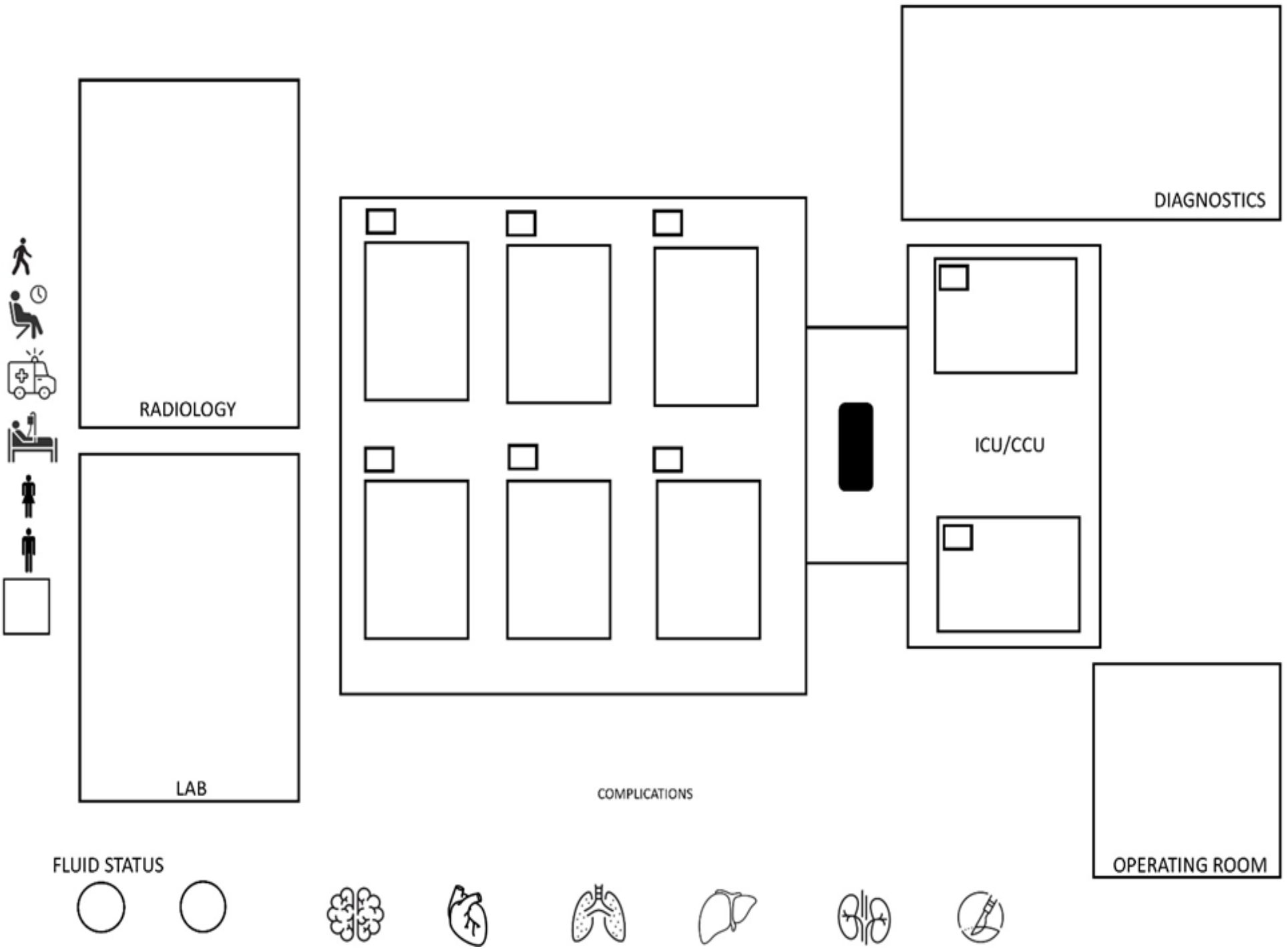
NURSINGKALC

PROVIDING THE KEY'S TO NURSING

LAB PRACTICUM COMPANION-101


DIAGNOSTICS
RADIOLOGY
ICU/CCU
LAB
COMPLICATIONS
OPERATING ROOM
FLUID STATUS

Room/Name Allergies

Age Gender

HCP

Admit Date: DX PCP

Consults: ☐ C ☐ P ☐ R ☐ ID ☐ PSY ☐ Neuro ☐ Surg ☐ Wound ☐ Ortho ☐ PT ☐ OT ☐ SW

PMHX: ☐ CAD ☐ HTN ☐ PVD ☐ ACS ☐ MI ☐ A-FIB ☐ Aflutter ☐ Cath ☐ CABG x ☐ Stent x ☐ CHF R L
☐ PE ☐ DVT ☐ COPD ☐ Asthma ☐ Emphysema ☐ PNA ☐ COVID ☐ CKD

