# Gerontology Process Paper: M.M.

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## Data Collection

### Client Profile

M.M. is a 90 year old female. She came to Nobles Pond on 9/11/2011. The chief complaint was a closed trochanteric fracture of the right femur and hip discomfort. Her other medical conditions include coronary atherosclerosis, osteoarthritis, osteoporosis, hypothyroidism, hyperlipidemia, anxiety, history of ramus fracture, depressive disorder, hemorrhoids without complications, hypertension, dementia, lack of coordination, closed inter-trochanteric weakness of muscle, and walking difficulty. She had no surgeries since admission. Her family history consists of heart disease. Her social history is that she is widowed, a non-smoker, and a non-drinker. She has allergies to Augmentin, Celebrax, Cipro, Crestor, Equanil, and Zithromax. Her diet is a regular diet. Her activity level is assist with 1 for ambulation, bathing, bed mobility, transfer, and grooming and dressing. She grew up Lutheran, but later converted to Catholicism. M.M. Has stated that she worked as a store clerk and house designer. For M.M., there were no major events leading up to the day I provided care for. She has been a long-term resident of the nursing home with little complications.

### Pathophysiology

*Fracture of the Hip*

A hip fracture is a fracture in the proximal end of the femur (Black & Hawk, 2009, p. 527). Hip fractures are becoming one of the leading causes of mortality and morbidity in the older populations (Black & Hawk, 2009, p. 525). Hip fractures have been associated with osteoporosis, impaired vision, lower limb dysfunction, and neurological conditions, as well as environmental hazards like slippery floors, poor lighting, and loose carpeting or rugs (Black &

Hawk, 2009, p. 525-526). More than 90% of hip fractures have been caused by falls (Black & Hawk, 2009, p. 525).

Fractures of the hip are either extracapsular, which means located outside the joint capsule, or intracapsular, which means located within the joint. Fractures are described on their location in the hip as well. A femoral neck fracture is a fracture at the femoral neck of the hip. This fracture is the most common in older adults and is most associated with osteoporosis. An intertrochanteric fracture is a fracture that occurs between the femoral neck and the greater trochanter. This fracture is most often seen in males and is associated with traumatic force. The subtrochanteric fracture is a fracture that occurs below the trochanter and it, like the intertrochanteric fracture, is most often seen in males and is associated with traumatic force. An intracapsular fracture is one that occurs in the head of the femur. After the injury blood circulation to the hip may be delayed, which will delay healing and may cause non-union in the areas where circulation is impaired (Black & Hawk, 2009, p. 526).

Traumas, like falls, are the usual cause of hip fractures. After the trauma, the patient will not be able to bear weight on the leg that is affected (Black & Hawk, 2009, p. 526). The leg may be shortened and externally rotated. If the fracture is displaced then a deformity may be present. With subtrochanteric fractures, ecchymosis may be present. Groin and hip pain that increases with movement characterizes femoral neck fractures. In intertrochanteric fractures, severe pain occurs over the greater trochanter of the femur, while in subtrochanteric fractures, the pain occurs over the proximal hip. Some hip fractures are not readily found. Sometimes, clients, especially those with dementia, will ambulate normally and only complain of pain in the hip area (Black & Hawk, 2009, p. 527).

Diagnosis of hip fractures is comprised of many things. Patient's clinical manifestation and history of trauma are used in the diagnosis. An antroposterior radiograph is used to confirm the presence of a fracture. CT scans, bone scans, and MRI's may also be used to confirm the site of the fracture (Black & Hawk, 2009, p. 527).

Management and treatment of hip fractures can either be nonoperative or operative (Black & Hawk, 2009, p. 527-528). A spica or skeletal traction can be used for patients who were not ambulatory before the injury or for those who cannot tolerate anesthesia. Excellent skin care must be provided because of immobility and, in the case of traction, the skin is open, which can increase the risk for infection. Patients should be informed to do leg exercises that may decrease their chance of producing clots (Black & Hawk, 2009, p. 527). Compression devices and anticoagulant medications can also be used to lessen the chance of producing clots (Black & Hawk, 2009, p. 527-528). For operative patients, blood loss can occur. If the patient is left on bedrest, even more deterioration can occur, so early mobilization is important. The goal of operative or surgical treatment is to gain internal fixation and stable reduction of the fracture fragments, which help support early ambulation. Fixation may be done through the use of implants, plates, intramedullary pins, and screws (Black & Hawk, 2009, p. 528).

