N303 Care Plan # 1

Lakeview College of Nursing

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<div align="center">**Demographics (3 points)**</div>

Date of Admission 2/3/19	Patient Initials DK	Age 69	Gender Male
Race/Ethnicity White/Caucasian	Occupation Retired	Marital Status Married	Allergies No known allergies
Code Status Full code	Height 180.3 cm	Weight 99.7 kg	

<div align="center">**Medical History (5 Points)**</div>

Past Medical History: acute lymphatic leukemia, CAD, cardiomyopathy, depression, H/O stem cell transplant, history of multiple myeloma, Hx of CABG, hypercholesterolemia, hyperlipidemia, hypertensive cardiovascular disease myeloma, S/P IVC filter

Past Surgical History: Blood transfusion, CABG, Decompression laminectomy of lower spine, tonsillectomy, and adenoidectomy

Social History (tobacco/alcohol/drugs, pertinent social factors):

- **Tobacco: never smoked**
- **Alcohol: Denies use**
- **Drugs: No drug use**
- **Assistive devices: Patient states he uses a wheelchair at home**
- **Marital status: Married**
- **Living situation: Lives with wife**
- **Occupation: Retired, works on cars**
- **Education level: High school education**

<div align="center">**Admission Assessment**</div>

Chief Complaint (2 points): Cough, weakness

History of present Illness (10 points): Patient presented to the emergency department with a cough and generalized weakness. Patient explained that this had been going on for 1 week throughout each day. The cough can be heard as productive and seen as productive as the patient's sputum is coughed up. The patient stated, "Lying down makes the pain worse." To

relieve the pain and cough the patient states, "I drink water." The patient is currently on antibiotics and antivirals due to chemotherapy. Patient also rated the pain at 4/10 when first admitted.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Influenza A

Secondary Diagnosis (if applicable): .

<mark>**Pathophysiology of the Disease, APA format (20 points):**</mark> .

Influenza type A usually takes place in animals not humans. However, it can be easily transmitted from animals to humans. Influenza A is usually transmitted via airborne. For example, someone coughing or even sneezing. "Flu viruses enter the body through the mucus membranes of your nose, eyes, or mouth" (Different Types of Flu: Influenza A, B, C and more). This virus attaches to the cells of the upper respiratory tract. In the upper respiratory tract is hair-like microvilli and cilia on the surface of the trachea. The influenza A virus binds to these hair-like structures and enters the body to multiply.

Signs and symptoms of this disease include a fever over 38 degrees Celsius, have aching muscles all over, chills and night sweats, throbbing headache, cough, fatigue and weakness, nasal congestion, sore throat. The patient showed a few of these different signs and symptoms of influenza. The patient showed a temp of 37

degrees throughout the day, no fever. The patient did, however, show symptoms of aching muscles. The patient explained that he felt tired all over. Patient did show symptoms of nasal congestion, however, a lot of it was coughed up and his nose would clear again. If this were to go untreated the patient would have possible developed an ear infection, diarrhea, nausea, vomiting, dizziness, abdominal pain, or possible chest pain. The patient did not show any of these symptoms. Vital signs would include tachycardia, tachypnea, possibly low blood pressure, O2 diminished, and a high temperature. The vital signs of this patient were normal compared to what someone with influenza A could possibly show.

Diagnostic finding would include a culture to figure out what kind of bacteria or virus is in the body. This culture can be done either sputum, swab of the mouth, or swab of the nose. Some doctors might even diagnose Influenza A purely on the symptoms that the patient presents with.

Treatment of influenza A can be use of antiviral medications. Unfortunately, the most common treatment is recommended rest, plenty of water, and pain relievers. The patient used all four of these treatment options.

Reference:

Hinkle, J. L., & Cheever, K. H. (2018). Brunner & Suddarths textbook of medical-surgical nursing. Philadelphia: Wolters Kluwer.

Different Types of Flu: Influenza A, B, C and more. (n.d.). Retrieved from

https://www.webmd.com/cold-and-flu/advanced-reading-types-of-flu-viruses#1

Laboratory Data (15 points)

CBC: ==Highlight All Abnormal Labs==—**Explanations must be in complete sentences and contain in-text citations in APA format.**