ESR S M T W T F S ☐ PD ☐ DM 1 ☐ DM 2 ☐ AKI ☐ Stroke ☐ CA

☐ Depression Thyroid ↓ ☐ Seizure

☐ Smoker ☐ ETOH **SCALE**_____**SCORE**_____

Precautions	LOC	A&O x ☐ 1 ☐ 2 ☐ 3 ☐ Confused ☐ Lethargic		
☐ **FALL**	**TIME**			MEDICATIONS & TREATMENTS
☐ 💧 D	**TEMP**			
☐ 🗣 A	**PULSE**			_____@_____
☐ ⓘ S	**RESP**			_____@_____
☐ 🤚 C	**BP**			_____@_____
☐ CDIFF	**SPO2**			
☐ MRSA	**PAIN**			
☐ VRE				
☐ OBS				
☐ 1:1				
☐ Neut				
☐ Sitter				

☐ WNL ☐ NCL % ☐ CPAP ☐ BiPap ☐ NG ☐ R - ☐ L ☐ PEG ☐ ILIOST ☐ COLOST

☐ NEBS ☐ Chest Tube ☐ NPO-

Trach # ☐ C ☐ U ☐ TPN

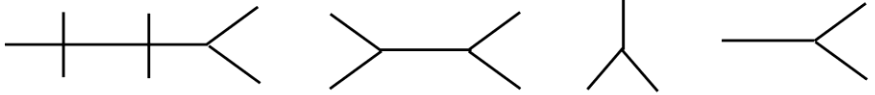
☐ Incentive S@BS DIET BM

ECG—Lead ☐ NSR ☐ ST ☐ SB ☐ A- fib ☐ A-Flutter ☐ Foley **Output:** **Intake:**

RATE ☐ PAC ☐ PVC ☐ AV Block ☐ 1 ☐ 2 ☐ 3

EF % ☐ S1 ☐ S2 ☐ S3 ☐ S4 ☐ MURMUR

☐ VALVE T P M A **BS** **BS** **A1C**



Lines

Infusions

☐ IV #

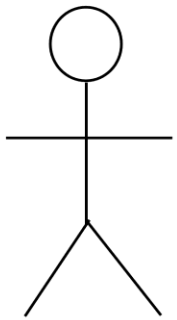
☐ IV #

☐ PICC ☐ I-Port A D ☐ TLC

☐ TPN ☐ LIPIDS ☐ BLOOD

Edema

0
1
2
3
4
P
W



Pulses

1
2
3
4
Dop

Drains ☐ SCD

JP **HV** **WV**

To Do/ Orders/Notes

☐

☐

☐

☐

IVF

_____@_____

_____@_____

_____@_____

Schedule Task

07	☐
19	
08	☐
20	
09	☐
21	
10	☐
22	
11	☐
23	
12	☐
24	
13	☐
01	
14	☐
02	
15	☐
03	
16	☐
04	
17	☐
05	
18	☐
06	
19	☐
07	

AS(assess) VS (vitals) BS(POC) TU(turn) LI(IV)
DR(dressing) RX(med) OOB I/O

SCHEDULED

☐ Cath ☐ US ☐ MRI ☐ CT
☐ CXR ☐ Dop ☐ Stress T
☐ ECHO ☐ EEG ☐ Surgical

Discharge: ☐ F-Meeting
☐ Home ☐ Home Health ☐ Rehab ☐ SNF
☐ ALF ☐ NH ☐ Hospice
☐

S-SITUATION

Code Status ☐ FC ☐ DNR ☐ DNI ☐ HCP ☐ MOLST - Admit Date-

Primary Admit Dx Allergies

The Problem I am calling about-

I just assessed the pt personally vitals are

T P R BP 02

Previously they were MAP MAP

T P R BP 02

I am concerned about the

BP >200_____ <200_____ 30mm Diff.

Pulse >130_____ <50_____ Pulse OX

Resp <8_____ >30_____

Temp

<96F/35.5C

>103F/39.4C

B-BACKGROUND

Dementia Ca Angina MI AFIB CABG HTN ACS

CHF COPD Asthma CKD DM I II HD PD Seizure other

Patient is Currently – A&O x T PL P **Mentation Changed** - Yes No

☐ **Confused** - Cooperative Non Cooperative

☐ **Agitated** Combative Verbally Abusive Threatening

☐ **Lethargic** but conversant able to swallow

☐ **Stuporous** not talking clearly might not be able to swallow

☐ **Comatose-**Eyes Closed not responding to stimulation

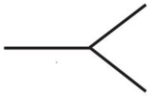
Patient is: ☐ On Oxygen ☐ Not on Oxygen

The patient has been on: (l/pm) % for _____Hrs/min o2 Sats _____ NEBS— ☐ ☐ ☐

ABG ☐ Ph PaCo2 HCO3 PaO2 Lactic Acid Troponin

A-ASSESSMENT

IV's-PRN's



This is what I think the problem is that it seems to be:

☐ Cardiac ☐ Pulmonary ☐ Infection ☐ Neuro ☐ Meds

☐ I'm not sure what the Problem is but the patient is deteriorating.

☐ The patient seems unstable and may get worse, we need to do something.

R-RECOMMENDATION

I would like to suggest:

☐ Transfer to ICU

☐ Come to see the patient

☐ Talk to family about code status

☐ Ask on-call to see pt now

☐ Ask for a consult from:

Are there any test needed:

☐ CXR ☐ ABG ☐ EKG ☐ CBC ☐ BMP _____

Would you like any changes?