*Osteoporosis*

Osteoporosis is a skeletal disorder that is defined compromised bone strength (Black & Hawk, 2009, p. 487). There are many genetic and environmental factors that are involved in the development of osteoporosis. In osteoporosis, remodeling, which is the process by which old bone is replaced by new bone, is compromised, in which the rate of bone loss is greater than the rate of bone growth resulting in compromised bone strength (Black & Hawk, 2009, p. 488-489).

The diagnosis of osteoporosis is usually made after a fracture, although lab tests, like calcium levels and phosphate levels, and biochemical markers of bone remodeling can be used to rule out other disorders. Measuring bone mineral density by using DXA and quantitative ultrasound can help diagnose osteoporosis as well (Black & Hawk, 2009, p. 489-490). Management and treatment of osteoporosis includes many things. It is important to have adequate calcium and vitamin D intake, exercising, and avoiding alcohol and smoking. There are as well many medications, like hormone replacement therapy, raloxifene, calcitonin, triparatide, and biphosphanates, that can be used to prevent and treat osteoporosis (Black & Hawk, 2009, p. 490-492).

*Dementia*

Dementia is a chronic syndrome that results from acquiring progressive, life-limiting disorders that erase the patient's memory, which affects the patient's usual way of interacting in the world (Tabloski, 2010, p. 741). To be considered dementia, the decline in memory has to affect the ability to make coherent speech and understand language, ability recognize objects, ability to perform motor activities, or the ability to think abstractly by making sound judgment and planning and performing complex task (Tabloski, 2010, p. 742). Loss starts with the patient's activities of daily living then progresses onto making the patient dependent in all aspects of self-care (Tabloski, 2010, p. 741). Risk factors for dementia would include improper management of disease, like diabetes, and taking medications that contribute to confusion (Black & Hawk, 2009, p. 1805).

There are four type of dementia. Alzheimer's disease, the most common, has an onset that is insidious and it may be linked to an environmental and genetic component (Tabloski, 2010, p. 742). Vascular dementia is the second common. It is caused by vascular components and is

usually more acute in nature. Lewy body dementia occurs when there is Lewy bodies and neuritis in the brain. Frontotemporal dementia occurs when the frontotemporal lobe of the brain atrophies causing personality change. These dementias can mix, like having Alzheimer's disease with vascular dementia (Tabloski, 2010, p. 743). Dementia goes through 3 stages, mild, moderate, and severe, in which memory, orientation, judgment, problem solving, community affairs, personal care, and hobbies are affected (Tabloski, 2010, p. 745-746).

There are no labs or diagnostic tests for dementia at this time. X-rays and labs may be used, but this is only to see if there is another disease that may be treated that might help the dementia. The treatments for dementia are targeted at slowing the disease progression, while improving function. Medications, like cholinesterase inhibitors, are a big group that are used during the treatment process (Tabloski, 2010, p. 746).

**Assessment**

While assessing M.M., there were a few parts of her assessment that were not normal. M.M. responded to touch and the calling out of her name. She was identified by name and date of birth. Her speech was clear, but it did usually take her some time to reply to a question or follow a command. She was alert, but would gradually lose attention. She was A&Ox1 and could only relate to person, but not to place or time. M.M. wears glasses. She could follow my finger with her eyes. Both her eyes were at size 3 and both eyes reacted briskly to light. Her Galsgow Coma Scale score was a 14 with her eye response being 4, her verbal response a 4, and her motor response a 6. Her upper and lower extremities were both weak. Her hand grasps were strong. Sensation was absent in the feet. When asked to point to objects, M.M. took some time to perform the actions and at times did not perform it at all.

M.M was found in her wheel chair. Her breathing, breathing pattern, and effort were normal. No accessory muscle use was seen. No cough was noted. Lung sounds were auscultated anterior and posteriorly and were clear. Her respirations were 20 breathes per minute, which is on border of normal and high. Her pulse ox was 98%.