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**4.7-6.1**	==2.95==	==2.72==	**The reason for this being low is because he has leukemia (Hinkle, J. L., & Cheever, K. H. 2018, 2018).**
Hgb	**14-18**	==.9.8==	==8.9==	**This could be the result of chemotherapy drugs also leukemia (Hinkle, J. L., & Cheever, K. H. 2018, 2018).**
Hct	**42-52**	==28.6==	==26.5==	**This is the result from having leukemia and using chemotherapy drugs (Hinkle, J. L., & Cheever, K. H. 2018, 2018).**
Platelets	**150-450**	==60==	==59==	**Chemotherapy is the cause of the low platelet count (Hinkle, J. L., & Cheever, K. H. 2018, 2018).**
WBC	**5-10**	==1.9==	==1.3==	**The low white blood cell count is the result of leukemia and the influenza infection (Hinkle, J. L., & Cheever, K. H. 2018, 2018).**
Neutrophils	**45.3-79**	N/A	77.9	.
Lymphocytes	**11.8-45.9**	N/A	==9.1==	**The low lymphocytes are due to the leukemia and influenza A (Hinkle, J. L., & Cheever, K. H. 2018, 2018).**
Monocytes	**4.4-12.0**	N/A	10.1	.N/A
Eosinophils	**0.0-6.3**	N/A	2.1	N/A
Bands	**0-5**	N/A	0.8	.N/A

Chemistry: <mark>Highlight Abnormal</mark>—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal
Na+	135-145	136	141	.N/A
K+	3.5-5.0	4.0	3.8	.N/A
Cl-	98-106	101	<mark>110</mark>	This is probably because the patient had too much salt in his diet from a previous meal. This is not too high to draw concern (Hinkle, J. L., & Cheever, K. H. 2018, 2018).
CO2	22-29	23	24	.N/A
Glucose	70-250	113	101	.N/A
BUN	10-20	15	12	.N/A
Creatinine	0.6-1.2	1.13	0.95	.N/A
Albumin	3.5-5.0	<mark>3.4</mark>	N/A	This is due to the patient having a low protein diet the day before this is not enough to be worried about (Hinkle, J. L., & Cheever, K. H. 2018, 2018).
Calcium	9.0-10.5	<mark>8</mark>	<mark>7.3</mark>	The low calcium is the result from certain chemotherapy drugs (Hinkle, J. L., & Cheever, K. H. 2018, 2018).
Mag	1.3-2.1	N/A	N/A	.N/A
Phosphate	2.5-4.5	N/A	N/A	.N/A
Bilirubin	0.1-1.3	1.3	N/A	.N/A
Alk Phos	35-105	59	N/A	.N/A

AST	5-40	<mark>45</mark>	N/A	This low AST is due to leukemia (Hinkle, J. L., & Cheever, K. H. 2018, 2018).
ALT	42-128	42	N/A	.N/A
Amylase	56-90	N/A	N/A	.N/A
Lipase	0-110	N/A	N/A	.N/A
Cholesterol	<200	N/A	N/A	.N/A
Triglycerides	<150	N/A	N/A	.N/A
Lactic Acid	2-4	N/A	N/A	.N/A
Troponin	<0.2	0.03	N/A	N/A
CK-MB	30-170	N/A	N/A	N/A
Total CK	22-198	N/A	N/A	N/A

Other Tests <mark>Highlight Abnormal</mark>—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	2.0-3.0	N/A	N/A	N/A
PT	11-12.5	N/A	N/A	N/A
PTT	16-40	N/A	N/A	N/A
D-Dimer	0.43-2.33	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A

Urinalysis <mark>Highlight Abnormal</mark>—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
Color & Clarity	Yellow, clear	N/A	N/A	N/A
pH	5.0-8.0	N/A	N/A	N/A
Specific Gravity	1.005-1.034	N/A	N/A	N/A
Glucose	Normal	N/A	N/A	N/A
Protein	Negative-Normal	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	<5	N/A	N/A	N/A
RBC	0-3	N/A	N/A	N/A
Leukoesterase	Negative	N/A	N/A	N/A

Arterial Blood Gas <mark>Highlight Abnormal</mark>—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.38-7.42	N/A	N/A	N/A
PaO2	75-100	N/A	N/A	N/A
PaCO2	38-42	N/A	N/A	N/A
HCO3	22-28	N/A	N/A	N/A
SaO2	94-100	N/A	N/A	N/A

Cultures <mark>Highlight Abnormal</mark>—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	Negative	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (APA): .

Hinkle, J. L., & Cheever, K. H. (2018). Brunner & Suddarths textbook of medical-surgical

    nursing. Philadelphia: Wolters Kluwer.

Diagnostic Imaging—All Other Diagnostic Tests (EKG, Echocardiogram, X-rays, CT scan,

etc.) (5 points): .

- **Chest x-ray**
    - o **This test was done to detect any form of atelectasis because of the chronic**

        cough the patient has.

Diagnostic Test Correlation, APA Format & References (5 points): .