How often would you like vitals?

How long do you think this problem will last?

If the patient doesn't get better would you want to be called back? When?

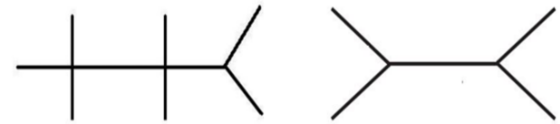
Vital Nursing Assessment

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

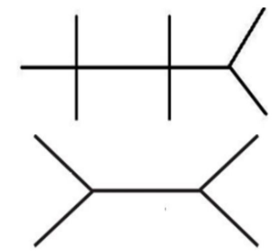
Vital Nursing Assessment

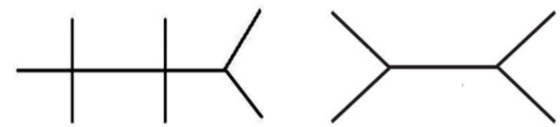
Room/DOA	Diagnosis	PRICE	Admission Labs-Diff
		P R I C E	

Admit VS	T-	P-	R-	O2-	BP/MAP-
	T-	P-	R-	O2-	BP/MAP-
	T-	P-	R-	O2-	BP/MAP-

Antibiotics- MOST PT DO WISH	Duo/Nebs	Oxygen	BP Meds
RN LPN			

Current Labs

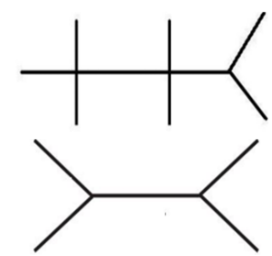


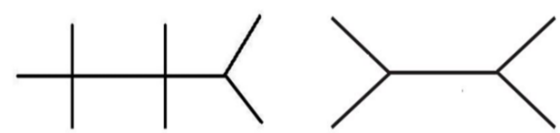
Room/DOA	Diagnosis	PRICE	Admission Labs-Diff
		P R I C E	

Admit VS	T-	P-	R-	O2-	BP/MAP-
	T-	P-	R-	O2-	BP/MAP-
	T-	P-	R-	O2-	BP/MAP-

Antibiotics- MOST PT DO WISH	Duo/Nebs	Oxygen	BP Meds
RN LPN			

Current Labs

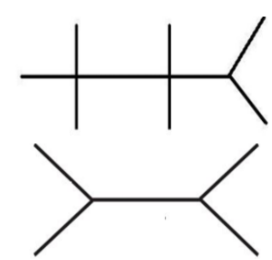


Room/DOA	Diagnosis	PRICE	Admission Labs-Diff
		P R I C E	

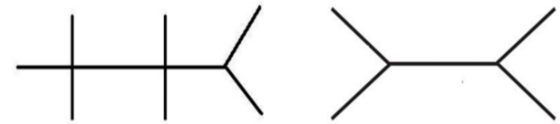
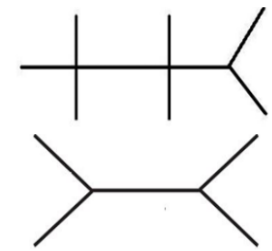
Admit VS	T-	P-	R-	O2-	BP/MAP-
	T-	P-	R-	O2-	BP/MAP-
	T-	P-	R-	O2-	BP/MAP-

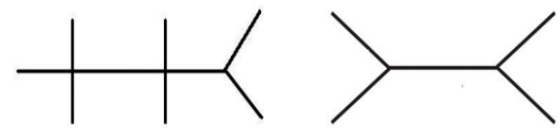
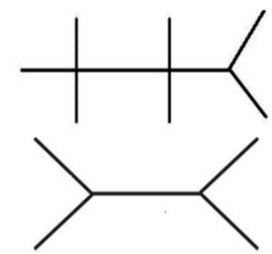
Antibiotics- MOST PT DO WISH	Duo/Nebs	Oxygen	BP Meds
RN LPN			

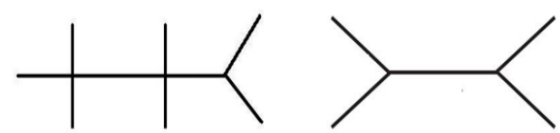
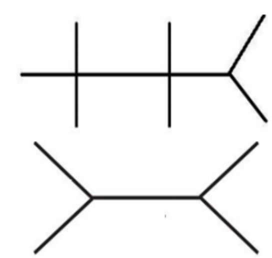
Current Labs



Vital Nursing Assessment

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs 
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs 
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs 
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

PRACTICAL LAB Case Study CAD

Unit 101 – Room 100 – Bed A
Patient Name: Joseph T. **Age / Gender:** 67-year-old male **Admit Date:** 07/27/2026 **Primary Diagnosis:** Coronary Artery Disease (CAD) – rule-out unstable angina / NSTEMI **Code Status:** Full Code **Tobacco:** Former smoker (quit 2019, 40-pack-year history) **Alcohol:** Denies **Special Variable:** Hard of hearing (bilateral hearing aids in place; speak facing patient, raise volume slightly, confirm understanding) **Mobility:** Ambulates with front-wheeled walker, assist of 1 for safety and balance. Independent with ADLs once at bedside, SCD's while in bed. **Diet:** Cardiac diet – 2 g sodium, low cholesterol, heart-healthy
Precautions: Standard **IV Access:** 20-gauge peripheral IV, left forearm, saline locked, site clean/dry/intact