The client's heart rhythm was rhythmic and normal. Her radial pulses were both +2 and her dorsalis pedis pulses were both a +1. Her pulse was 46 beats per minute, which is below normal, and her blood pressure was 167/64. No JVD was seen. The client's capillary refill and skin turgor were both less than 3 seconds and non-pitting edema was noted bilaterally in the feet. Her skin was pink, warm, and dry. Her skin was intact and no areas of redness were noted. Her Braden Score was a 13 with the moisture score being a 4, the mobility score being a 2, the activity score a 2, the nutrition score a 3, and the friction score a 2. M.M. is incontinent sometimes.

The patient's oral mucosa was pink and dry. Her tongue was pink, as well. Her abdomen was flat and soft to the touch and no tenderness was noted. Her bowel sounds were present in all four quadrants. She had bladder movement during my shift. The urine was yellow and aroma was normal. The patient had no peripheral IV. Her temperature was 98.4$^{o}$F. M.M stated she had a pain of 0 out of 10.

**Gordon's Functional Health Patterns**

*Health Perception and Management*

Subjective

- The client believes that she is healthy and she has a good sense of well-being.
- She denied being a smoker or use of alcohol.

- She stated that she does not exercise much, but does participate in some activities, like bingo.

Objective

- Her vitals and assessment was fairly normal with only a few abnormals.

Indirect

- In her chart, it stated that she had her Mantoux test on 9/9/12 and her influenza vaccine on 10/2/12.
- In her chart, it was shown that she had many preexisting conditions, like atherosclerosis, osteoporosis, and hypothyroidism.

Interpretation

- M.M. has a few barriers to health perception and management. Although she has preventative care and she is not a smoker or drinker, she does have many pre-existing conditions and a few parts of her assessment were not normal, like no sensation in her feet and having edema.

*Nutritional and Metabolic*

Subjective

- Patient stated that she eats well and that she eats breakfast, lunch, and dinner.
- She states that she gets enough fluids throughout the day.
- She denied any difficulty eating or drinking.
- She states she has good appetite.

Objective

- Her skin was intact and pink, warm, and dry.
- Her oral mucosa was pink and dry with her tongue being pink as well.

- Nail bed color was normal and capillary refill was under 3 seconds.
- Her teeth are in good condition.
- Skin turgor was under 3 seconds.
- Patient ate about 50% of her dinner and drank some fluids too.

Indirect

- Her charts stated that she had low protein, which could indicate mal nutrition.

Interpretation

- M.M. has a few barriers to her nutrition. Although she says she gets enough food, she only ate about half when I was present. Her protein was low, which may indicate a nutrition problem.

*Elimination*

Subjective

- Patient states that she usually does not have any problems with urine or bowels.

Objective

- Patient asked to use the bathroom and had a bladder movement.
- Urine was yellow and had a normal aroma.
- Her abdomen was flat and soft to the touch with no tenderness being noted.
- Her bowel sounds were present in all four quadrants

Indirect

- Chart stated that patient had bowel incontinence sometimes.
- Patient has dementia.
- She has a few laxatives, stool softeners, and enemas in her chart.

Interpretation

- M.M. has a few barriers for elimination. She has dementia which may lead to her being more incontinent than she is and she has bowel incontinence at times. A schedule should be formed to offer her to use the bathroom, which may relieve her incontinence.

*Exercise and Activity*

Subjective

- She stated that she does not exercise much, but does participate in some activities, like bingo.
- She stated if the activity is hard enough then she will get out of breath.

Objective

- Patient sat in her wheel chair through my shift.
- Patient did not perform activities when asked to sometimes, like pointing to objects, which could be due to not understanding what was asked or having a reluctance to move the body part.
- Vitals were mainly in the normal range.
- Her upper and lower extremities were both weak.
- Her hand grasps were strong.

Indirect

- Chart states patient is to be assisted with ambulation, bathing, bed mobility, transfer, and grooming and dressing.

Interpretation

- M.M. has some barriers to exercise and activities. Sitting in the wheel chair all day, general weakness, and not exercising much are big factors that need to be focused on.

*Sexuality and Reproduction*

Subjective

- Patient stated she had a good relationship with her husband.

Objective

- None

Indirect

- Chart states patient is widowed.

Interpretation

- M.M. has effective patterns for sexuality and reproduction. She had a good relationship with her husband and does not regret it.