Hinkle, J. L., & Cheever, K. H. (2018). Brunner & Suddarths textbook of medical-surgical

    nursing. Philadelphia: Wolters Kluwer.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Famotidine (Pepcid)	Prednisone (deltasone)	Ciprofloxacin (cipro)	Rosuvastatin (Crestor)	Sertraline (Zoloft)
Dose	20 mg once daily	50 mg once daily	500 mg once daily	10 mg once daily	50 mg once daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Antiulcer agent	Anti-inflammatory	Antibiotic	antihyperlipidemic	Antianxiety
Action	This drug reduces HCl formation by preventing histamine from binding with H2 receptors	Binds to intracellular glucocorticoid receptors and suppresses inflammatory and immune responses	Inhibits the enzyme DNA gyrase, which causes the bacteria to die	Reduces lipid levels by increasing the number of LDL receptors	Inhibits reuptake of the neurotransmitter serotonin which increases the amount of serotonin available
Reason Client Taking	To prevent recurrence of duodenal ulcer	To treat leukemia	To treat staphylococcus infection	To treat hyperlipidemia	To treat depression
Contraindications (2)	Hypersensitivity, hypersensitivity to phenylketonuria	Hypersensitivity, fungal infection	Hypersensitivity, myasthenia, gravis	Active liver disease, hypersensitivity	Hypersensitivity, use of disulfiram
Side Effects/Adverse Reactions (2)	Anxiety, fever, headache, diarrhea	Euphoria, Edema, diaphoresis	Oral candidiasis, agitation, anxiety	Dizziness, thrombocytopenia, increased cough	Hyperglycemia, abdominal cramps, coughing
Nursing Considerations (2)	Shake oral suspension for 5-10 seconds, monitor risk for	Administer once daily to match body's normal cortisol	Obtain culture and sensitivity test results, Patient should be	Monitor AST, ALT, Monitor serum lipoprotein levels	Do not give to patients with bradycardia, monitor liver enzymes and

	aspiration with chewable tablets	secretion, Prolonged use can cause hypothalamic-pituitary adrenal suppression	well hydrated while taking this medication		BUN, Watch closely for suicidal tendencies
Client Teaching needs (2)	**Instruct to avoid alcohol, instruct to carefully chew tablets**	**Take with food, Caution patient not to stop abruptly**	**Complete full course of medication even if the patient feels better, do not take with dairy products**	**Encourage patient to follow a low-fat diet, wait two hours to take antacids after taking this drug**	**Avoid hazardous activities until known drug effects, do not stop taking drug abruptly**

Hospital Medications (5 required)

Brand/Generic	**Azithromycin (Zithromax)**	**Ceftriaxone (Rocephin)**	**Acetaminophen (Tylenol)**	**Levothyroxine (Tirosint)**	**Benzonatate (Zonatuss)**
Dose	**500 mg**	**1,000 mg**	**500 mg**	**25 mcg**	**200 mg**
Route	**IV piggyback**	**IV piggy back**	**Oral**	**Oral**	**Oral**
Classification	**Antibiotic**	**antibiotic**	**antipyretic**	**Thyroid hormone**	**Non-narcotic antitussive**
Action	**Concentrates in phagocytes, macrophages, and fibroblasts, which may help move it to infection**	**Interferes with bacterial cell wall synthesis which can make bacterial cells rupture and die**	**Inhibits cyclooxygenase, blocks prostaglandin production and interferes with pain impulse**	**Increases energy expenditure, accelerates the rate of cellular oxidation, regulates growth**	**Anesthetizes stretch receptors in respiratory tract, lung tissue, pleura which reduces cough**
Reason Client Taking	**To treat influenza**	**To treat staphylococcus aureus**	**To control mild pain**	**To treat hypothyroidism**	**To relieve cough**

Contraindications (2)	History of jaundice, hypersensitivity	Hypersensitivity, calcium-containing I.V. solutions	Hypersensitivity, hepatic impairment	Hypersensitivity, untreated thyrotoxicosis	Hypersensitivity, patients who cannot swallow
Side Effects/Adverse Reactions (2)	Anxiety, chest pain, hyperglycemia	Chills, fever, Stevens Johnson syndrome	Coma, jaundice, nausea	Fatigue, headache, weight gain	Headache, burning eyes, rash
Nursing Considerations (2)	Monitor closely for arrhythmias, Obtain culture and sensitivity	Obtain culture and sensitivity results, Assess CBC, hematocrit, bilirubin, and liver enzymes	Monitor renal function, use cautiously with alcoholics	Monitor PT of patients who receive anticoagulants, Monitor blood glucose levels	Don't break or crush this medication, Assess type and frequency of cough
Client Teaching needs (2)	Take 1 hour before food, Educate patient on symptoms of superinfection	Report bloody, watery stools, Report hypersensitivity reactions, such as rash, itching	May be crushed or swallowed whole, do not exceed recommended dose	Inform this will be a lifetime drug, take with full glass of water to prevent aspiration	Swallow capsules whole, Emphasize importance of keeping drug out of reach from children

Medications Reference (APA Format):.