Labs
Admission Labs (07/27)
- Troponin I: 0.08 ng/mL
- BNP: 285 pg/mL
- WBC: 8.4
- Hgb: 13.1 Hct: 39.2
- Platelets: 228
- Na: 138 -Cl: 97
- K: 3.9 -CO2: 24
- BUN: 22
- Creatinine: 1.1
- Glucose: 118
- PT/INR: 12.1 / 1.0
- Total Cholesterol: 214

Current Labs (07/29 AM)
Troponin I: 0.04 ng/mL (trending down)
BNP: 210 pg/mL
K: 3.6
Creatinine: 1.2
Digoxin level: pending (drawn this morning)

Vitals	Admission (07/27 14:20)	Current (07/29 08:00)
BP	158/92	142/84
HR	92	78
RR	20	18
T	98.6 °F (37.0 °C)	98.4 °F (36.9 °C)
SpO_2	95% on RA	97% on RA
Pain	4/10 (substernal pressure)	1/10

Medications	
Aspirin 81 mg PO daily	Atorvastatin 40 mg PO at bedtime
Metoprolol tartrate 25 mg PO BID	Lisinopril 10 mg PO daily
	Digoxin 0.125 mg PO daily

Admission Head-to-Toe Assessment (07/27)
General: Alert, oriented ×4. Appears anxious. Hard of hearing – responds appropriately when facing him and speaking clearly. Hearing aids in place and functional.
Neurological: Pupils equal, round, reactive to light. Strength 5/5 all extremities. No focal deficits. Steady gait with walker.
Cardiovascular: Heart rate regular, S1S2, no murmurs, rubs, or gallops noted on admission. Capillary refill < 3 seconds. Mild +1 bilateral ankle edema. No JVD.
Respiratory: Breath sounds clear bilaterally. Mild increased work of breathing with activity. SpO_2 95% on room air. No cough or sputum.
Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present ×4. Last BM yesterday. Tolerating cardiac diet.
Genitourinary: Voids independently. Clear yellow urine. No dysuria or frequency reported.
Integumentary: Skin warm, dry, intact. No pressure injuries. Peripheral IV site left forearm clean, dry, intact, no redness or swelling.
Musculoskeletal: Ambulates with front-wheeled walker, steady with assist of 1. Full ROM all extremities. No jointswelling or tenderness.
Psychosocial: Cooperative, anxious about possible heart attack. Wife at bedside. States he "just wants to get home and back to normal."

PRACTICAL LAB Case Study HTN

Unit 101 – Room 100 – Bed B
Patient Name: Ruth K. **Age / Gender:** 72-year-old female **Admit Date:** 07/28/2026 **Primary Diagnosis:** Hypertension – uncontrolled **Code Status:** Full Code **Tobacco:** Never smoker **Alcohol:** Occasional glass of wine (1–2 per week) **Special Variable:** Hard of hearing (uses one hearing aid in right ear; faces speaker, speaks clearly) **Mobility:** Independent with cane for longer distances; steady gait, no assist needed for short distances **Diet:** Low-sodium (2 g) cardiac diet
Precautions: VRE **IV Access:** 22-gauge peripheral IV, right forearm, saline locked, site clean/dry/intact

Labs
Admission Labs (07/28)
- Na: 141
- K: 3.8
- BUN: 19
- Cl: 98 Co2: 27
- Creatinine: 0.9
- Glucose: 102
- WBC: 7.1
- Hgb: 12.8
- Hct: 38.4
- Platelets: 245

Current Labs (07/29 AM)
- K: 3.7
- Creatinine: 0.9
- Na: 140

Current Labs (07/29 AM)
K: 3.7
Creatinine: 0.9
Na: 140

VITALS	Admission (07/28 11:40)	Current (07/29 07:45)
BP	178/98	152/86
HR	88	76
RR	18	16
Temp	98.2 °F (36.8 °C)	98.1 °F (36.7 °C)
SpO_2	98% on RA	98% on RA
Pain	0/10	0/10

Medications
Amlodipine 10 mg PO daily
Losartan 50 mg PO daily
Hydrochlorothiazide 25 mg PO daily
Metoprolol succinate 50 mg PO daily

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented ×4. Cooperative. Hard of hearing – responds well when facing her and speaking at moderate volume. Hearing aid in place.

Neurological: Pupils equal, round, reactive. Strength 5/5 all extremities. No focal deficits. Steady gait with cane.

Cardiovascular: Heart rate regular, S1S2, no murmurs or extra sounds. Capillary refill < 3 seconds. No edema. No JVD.

Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO_2 98% on room air.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present ×4. Last BM this morning.

Genitourinary: Voids independently. Clear yellow urine. No complaints.