*Sleep and Rest*

Subjective

- Patient stated that she gets up when the sun rises and usually goes to sleep when it falls.
- Patient stated that she is rested and ready for activities

Objective

- Patient seemed calm and did not show any symptoms of fatigue.

Indirect

- None

Interpretation

- M.M. has effective patterns for sleep and rest as she stated that she is rested and that she was calm, with no symptoms of fatigue.

*Cognitive and Perceptual*

Subjective

- Patient stated that her "memory is not what it used to be."

- She stated sometimes it's hard for her to concentrate.
- Stated that her father, mother, and husband are dead, but then a little longer in the conversation says that she is waiting for her father to come home.
- She denies any problems hearing and states that she wears glasses because she has bad eye sight.
- When asked to name objects, patient was able to do so successfully and correctly.

Objective

- Patient was A&Ox1.
- She wears glasses.
- She was able to hear me and read a little bit as well.
- Her speech was clear.
- She had a short attention span and sometimes would repeat stories.
- She seemed confused at times and sometimes would forget things she did minutes ago.

Indirect

- Chart listed dementia as an existing condition.

Interpretation

- M.M. has a few barriers for cognition. She has dementia, she is confused at times, and she is disoriented. She stated that it is hard for her to concentrate sometimes, her memory is not what it used to be, and her attention span is short.

*Role and Relationships*

Subjective

- Patient stated that family randomly comes and visits her throughout the week.
- She states she has friends in the nursing home.

- She says she participates in bingo with her friends.
- M.M. stated that her father, mother, and husband are dead.
- M.M says that she has two daughters.

Objective

- Patient participated in bingo during the shift, but no interaction with other people was noted.
- Patient interacted with nursing home faculty.

Indirect

- Chart states that patient is widowed.

Interpretation

- M.M. has effective patterns for role and relationships as her family visits her and she states that she has friends at the nursing home. She interacted with the faculty and participated in bingo, which is healthy.

*Self-Perception and Self-Concept*

Subjective

- M.M. said that she feels good about herself and is proud of her life.
- She stated that she feels happy most of the time.
- She stated she does not feel angry, lonely, anxious, depressed, or fearful.

Objective

- Patient was able to keep eye contact with me most of the time.
- She had a short attention span and sometimes would repeat stories.
- Patient seemed calm.
- She seemed confused at times and sometimes would forget things she did minutes ago.

Indirect

- Chart states that patient's other pre-existing condition are dementia and anxiety.
- In her chart was a medication for anxiety.

Interpretation

- M.M. has effective patterns for self-perception and self-concept as she feels good about herself and feels happy at the moment. She as well was calm. Things to not though that might be barriers are that she was confused at times and as well had a short attention span.

*Coping and Stress Tolerance*

Subjective

- Patient states that she has no stress right now and is usually relaxed.
- A big event in her life was when her parents divorced and that had an impact on her.
- She stated that she misses her dad.
- She stated God has helped her a lot throughout life.

Objective

- None

Indirect

- Chart states that patient moved into the nursing a little over 1.5 years ago.

Interpretation

- M.M. has effective patterns for coping and stress because she currently has no stress at the moment and when she does, she has someone to go to that she sates helps her get through the hardships.

*Values and Beliefs*

Subjective

- Patient stated that religion is important to her. She was previously a Lutheran than converted to Catholicism.
- She views life as worth living and stated that she believes that she lived a good life.
- She stated God has helped her a lot throughout life.

Objective

- None

Indirect

- None

Interpretation

- M.M. has effective patterns for values and beliefs as they have helped find meaning in life and have helped her get through hardships.

**Nursing Diagnoses**

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| **Primary Nursing Diagnosis** | Impaired memory related to the physiological changes of aging secondary to dementia as evidenced by disorientation, altered attention span, slow reaction time, repeating stories several times in a row, and stating that her "memory is not what is used to be." (Doenges, Moorhouse, & Murr, 2010, p. 805; Black & Hawk, 2009, p. 1602) |
| Nursing Intervention #1 | Reorient the patient to person, place, and time, if needed, as this will help the patient focus (Doenges, Moorhouse, & Murr, 2010, p. 806; Black & Hawk, 2009, p. 1807). |

