was nervous about the pain getting worse. Pt c/o constipation. Pt stated stool are normally hard and formed. Pt denied any dysuria or hematuria. MAE.
Strong & equal hand grasps bilaterally. Strong & equal pedal pushes bilaterally.
Pt denied numbness or tingling in extremities.
Dorsal pedis & Posterior tibial +2 bilaterally.

Lab Values/Diagnostic Test Results

-ALT: 14
-Albumin: 3.3 (L)
-Bilirubin: 0.15
-Total protein: 5.7 (L)
-HDL: 43
-LDL: 71

Treatments

-1 side rail up bilaterally as enabler every shift, night, days, and evenings
-Skin assessment every week on Wed.
-Pressure reduction mattress to bed to maintain skin integrity every shift 10pm, 6am, 2pm
-Elevate heels off bed at all times every shift 10pm, 6am, 2pm
-Encourage resident to turn and reposition every 2 hours every shift 10pm, 6am, 2pm
-See house podiatrist PRN.
-VS & BP every month on 15th, BP every Wed.

Priority Nursing Diagnosis #1

Nursing Diagnosis:	Acute Pain related to abdomen tenderness as evidenced by pain 10/10, grimace with palpation, and client's complaint of stabbing pain throughout abdomen while resting and with palpation.
Short term Goal:	The client will experience a satisfactory relief measure as evidenced reporting pain less than 5 on a 1-10 pain scale within 1 hour.
Interventions:	1. **Intervention:** Administer opioid analgesics as needed for severe pain. **Rationale:** Use of opioid analgesics is recommended in the treatment of patients with acute abdominal pain, as it can improve patient comfort and does not increase the risk of error in diagnosis or treatment decision-making (Briggs, 270, 2008). 2. **Intervention:** Use a pain assessment tool to assess the client's pain before administration of meds and 30 minutes after medication administration. **Rationale:** Pain tools give us a better understanding of how the patient is feeling and it helps the patient express their needs more accurately. Pain tools are an important part of assessing the pain properly, addressing the problem effectively, and helpful with nurses assessing pain efficiently (Young, Horton, Davidhizar, 416, 2006). 3. **Intervention:** Teach the client how to perform relaxation techniques as needed. **Rationale:** The use of noninvasive pain-relief measures can enhance the therapeutic effects of pain-relief medications (Carpenito-Moyet, 2010). 4. **Intervention:** Practice distraction techniques with the client, like listening to music or performing guided imagery, as needed. **Rationale:** Studies have shown the human brain secretes endorphins, which have opiate-like properties that relieve pain. The release of endorphins may be responsible for the positive effects of noninvasive pain-relief measures (Carpenito-Moyet, 2010).
Evaluation of Goal:	The client reported a pain level of 5 out of 10 and stated she felt less discomfort in her abdomen. Will continue to monitor.

Nursing Diagnosis #2

Nursing Diagnosis:	Anxiety related to fear of pain in stomach increasing as evidenced by anxiety level 6/10, unknown cause of pain, complaints of nervousness, and client not wanting her stomach palpated.
Short term Goal:	The client report feeling more at ease and will express increased psychological and physiologic comfort by end of shift.
Interventions:	1. **Intervention:** Assist the client to reduce present level of anxiety by providing reassurance that a solution can be found and reminding the client that feelings are not harmful as needed. **Rationale:** Providing emotional support and encouragement may help a client clarify and verbalize fears, allowing the nurse to give realistic feedback and reassurance (Carpenito-Moyet, 2010). 2. **Intervention:** Demonstrate relaxation and breathing techniques, asking

	the client to practice the techniques with you, as needed. **Rationale:** Anxiety tends to feed on itself, trapping the client in a spiral of increasing anxiety and physical pain, so it is important to encourage relaxation techniques to prevent this from happening (Carpenito-Moyet, 2010). **3. Intervention:** Provide physical measures that aid in relaxation such as warm baths, back massage, aromatherapy, and music as needed. **Rationale:** Relaxation techniques help the person switch the autonomous system from the fight-or-flight response to a more relaxed response (Carpenito-Moyet, 2010). **4. Intervention:** Promote resiliency by gently encouraging humor, optimism, and discussion with significant others as needed. **Rationale:** Resilience is a combination of abilities and characteristics that interact to allow and individual to bounce back, cope successfully, and function above the norm in spite of significant stress or adversity (Carpenito-Moyet, 2010).
Evaluation of Goal:	Client reported feeling more calm and at east, less worried, and a decrease in feeling of anxiety by the end of my shift.

Nursing Diagnosis #3

Nursing Diagnosis:	Constipation related to motility disturbances secondary to irritable bowel syndrome as evidenced by hard, formed stool, only one bowel movement per week, and hypoactive bowel sounds.
Long term Goal:	The client will report softer stools and having bowel movements at least every 2 to 3 days within 30 days.
Interventions:	**1. Intervention:** Encourage adequate fluid intake of at least 2 L (8 to 10 glasses) every day. **Rationale:** Sufficient fluid intake, at least 2 L daily, is necessary to maintain bowel patterns and to promote proper stool consistency (Carpenito-Moyet, 2010). **2. Intervention:** Recommend drinking a glass of hot water 30 minutes before breakfast every day. **Rationale:** Hot liquids stimulate bowel evacuation (Carpenito-Moyet, 2010). **3. Intervention:** Provide for moderate physical exercise or ambulation for 15-30 minutes at least three times every day. **Rationale:** Regular physical activity promotes muscle tonicity needed for fecal expulsion and increases circulation to the digestive system, which promotes peristalsis and easier feces evacuation (Carpenito-Moyet, 2010). **4. Intervention:** Suggest foods high in fiber like fresh fruits, cooked/uncooked vegetables, bran, nuts, fruit juices, beans, whole-grain breads, and whole-grain cereals into daily diet as needed. **Rationale:** Diets high in fibrous food produce large, soft stools that decrease the colon's susceptibility to disease (Carpenito-Moyet, 2010).
Evaluation of Goal:	The client reported having 1 or 2 bowel movements about every 3 days and having softer stools at the end of 30 days.

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