Integumentary: Skin warm, dry, intact. No pressure injuries. Peripheral IV site right forearm clean, dry, intact.

Musculoskeletal: Full ROM. Uses cane for longer walks. Independent with ADLs.

Psychosocial: Calm. States she “didn’t realize her pressure was that high.” Daughter at bedside.

PRACTICAL LAB Case Study CHF

Unit 101 – Room 102 – Bed A
Patient Name: Samuel M. **Age / Gender:** 74-year-old male **Admit Date:** 07/22/2026 **Primary Diagnosis:** Congestive Heart Failure (CHF) exacerbation **Code Status:** Full Code **Tobacco:** Former smoker (quit 12 years ago) **Alcohol:** Denies **Special Variable:** Right below-knee amputation (BKA) – prosthetic available but not currently in use **Mobility:** Wheelchair for distances; transfers with assist of 1–2; stands at edge of bed with assist **Diet:** Cardiac diet, 2 g sodium, 1500 mL fluid restriction
Precautions: MRSA - **IV Access:** 20-gauge peripheral IV, left forearm, saline locked, site clean/dry/intact

Labs
Admission Labs (07/28)
- BNP: 1,240 pg/mL
- Na: 136
- K: 3.5
- Cl: 102 CO2: 26
- BUN: 29
- Creatinine: 1.3
- Glucose: 126
- WBC: 8.9
- Hgb: 12.4
- Hct: 37.1
- Platelets: 210

Current Labs (07/29 AM)
- BNP: 890 pg/mL
- K: 3.7
- Creatinine: 1.3
- Na: 137

VITALS	Admission (07/28 16:15)	Current (07/29 08:30)
BP	162/94	138/78
HR	98	82
RR	24	18
Temp	98.5 °F (36.9 °C)	98.3 °F (36.8 °C)
SpO_2	93% on RA → 96% on 2 L NC	96% on 2 L NC
Pain	2/10 (generalized fatigue)	1/10

Medications
Furosemide 40 mg PO BID
Lisinopril 10 mg PO daily
Carvedilol 6.25 mg PO BID
Spironolactone 25 mg PO daily

Admission Head-to-Toe Assessment (07/28)
General: Alert, oriented ×4. Mild respiratory distress at rest. Appears fatigued.
Neurological: Pupils equal, round, reactive. Strength 5/5 left lower extremity and both upper extremities. Right BKA residual limb intact, well-healed.
Cardiovascular: Heart rate regular, S1S2 with soft S3. +2 pitting edema bilateral lower extremities (left leg and right residual limb). Capillary refill 3 seconds. Mild JVD noted.
Respiratory: Bibasilar crackles. Mild increased work of breathing. SpO_2 93% on room air, improved to 96% on 2 L nasal cannula.
Gastrointestinal: Abdomen soft, slightly distended, non-tender. Bowel sounds present ×4. Last BM yesterday.
Genitourinary: Voids independently. Clear yellow urine. Intake and output being strictly monitored due to fluid restriction.
Integumentary: Skin warm, intact. Sacrum and residual limb skin intact without breakdown. Peripheral IV site left forearm clean, dry, intact.
Musculoskeletal: Transfers with assist of 1–2. Uses wheelchair. Right residual limb soft, no signs of infection or pressure.
Psychosocial: Cooperative but frustrated with limited mobility. Wife at bedside. States he “just wants to get the fluid off so I can breathe better.”

PRACTICAL LAB Case Study COPD - Emphysema

Unit 101 – Room 102 – Bed B
Patient Name: Elijah S. **Age / Gender:** 69-year-old male **Admit Date:** 07/28/2026 **Primary Diagnosis:** COPD exacerbation – Emphysema **Code Status:** Full Code **Tobacco:** Current smoker (1 PPD × 48 years) – counseling initiated **Alcohol:** Denies **Special Variable:** Limited English proficiency (primary language Spanish – use interpreter or language line for teaching and consent) **Mobility:** Ambulates independently short distances with frequent rest; uses front-wheeled walker for longer distances **Diet:** High-calorie, high-protein, small frequent meals
Precautions: TB **IV Access:** 22-gauge peripheral IV, right hand, saline locked, site clean/dry/intact

Labs

Admission Labs (07/28)

- WBC: 11.2
- Hgb: 15.8
- Hct: 48.1
- Platelets: 265
- Na: 139
- K: 4.1
- Cl: 108 CO2: 20
- BUN: 18
- Creatinine: 0.9
- Glucose: 122

ABG (on 2 L):
pH 7.36 / $PaCO_2$ 52 / PaO_2 64 / HCO_3 28

Current Labs (07/29 AM)

- WBC: 9.8
- K: 4.0
- Creatinine: 0.9

	Admission (07/28 19:10)	Current (07/29 08:00)
BP	148/86	136/78
HR	102	88
RR	28	20
Temp	98.8 °F (37.1 °C)	98.4 °F (36.9 °C)
SpO_2	88% on RA → 92% on 2 L NC	93% on 2 L NC
Pain	0/10	0/10