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| Nursing Intervention #2 | Involve the patient in activities, exercises, and diversional programs because it this will promote endorphins to be released, which can improve thinking and enhance the patient's sense of well-being (Doenges et al., 2010, p. 806). |
| Nursing Intervention #3 | Place familiar objects in the room as this will help the client be more comfortable in their environment and, as well, help them to be able to identify their room or bed as their own (Doenges et al., 2010, p. 1805; Black & Hawk, 2009, p. 1807). |
| Nursing Intervention #4 | Allow the patient adequate time to respond to questions or to make comments and decisions because reaction times can be slowed as a result of aging (Doenges et al., 2010, p. 805; Black & Hawk, 2009, p. 1807). |
| Nursing Intervention #5 | Give the patient short explanations because the patient will not understand or remember long explanations (Black & Hawk, 2009, p. 1807). |
| Short Term Goal | M.M will maintain or improve usual orientation (A&Ox1) for the shift. |

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| Outcomes, Rationale, and Revisions | Goal was met as patient was able to keep usual orientation without degrading further. She was oriented a few times to place and times, but she could not keep that orientation. |
| **Secondary Nursing Diagnosis** | Bowel incontinence related disorientation and generalized weakness secondary to dementia as evidenced by M.M. being incontinent sometimes and needing help in the bathroom (Doenges et al., 2010, p. 777). |
| Nursing Intervention #1 | Assess prior pattern for bowel movement because if the current pattern is not set up in the way that the client is used to, then changes will be required so that it is set up to promote bowel continence (Doenges et al., 2010, p. 777) |
| Nursing Intervention #2 | Ask the patient if they want to use the toilet at regular intervals because following a regular schedule may prevent incontinence and accidents, like falls (Doenges et al., 2010, p. 778). |
| Nursing Intervention #3 | When incontinence does occur, convey acceptance as this will decrease the embarrassment and helplessness that the patient may be feeling (Doenges et al., 2010, p. 778). |

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| Nursing Intervention #4 | Change the patient promptly and provide good skin care when incontinence does occur as this will reduce the risk of skin irritation and breakdown (Doenges et al., 2010, p. 778). |
| Nursing Intervention #5 | Be alert to nonverbal cues as they may signal inattention by the patient to the cues or urgency (Doenges et al., 2010, p. 778). |
| Short Term Goal | Patient will be continent during the shift. |
| Outcomes, Rationale, and Revisions | Goal was met as M.M. was continent during the whole shift. M.M. was told to ask to use the bathroom when she needs to, which she did. |
| **Tertiary Nursing Diagnosis** | Risk for injury related to previous injuries, anemia, generalized weakness, and disorientation secondary to dementia and osteoporosis as evidenced by decreased muscle strength, absent sensation in the feet, bowel incontinence, slow reaction time, reluctant to perform movements sometimes, she wears glasses, and the use of diltiazem, metoprolol tartrate, and lasix, which both can decrease pulse and blood pressure. |
| Nursing Intervention #1 | Perform fall risk assessment because this will determine if the |

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| | patient has the potential to fall and will identify the patient's risk factors (Doenges et al., 2010, p. 816). |
| Nursing Intervention #2 | Ask patient about their view on falls, if they think they are at risk for falls, and what could be done to decrease their risk for falls because exploring the patient's fears and beliefs about falls and perceived barriers will help build an approach to decrease the patient's risk for falls (McMahon, Talley, & Wyman, 2011, p. 294, 296). |
| Nursing Intervention #3 | Assist with transfers and ambulation because this will prevent falls in patients with generalized weakness and visual problems (Doenges et al., 2010, p. 816). |
| Nursing Intervention #4 | If patient is in bed, leave the bed in low position because this would help minimize the injury if the patient were to try to get out of bed and injure themselves (Black & Hawk, 2009, p. 1807). |
| Nursing Intervention #5 | Ask the patient if they want to use the toilet every 2 hours because falls are commonly due to trying to get to the toilet (Black & Hawk, 2009, p. 1807). |

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| Short Term Goal | Patient will not fall during my shift. |
| Outcomes, Rationale, and Revisions | The goal was met as the patient did not fall. The patient was in her wheel chair most of the day. She was informed to ask someone to help her if she needed to do something, like go to the bathroom or get on her bed, which she did. |