2018 Nurses drug handbook. (2018). Burlington, MA: Jones & Bartlett Learning

Assessment

Physical Exam (18 points)

NEUROLOGICAL (2 points): MAEW: Y ⊠ N☐ PERLA: Y ⊠ N☐ Strength Equal: Y ⊠ N ☐ if no - Legs ☐ Arms ☐ Both ☐	Patient is awake and sitting in the bed. Patient is A&O x4. This patient enjoys talking and seems used to the hospital setting. English speaking and uses a good pace while talking. Patient MAEW for current age and condition.

Orientation, Mental Status, Speech, Sensory, LOC:	**Patient has bilaterally equal strength. There is no sign of neurological damage.**
MUSCULOSKELETAL (2 points): **Neurovascular status, ROM, Supportive devices/strength** **ADL Assistance Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	**Morse Fall risk score of 45** **Patient has active range of motion bilaterally. There is no sign of neurovascular deficit. Patient is a fall risk. Needs assistance for standing and uses a wheelchair to get around the house at home.**
CARDIOVASCULAR (2 points): **Heart sounds: S1, S2** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable)** **Peripheral Pulses: Present** **Capillary refill: Under 3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema N/A**	**Patient is not on telemetry. Patient has a normal heart rate with S1 and S2 sounds. Radial and pedal pulses were assessed. Capillary refill time was under 3 seconds. There are no signs of edema. There is no neck vein distention.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character:** **Clear**	**Patient is breathing at a normal pace. There is no use of accessory muscles to breath. Anterior and posterior lung sounds auscultated. Lungs sounds clear. Patient is not on any oxygen. Currently on room air**
GASTROINTESTINAL (2 points): **Diet at home: regular** **Current Diet: regular** **Height: 180.3 cm** **Weight: 99.1 kg** **Auscultation Bowel sounds: Present in all 4 quadrants** **Last BM: 02/03/19** **Palpation: Pain, Mass etc.: Nothing palpable** **Inspection: distention, incisions, scars, drains, wounds: No scars or wounds** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Feeding tubes/PEG tube Y ☐ N ☒** **Type/A**	**Patient's current diet is regular. Patient denies use of substances, tobacco, and alcohol. No ostomy, NG tubes, PEG tubes, or drains. Bowel sounds auscultated in all four quadrants. Patient states last bowel movement was 02/03/19. No pain in the abdomen or palpable masses were found. No distention, incisions, scars, or wounds were seen.**

INTEGUMENTARY (2 points): Skin color: character, turgor, rashes, bruises: wounds: . Braden scale: 21 Drains present: Y☐ N ☒ Type_____	Braden scale of 21 Patient is a Caucasian male that is his normal skin tone. Skin has normal elasticity and warm to the touch. There were no signs of bruising on this patient. No skin turgor
HEENT (2 points): Head: . Ears: Eyes: Nose: Teeth	Head is midline. Ears show no abnormal drainage. Patient had no problem with hearing. PEERLA is noted. Patient feels a little stuffed up but seems to cough up a lot of the mucus. Oral mucosa is pink and moist.
GENITOURINARY (2 Points): Color, character, quantity of urine, pain, Dialysis Y ☐ N ☒ Inspection of genitals Catheter: Y ☐ N ☒ Type_____	No dialysis, catheter. Patient does not have any problems urinating.
PSYCHOSOCIAL/CULTURAL (2 points): Coping methods, Educational level Developmental level, Ethnicity, Religion & what it means to pt. Occupation (previous if retired) Personal/Family Data (Think about home environment, family structure, and available family support)	Patient enjoys talking to nurses. Patient slept well last night. Patient is not an alcohol, tobacco, or drug user. Patient graduated high school and loves to work on cars. Patient lives at home with his wife. Patient does not have any religious practices

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
12:30	72 beats per minute	101/57	18	38 Celsius	97%
4:00	75 beats per minute	106/62	18	37.7 Celsius	.97%

Vital Sign Trends: Patient's vital signs stayed roughly the same throughout the day. Even after administering antibiotics the patient's vital signs stayed stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1:15	0/10	N/A	N/A	N/A	N/A
3:30	0/10	N/A	N/A	N/A	N/A

==IV Assessment (2 Points)==

Site Location, Patency/Condition & Date	Fluid Type/Rate or Saline Lock
Central line (implanted port single) right upper arm 20 gauge accessed at 02/03 @14:12 no signs of drainage, clean dry and intact	Ceftriaxone 250 mL/hr.