Medications

Albuterol 2.5 mg via nebulizer every 4 hours and PRN
Ipratropium 0.5 mg via nebulizer every 6 hours
Prednisone 40 mg PO daily
Azithromycin 250 mg PO daily

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented ×4. Appears dyspneic at rest. Using pursed-lip breathing. Spanish-speaking; interpreter used for full assessment.
Neurological: Pupils equal, round, reactive. Strength 5/5 all extremities. No focal deficits.
Cardiovascular: Heart rate regular, S1S2, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.
Respiratory: Barrel chest. Diminished breath sounds bilaterally with prolonged expiratory phase. Occasional mild expiratory wheezes. Increased work of breathing. SpO_2 88% on room air, improved to 92% on 2 L nasal cannula.
Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present ×4. Reports decreased appetite.
Genitourinary: Voids independently. Clear yellow urine.
Integumentary: Skin warm, dry, intact. No pressure injuries. Peripheral IV site right hand clean, dry, intact. Clubbing of fingers noted.
Musculoskeletal: Ambulates short distances independently, requires rest periods. Uses walker for hallway. Full ROM.
Psychosocial: Anxious about breathing. Cooperative once interpreter present. Daughter at bedside translating initially. States he “wants to get the breathing under control so I can go home.”

PRACTICAL LAB Case Study CKD

Unit 101 – Room 104 – Bed A

Patient Name: Martha L. **Age / Gender:** 71-year-old female **Admit Date:** 07/28/2026 **Primary Diagnosis:** Chronic Kidney Disease (CKD) Stage 4 with fluid overload **Code Status:** Full Code **Tobacco:** Never smoker **Alcohol:** Denies **Special Variable:** Hemodialysis (Monday-Wednesday-Friday schedule; left arm AV fistula) **Mobility:** Independent ambulation short distances; uses walker for longer distances due to fatigue **Diet:** Renal diet – low potassium, low phosphorus, controlled protein, 1500 mL fluid restriction

Precautions: Standard **IV Access:** 22-gauge peripheral IV, right forearm, saline locked. Left arm AV fistula present (thrill and bruit intact)

Admission Labs (07/28)

- BUN: 48
- Creatinine: 3.8
- GFR: 12
- Na: 137
- K: 5.2
- Cl: 108 CO2: 25
- Phosphorus: 5.8
- Calcium: 8.4
- Glucose: 118
- WBC: 7.6
- Hgb: 9.8
- Hct: 29.6
- Platelets: 198

	Admission (07/28 14:50)	Current (07/29 07:50)
BP	168/92	154/84
HR	86	78
RR	20	18
Temp	98.3 °F (36.8 °C)	98.2 °F (36.8 °C)
SpO_2	96% on RA	97% on RA
Pain	1/10 (generalized)	0/10

Current Labs (07/29 AM)

- BUN: 44
- Creatinine: 3.6
- K: 4.9
- Phosphorus: 5.4

Medications

- Sevelamer 800 mg PO three times daily with meals
- Lisinopril 5 mg PO daily
- Furosemide 40 mg PO daily
- Sodium bicarbonate 650 mg PO twice daily

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented ×4. Appears mildly fatigued. Cooperative.

Neurological: Pupils equal, round, reactive. Strength 5/5 all extremities. No focal deficits. Steady gait with walker.

Cardiovascular: Heart rate regular, S1S2, no murmurs. +1 pitting edema bilateral lower extremities. Capillary refill < 3 seconds. No JVD. Left arm AV fistula with palpable thrill and audible bruit.

Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO_2 96% on room air.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present ×4. Reports occasional nausea.

Genitourinary: Oliguric (urine output ~300–400 mL/day). Clear yellow urine when voiding. Strict intake and output monitoring.

Integumentary: Skin warm, dry, intact. Mild uremic frost not present. No pressure injuries. Peripheral IV site right forearm clean, dry, intact. AV fistula site without redness or drainage.

Musculoskeletal: Ambulates with walker for distances. Full ROM. Independent with most ADLs.

Psychosocial: Calm. Understands dialysis schedule. Daughter at bedside. States she “just needs to get the fluid under control before her next treatment.”

PRACTICAL LAB Case Study Diabetes

Unit 101 – Room 104 – Bed B
Patient Name: Daniel R. **Age / Gender:** 48-year-old male **Admit Date:** 07/28/2026 **Primary Diagnosis:** Type 1 Diabetes Mellitus – hyperglycemia, rule-out mild DKA **Code Status:** Full Code **Tobacco:** Never smoker **Alcohol:** Occasional beer (1–2 per month) **Special Variable:** Legally blind (diabetic retinopathy) – requires assistance with reading labels, insulin dosing verification, and written materials **Mobility:** Independent ambulation; steady gait **Diet:** Consistent carbohydrate diabetic diet / carb counting
Precautions: C-dif **IV Access:** 20-gauge peripheral IV, left forearm, saline locked, site clean/dry/intact

Admission Labs (07/28)
- Glucose: 348 mg/dL
- Na: 134
- K: 4.8
- BUN: 24
- Cl-112 CO2: 18
- Creatinine: 1.1
- Anion gap: 14
- WBC: 9.1
- Hgb: 13.6
- Hct: 40.8
- Platelets: 232
- A1C: 9.8%

