# Relearning: Clinical Judgment Plan of Care Template

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| Student Name:<br>Client Initials: L.S.<br>Age/DOB: 89 years<br>Allergies: NKDA<br>BSA/BMI: 29.3 Code Status: DNR | Date of Admission: 6/13<br>Date of Care: 6/13<br>Admitting Diagnosis:<br>• Comorbidities: Alzheimer's dementia<br>• Breast cancer<br>• Osteoporosis<br>• Hyperlipidemia<br>• Kyphosis<br>• Urinary and bowel incontinence<br><br>Planned Treatments/Procedures: The client will need evaluation and treatment for a possible infection, including urine and blood tests and starting antibiotics as ordered. Vital signs and mental status will be monitored closely for signs of worsening delirium or sepsis. Fever control, hydration, and perineal care will be provided. Safety precautions and close observation are important because of confusion and aggression. Wound care will continue for the skin tear on the left forearm, and the healthcare provider and daughter will stay involved in the plan of care. |

| Nursing and HCP Collaborative Plan for Care: Include a description of priority client specific information, nursing actions, and provider orders | |
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| Cultural/Spiritual: Assess for any cultural or spiritual needs and involve family in care decisions if appropriate. Provide comfort and reassurance because the client is confused and agitated | Health Promotion/Development: Focus on preventing complications of immobility, infection control, and maintaining safety. |
| Neurological/Cognition/Coping/Adaptation/Function: Client is disoriented ×4 with baseline only oriented to self and is showing aggression toward staff. Monitor mental status closely and assess for causes of acute confusion like infection or delirium. Use calm communication and reorientation. | Infection/Immunity/Inflammation: Hot skin, fever, foul urine, and confusion suggest possible infection like UTI or sepsis. Monitor temperature, labs, and wound/urine characteristics. Administer antibiotics as ordered. |
| Nutrition/Elimination: Client is incontinent with foul-smelling urine, which may indicate infection. Monitor intake/output, provide perineal care, and encourage fluids if safe. | Mobility: Likely limited mobility and high fall risk due to confusion. Assist with movement and repositioning. |
| Fluid/Electrolytes/Acid-Base: Risk for imbalance due to possible infection and fever. Monitor labs and hydration status. | Pain/Comfort/Tissue Integrity: Skin tear on left forearm treated with dressing. Monitor for pain, healing, and additional skin breakdown. |
| Gas Exchange/Perfusion: Tachypnea present but lungs clear. Continue to monitor respiratory status and oxygenation. | Safety: Very high safety risk due to aggression, confusion, and attempts to hit/ bite staff. Use close observation, de-escalation, and follow restraint protocol only if necessary. |
| Glucose Regulation: Check glucose because infection or stress can cause changes, especially in older adults. | Other: Evaluate delirium related to infection or fever and notify provider of status change. |

| START of Shift (CJSim™) Priorities (Complete after receiving REPORT AND reviewing the EHR connected to phase 1/Question 1 section) | | | |
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| **Recognize & Analyze Cues** | **Prioritize Hypotheses** | **Generate Solutions & Take Actions** | **Evaluate Outcomes** |