**Discharge Planning and Education Needs**

The main issue with M.M. is her dementia. With dementia, the patient becomes dependent on others for their activities of daily living. This means that if M.M. were to be discharged, her family would most likely be the care takers. I was not able to meet the family, but establishment of what they know and do not know would be critical. They would need to understand that as the disease progresses, M.M. would become more dependent on them for their activities of daily living (Tabloski, 2010, p. 749). A schedule would be helpful in helping the family and M.M. do the activities of daily living. It would also help them see what they have done and have not done through the day, which is important in the managing of medications. M.M (Doenges et al., 2010, p. 816). M.M. has many medications, so the family should be informed on what each one does and as well should be advised to use a box with days and time slot and organize the medications in the days and times that they are to be taken to help ease management of the medications. The family should also be informed about the side effects of the medications and when to call the doctor. Another issue with M.M. is her edema in her feet. Since

she barely gets up, she should be taught to raise her legs when she is sitting to help increase venous return, which may help alleviate some of the edema.

**Lab Values/Diagnostic Tests**

| Abnormal Labs | Normal Value | Patient's Value | Analysis |
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| RBC | 4-5.5 million/mm3 ("Lab Values," n.d.). | 2.88 million/mm3 (Low) | This indicates that the patient is experiencing anemia and should be monitored for fatigue, tachycardia, dyspnea, and tachypnea ("Lab Values," n.d.). |
| Hemoglobin | 12-15 g/dl ("Lab Values," n.d.). | 8.5 g/dl (Low) | This indicates that the patient is experiencing anemia and should be monitored for fatigue, tachycardia, dyspnea, and tachypnea ("Lab Values," n.d.). |
| Hematocrit | 38-45% ("Lab Values," n.d.). | 27.6% (Low) | This indicates that the patient is experiencing anemia and should be monitored for fatigue, tachycardia, dyspnea, and tachypnea ("Lab Values," n.d.). |
| BUN | 7--20 mg/dl | 23 mg/dl (High) | This is relevant to the patient |

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| | ("Explanation of lab values," n.d.). | | because it could indicate kidney problems, but this lab is most likely elevated because BUN levels increase with age and the patient is 90 years old ("Explanation of lab values," n.d.). |
| WBC | 5-10 thousand/mm3 ("Lab Values," n.d.). | 4.2 thousand/mm3 (Low) | This is relevant to the patient because a low WBC count could make her more susceptible to infections. |
| Protein | 6.0-8.3 g/dL ("What are the causes of low serum protein," n.d.) | 5.4 g/dl (Low) | This could indicate a kidney problem, but it might also be due to malnutrition and the patient is not getting enough protein in their diet ("Low serum protein level," n.d.). |
| Albumin | 3.4-5.4 g/dL ("What does albumin mean in a test," n.d.). | 3.2 (Low) | This is indicative of nephrotic syndrome, as the patient has edema in the feet, and possibly |

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| | | | malnutrition and a low protein diet ("What does albumin mean in a test," n.d.). |
| HDL | >50mg/dL ("Understanding cholesterol numbers," n.d.) | 27 mg/dL (Low) | This is considered a risk factor for heart disease, which is important as she has heart disease in her family history ("Understanding cholesterol numbers," n.d.). |

No diagnostic tests of M.M.'s were available at the time.

**Medications**

| Medication | Purpose/ Mechanism of action | Normal Dose Range | Side Effects | Nursing Considerations |
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| **Diltiazem -Antianginal, antiarrhythmic, antihypertensive, calcium channel blocker** | Decrease blood pressure through systemic vasodilation, suppress arrhythmias, and decrease the severity and frequency of angina attacks (Deglin et al., 2011). | 30-120 mg 3-4 times a day (Deglin et al., 2011). | Abnormal dreams, anxiety, confusion, dizziness, drowsiness, headache, nervousness, psychiatric disturbances, weakness, blurred vision, disturbed equilibrium, epistaxis, tinnitus, cough, dyspnea, arrhythmias, CHF, peripheral edema, bradycardia, chest pain, hypotension, palpitations, syncope, tachycardia, abnormal liver function studies, anorexia, constipation, diarrhea, dry mouth, dysgeusia, dyspepsia, nausea, vomiting, dysuria, nocturia, polyuria, sexual dysfunction, urinary frequency, dermatitis, erythema | -Monitor blood pressure and pulse before any treatment. -Monitor I&O, weigh patient daily, and assess for signs of CHF. -Assess location , intensity, duration, and factors that precipitate patient's angina -Monitor patients EKG and report prolonged hypotension and bradycardia. |