Current Labs (07/29 AM)
- Glucose: 186 mg/dL
- K: 4.2
- Creatinine: 1.0
- Anion gap: 11

	Admission (07/28 21:30)	Current (07/29 08:15)
BP	138/84	128/76
HR	104	86
RR	22	16
Temp	98.7 °F (37.1 °C)	98.3 °F (36.8 °C)
SpO_2	98% on RA	98% on RA
Pain	0/10	0/10

Medications
- Insulin glargine 20 units SQ at bedtime
- Insulin lispro per sliding scale before meals and bedtime
- Lisinopril 5 mg PO daily
- Atorvastatin 20 mg PO at bedtime

Admission Head-to-Toe Assessment (07/28)
General: Alert, oriented ×4. Mildly dehydrated appearance. Legally blind – requires verbal description of environment and assistance with printed materials.
Neurological: Pupils equal, round, reactive (limited visual acuity). Strength 5/5 all extremities. No focal deficits. Reports mild bilateral foot numbness.
Cardiovascular: Heart rate regular, S1S2, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.
Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO_2 98% on room air. Mild fruity odor to breath on admission.
Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present ×4. Reports increased thirst and appetite recently.
Genitourinary: Polyuria on admission. Clear yellow urine. Now voiding normal volumes.
Integumentary: Skin warm, dry, intact. Multiple small healed injection sites on abdomen. No pressure injuries. Peripheral IV site left forearm clean, dry, intact.
Musculoskeletal: Independent ambulation. Full ROM. Steady gait.
Psychosocial: Cooperative and knowledgeable about Type 1 diabetes. Frustrated with recent high readings. Wife at bedside assisting with visual tasks. States he “needs help making sure the insulin doses are correct while my vision is this bad.”

PRACTICAL LAB Case Study CVA

Unit 101 – Room 106 – Bed A
Patient Name: Sarah J. **Age / Gender:** 76-year-old female **Admit Date:** 07/27/2026 **Primary Diagnosis:** CVA (left middle cerebral artery infarct) with residual right-sided weakness **Code Status:** Full Code **Tobacco:** Former smoker (quit 8 years ago) **Alcohol:** Denies **Special Variable:** Expressive aphasia and mild dysarthria – uses communication board and yes/no questions; allow extra time to respond **Mobility:** Right hemiparesis – assist of 2 for transfers; uses wheelchair; high fall risk
Diet: Dysphagia Level 2 (mechanically altered) with nectar-thick liquids – speech therapy following
Precautions: Contact **IV Access:** 20-gauge peripheral IV, left forearm, saline locked, site clean/dry/intact

Admission Labs (07/27)
- Na: 139
- K: 3.9
- BUN: 18 Creatinine: 0.9
- Cl:98 CO2: 25
- Glucose: 142
- WBC: 8.4
- Hgb: 12.9
- Hct: 38.7
- Platelets: 241
- PT/INR: 12.4 / 1.1

Current Labs (07/29 AM)
- K: 4.0
- Creatinine: 0.9
- Glucose: 118

	Admission (07/27 10:45)	Current (07/29 08:00)
BP	172/96	148/82
HR	88	76
RR	18	16
Temp	98.6 °F (37.0 °C)	98.2 °F (36.8 °C)
SpO_2	97% on RA	98% on RA
Pain	2/10 (right shoulder)	1/10

Medications
- Aspirin 81 mg PO daily
- Atorvastatin 40 mg PO at bedtime
- Lisinopril 10 mg PO daily
- Docusate sodium 100 mg PO twice daily

Admission Head-to-Toe Assessment (07/27)
General: Alert, oriented to person and place (time intermittent). Expressive aphasia present – follows simple commands, answers yes/no reliably, difficulty forming words. Contact precautions in place.
Neurological: Pupils equal, round, reactive. Right facial droop. Right upper and lower extremity strength 2/5. Left side strength 5/5. Mild right-sided neglect.
Cardiovascular: Heart rate regular, S1S2, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.
Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO_2 97% on room air.
Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present ×4. Last BM two days ago – stool softener started.
Genitourinary: Incontinent of urine on admission; now using purewick and timed toileting. Clear yellow urine.
Integumentary: Skin warm, dry, intact. No pressure injuries on admission. Right side of body requires careful positioning and skin checks. Peripheral IV site left forearm clean, dry, intact.
Musculoskeletal: Right hemiparesis. Requires assist of 2 for bed-to-chair transfers. High fall risk. Left side full ROM and strength.
Psychosocial: Frustrated with speech difficulty but cooperative. Husband at bedside. Uses communication board effectively for basic needs.