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| | | | multiforme, flushing, increased sweating, photosensitivity, pruritus, urticaria, rash, gynecomastia, hyperglycemia, anemia, leukopenia, thrombocytopenia., weight gain, joint stiffness, muscle cramps, paresthesia, tremor, Stevens-Johnson Syndrome, and gingival hyperplasia (Deglin et al., 2011). | -Monitor Potassium levels (Deglin et al., 2011). |
| **Lasix (Furosemide) -Diuretic, loop diuretic** | Mobilization of fluid excess and diuresis, as well as decreased blood pressure (Deglin et al., 2011). | Initially 20–80 mg per day as a single dose. Dose can be increased by 20–40 mg q 6–8 hour until desired | Blurred vision, dizziness, headache, vertigo, hearing loss, tinnitus, hypotension, anorexia, constipation, diarrhea, dry mouth, dyspepsia, nausea, pancreatitis, vomiting, excessive urination, photosensitivity, pruritis, rash, hyperglycemia, hyperuricemia, dehydration, hypocalcemia, hypochloremia, hypokalemia, hypomagnesemia, | -Assess fluid status, monitoring I&O, daily weights, edema, lung sounds, mucous membrane, and skin turgor -Monitor blood pressure and pulse before |

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| | | response (Deglin et al., 2011). | hyponatremia, hypovolemia, metabolic alkalosis, aplastic anemia, agranulocytosis, hemolytic anemia, leukopenia, muscle cramps, thrombocytopenia, paresthesia, fever, increased BUN, and nephrocalcinosis (Deglin et al., 2011). | treatment (Deglin et al., 2011). |
| **Klor-Con (Potassium supplements) -Electrolyte supplement and replacement** | Replacement of potassium and prevention of deficiency in potassium (Deglin et al., 2011). | 40-80 mEq/day (Deglin et al., 2011). | Confusion, restlessness, weakness, arrhythmias, EKG changes, abdominal pain, diarrhea, flatulence, nausea, vomiting, GI ulceration, stenotic lesions, paralysis, and paresthesia (Deglin et al., 2011). | -Assess for signs and symptoms of hypokalemia and hyperkalemia. -Monitor serum potassium levels before and after treatment (Deglin et al., 2011). |
| **Levothyroxine -hormones, thyroid** | Replaces thyroid hormone in | 75-125 mcg per day | Nervousness, headache, insomnia, irritability, arrhythmias, angina pectoris, | -Assess apical pulse and blood pressure before |

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| **preperation** | hypothyroidism (Deglin et al., 2011). | (Deglin et al., 2011). | hypo tension, tachycardia, cramps, diarrhea, vomiting, increased sweating, menstrual irregularities, hyperthyroidism, weight loss, and heat intolerance (Deglin et al., 2011). | and after therapy. -Monitor thyroid function studies. -Check for signs of hyperthyroidism, which would indicate overdose (Deglin et al., 2011). |
| **Mucinex (Guaifenesim) -Allergy, cold, and cough remedy, and expectorant** | Decreases the viscosity of secretions, which makes it easier to move and expectorate the secretions (Deglin et al., 2011). | 200-400 mg q 4 hours (Deglin et al., 2011). | Dizziness, headache, nausea, diarrhea, stomach pain, vomiting, rashes, and urticaria (Deglin et al., 2011). | -Assess lung sounds. -Check frequency and type of cough, along with the character of secretions (Deglin et al., 2011). |
| **Metoprolol** | Decreases | 25-100 mg | Fatigue, weakness, anxiety, | -Assess blood |