PRACTICAL LAB Case Study MS

Unit 101 – Room 106 – Bed B

Patient Name: Rachel T. **Age / Gender:** 52-year-old female **Admit Date:** 07/28/2026 **Primary Diagnosis:** Multiple Sclerosis exacerbation with Type 2 Diabetes Mellitus **Code Status:** Full Code **Tobacco:** Never smoker **Alcohol:** Denies **Special Variable:** Hard of hearing (bilateral hearing aids; face patient when speaking and confirm understanding) **Mobility:** Ambulates with bilateral crutches; requires rest periods due to fatigue; assist of 1 for safety on longer distances **Diet:** Consistent carbohydrate diabetic diet **Precautions:** Standard **IV Access:** 22-gauge peripheral IV, left hand, saline locked, site clean/dry/intact

Admission Labs (07/28)

- Glucose: 214 mg/dL
- Na: 138
- K: 4.0
- BUN: 16 Creatinine: 0.8
- CL-98 CO2-24
- WBC: 7.9
- Hgb: 13.2
- Hct: 39.5
- Platelets: 256
- A1C: 8.1%

Current Labs (07/29 AM)

- Glucose: 162 mg/dL
- K: 4.1
- Creatinine: 0.8

	Admission (07/28 15:20)	Current (07/29 08:10)
BP	142/86	134/78
HR	84	76
RR	18	16
Temp	98.4 °F (36.9 °C)	98.2 °F (36.8 °C)
SpO_2	98% on RA	98% on RA
Pain	3/10 (bilateral leg spasms)	2/10

Medications

- Prednisone 40 mg PO daily
- Metformin 1000 mg PO twice daily
- Baclofen 10 mg PO three times daily
- Insulin lispro per sliding scale before meals

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented ×4. Appears fatigued. Hard of hearing – responds appropriately when facing her and speaking clearly. Hearing aids in place.

Neurological: Pupils equal, round, reactive. Strength 4/5 bilateral lower extremities with mild spasticity. Upper extremities 5/5. Reports numbness and tingling in both feet. No acute focal deficits beyond baseline MS.

Cardiovascular: Heart rate regular, S1S2, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.

Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO_2 98% on room air.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present ×4. Last BM yesterday.

Genitourinary: Voids independently. Clear yellow urine. Occasional urgency reported (baseline).

Integumentary: Skin warm, dry, intact. No pressure injuries. Feet inspected – no open areas or breakdown. Peripheral IV site left hand clean, dry, intact.

Musculoskeletal: Ambulates with bilateral crutches, steady but fatigues quickly. Mild bilateral lower extremity spasticity. Full ROM upper extremities.

Psychosocial: Cooperative and knowledgeable about MS and diabetes. Frustrated with current flare and increased weakness. Husband at bedside. States she “just needs the steroids to kick in so I can get back on my feet.”

PRACTICAL LAB Case Study Parkinsons

Unit 101 – Room 108 – Bed A
Patient Name: Isaac H. **Age / Gender:** 78-year-old male **Admit Date:** 07/28/2026 **Primary Diagnosis:** Parkinson's disease with CAD and dementia **Code Status:** Full Code **Tobacco:** Former smoker (quit 15 years ago) **Alcohol:** Denies **Special Variable:** Hard of hearing (uses hearing aids bilaterally; face patient, speak clearly, reorient frequently due to dementia) **Mobility:** Shuffling gait with front-wheeled walker; assist of 1–2 for safety; high fall risk **Diet:** Cardiac diet, mechanical soft (aspiration risk secondary to Parkinson's)
Precautions: Standard
IV Access: 22-gauge peripheral IV, right forearm, saline locked, site clean/dry/intac

Admission Labs (07/28)
- Na: 138
- K: 4.1
- BUN: 22
- Creatinine: 1.2
- Glucose: 108
- WBC: 6.8
- Hgb: 12.6
- Hct: 37.9
- Platelets: 198

Current Labs (07/29 AM)
- K: 4.0
- Creatinine: 1.1
- Glucose: 102

	Admission (07/28 17:40)	Current (07/29 08:20)
BP	148/82	136/76
HR	78	72
RR	18	16
Temp	98.1 °F (36.7 °C)	98.0 °F (36.7 °C)
SpO_2	96% on RA	97% on RA
Pain	1/10	0/10

Medications
- Carbidopa/levodopa 25/100 mg PO three times daily
- Aspirin 81 mg PO daily
- Atorvastatin 40 mg PO at bedtime
- Donepezil 10 mg PO at bedtime

Admission Head-to-Toe Assessment (07/28)
General: Alert, oriented to person only. Appears pleasant but easily confused. Hard of hearing – responds better when facing him and speaking slowly. Hearing aids in place.
Neurological: Pupils equal, round, reactive. Resting tremor bilateral upper extremities (right > left). Mild cogwheel rigidity. Mask-like facial expression. Strength 4/5 all extremities. Follows simple one-step commands inconsistently.
Cardiovascular: Heart rate regular, S1S2, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.
Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO_2 96% on room air. Occasional soft cough.
Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present ×4. Last BM yesterday.
Genitourinary: Incontinent of urine at times; uses briefs and timed toileting. Clear yellow urine.
Integumentary: Skin warm, dry, intact. No pressure injuries. Peripheral IV site right forearm clean, dry, intact.
Musculoskeletal: Shuffling gait with walker. Stooped posture. Requires assist of 1–2 for transfers and ambulation. High fall risk related to Parkinson's and dementia.
Psychosocial: Cooperative when approached calmly. Wife at bedside and provides history. Becomes anxious when routines change. Responds well to simple, repeated instructions