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| **tartrate -Antianginal, antihypertensive, beta blocker** | blood pressure and heart rate along with frequency of anginal attacks (Deglin et al., 2011). | per day (Deglin et al., 2011). | depression, dizziness, drowsiness, insomnia,memory loss, mental status changes, nervousness, nightmares, blurred vision, stuffy nose, bronchospasm, wheezing, bradycardia, CHF, pulmonary edema, hypotension, peripheral vasoconstriction, constipation, diarrhea, drug-induced hepatitis, drymouth, flatulence, gastric pain, heartburn, nausea, vomiting, urinary frequency, rashes, hyperglycemia, hypoglycemia, arthralgia, back pain, joint pain, and drug induced lupus syndrome (Deglin et al., 2011). | pressure and pulse before and after treatment (Deglin et al., 2011). |
| **Detrol (tolterodine) -urinary tract antispasmodics,** | Decreases urinary frequency and urgency | 2 mg 2 times per day (Deglin et | Headache, dizziness, blurred vision, dry eyes, dry mouth, constipation, and dyspepsia (Deglin et al., 2011). | -Assess patient for urinary frequency, and urgency during |

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| **anticholingerics** | (Deglin et al., 2011). | al., 2011). | | treatment (Deglin et al., 2011). |
| **MiraLax (polyethylene glycol) -laxatives, osmotics** | Evacuation of the GI tract (Deglin et al., 2011). | 17g (Deglin et al., 2011). | Abdominal bloating, cramping, flatulence, and nausea (Deglin et al., 2011). | -Assess patient for bowel sounds and abdominal distention. -Assess color, consitency, and amount of stool (Deglin et al., 2011). |

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| **Trazodone**<br>**-Antidepressant** | Alters the effects of serotonin causing antidepressant action (Deglin et al., 2011). | 150 mg per day in 3 divided doses (Deglin et al., 2011). | Drowsiness, confusion, dizziness, fatigue, hallucinations, headache, insomnia, nightmares, slurred speech, syncope, weakness, blurred vision, tinnitus, hypotension, arrhythmias, chest pain, hypertension, palpitations, tachycardia, dry mouth, altered taste, constipation, diarrhea, excess salivation, flatulence, nausea, vomiting, priapism, urinary frequency, hematouria, rashes, anemia, leukopenia, mylgia, and tremors (Deglin et al., 2011). | -Monitor blood pressure and pulse before and after treatment.<br>-Assess mental status.<br>Assess CBC, especially WBC (Deglin et al., 2011). |

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| **Acetaminophen -Antipyretic, nonopioid analgesic** | It causes analgesia and antipyresis by inhibiting the synthesis of prostaglandins that can be mediators of pain and fever (Deglin et al., 2011). | 1g 3-4 times a day (Deglin et al., 2011). | Hepatic failure, hepatoxicity, renal failure, neutropenia, pancytopenia, leukopenia, rash, and urticaria (Deglin et al., 2011). | -Asses pain type, intensity, and location before and after treatment. -Assess overall health status (Deglin et al., 2011). |

References

Black, J.M., & Hawks, J.H. (2009). *Medical-surgical nursing* (8th ed.). St. Louis, MI: Mosby.

BUN (n.d.). Retrieved from http://labtestsonline.org/understanding/analytes/bun/tab/faq

Deglin, J. H., Vallerand, A. H., Sanoski, C. A. (2011). *Davis's drug guide for nurses*, 12th edition. [PDA software]. Philadelphia, PA: F.A. Davis Company.

Doenges, M.E., Moorhouse, M.F., & Murr, A.C. (2010). *Nursing care plans* (8th ed.). Philadelphia, PA: FA Davis Company.

Explanation of lab values (n.d.). Retrieved http://www.dciinc.org/values.php

Lab values (n.d.). Retrieved from http://web.missouri.edu/~proste/lab/

Low serum protein level (n.d.). Retrieved from http://www.livestrong.com/article/485772-low-serum-protein-level/

McMahon, S., Talley, K. M., & Wyman, J. F. (2011). Older people's perspectives on fall risk and fall prevention programs: a literature review. *International Journal Of Older People Nursing*, 6(4), 289-298. doi:10.1111/j.1748-3743.2011.00299.x

Tabloski, P.A. (2010). *Gerontological nursing* (2nd ed.). Upper Saddle River, NJ: Person Education, Inc.

Understanding cholesterol numbers (n.d.). Retrieved form http://www.webmd.com/cholesterol-management/guide/understanding-numbers

What are the causes of low serum protein (n.d.). Retrieved from http://www.ehow.com/about_6528648_causes-low-serum-protein_.html

What does albumin mean in a test (n.d.). Retrieved from http://www.medicalhealthtests.com/askquestion/186/what-does-albumin-mean-in-a-test.html