Intake and Output during Your Shift (2 points)

Intake	Output
500 ml	200 ml

Nursing Care

Summary of care- Narrative of Nursing care provided, patient status throughout the day, any major concerns, etc. (2 points): .

Patient enjoyed having nurses to talk to. Patient remained on the floor throughout the day. Patient denied any form of pain all evening. Patient received antibiotics and had no adverse effects to them. Vital signs stayed stable throughout the day. Patient white blood cell count was diminished from 1.9 to 1.3. Patient asked if his white blood cell count raised or not. Patient seemed to be tolerating regular diet well. Before leaving patient stated that he was about ready to go to the bathroom. Anticipate patient will return to the hospital again to assess the white blood cell count.

Discharge Planning- Identify discharge needs, education, home health services/equipment, family involved, etc. (2 points):

Upon discharge patient will be going home to his wife. Patient needs to remain free from falls, keep clear lung sounds, and keep pain level tolerable. Patient will need to be wheel chaired out considering he does use a wheel chair at home. Patient will need to understand importance of hand hygiene and how to stay away from infection considering he has a very low white blood cell count.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. .Risk for aspiration related to influenza A as evidenced by wet cough	.This nursing diagnosis was chosen due to the wet cough the patient had throughout the	1. Encourage fluids to loosen up secretions 2. Place patient	Patient understood why he was in high fowlers position. Patient asked why he should drink more fluids and understood how that

	day of care	in high fowlers to promote breathing	could help cough up more secretions. Patient is currently drinking more water, coughing up more secretions, and breathing normally.
2. .Risk for infection related to leukemia as evidenced by low WBC count	.This was chosen due to the low WBC count and the patient has a very high risk for developing an infection	1. .Routinely monitor WBC count 2. .Assess temperature every 4 hours	Patient asked routinely about WBC count. Patient's white blood cell count is still low. Patient's temperature stayed consistent throughout the day did not seem to raise at all. Patient understood why his temperature was being taken.
3. .Fall risk related to muscle weakness in legs as evidenced by wheelchair use	.This was chosen because his fall risk score was a 45. Also, the weakness in his legs do not allow him to walk on his own	1. Gait Belt used in any case the patient needs to get up 2. Bed alarm set up for the patient	Patient did not get up during the evening. Patient understood that he was not allowed to get up himself. Patient stated, "I use a wheelchair at home" so he understood his own strength. There were no problems with the bed alarm during time of care.
4. Risk for anxiety related to depression as evidenced by asking many questions about diagnosis	.With the depression this patient already has it is adamant that as a nurse I make sure his anxiety level is controlled	1. Encourage patient to express feelings of anxiety 2. Educate patient on different coping skills specific to him	Patient started to express feelings of anxiety after being encouraged to express his feelings. Patient was able to name a few different coping skills, such as working on cars or talking to his wife.
5. .Knowledge Deficit related to influenza A as evidenced by not understanding how he	.This patient was confused as to why he was sick. This patient needs to be taught why he got sick.	1.. Educate patient on proper hand washing techniques 2.. Educate patient on importance of taking the whole	Patient was educated on why he was sick. Patient understands the importance of hand hygiene. Patient seems to understand the importance of taking

acquired influenza		**prescribed medication of antibiotics**	**the whole prescribed antibiotic medication**

Overall APA Format/Neatness/Grammar (5 point):

Concept Map (20 Points):

Subjective
"Lying down makes the pain worse"
"I drink water to relieve the pain"
"Pain is at a 4/10"
Has felt pain for the past week

Nursing diagnosis/outcomes
1. .Risk for aspiration related to influenza A as evidenced by wet cough
Outcome
Patient will loosen up secretions to cough up more and get rid of infection
2. Risk for infection related to leukemia as evidenced by low WBC count
Outcome
Patient will understand why he has low WBC and stay away from infection
3. Fall risk related to muscle weakness in legs as evidenced by wheelchair use
Outcome
Patient will not fall and get assistance when getting up
4. Risk for anxiety related to depression as evidenced by asking many questions about diagnosis
Outcome
Patient will discuss any concerns with the nurse and lower anxiety level
5. Knowledge Deficit related to influenza A as evidenced by not understanding how he acquired influenza
Outcomes
Patient will learn how to properly wash hands and show nurse how to do it.

Objective
Wet cough
Low white blood cell count shows infection
A lot of bunch of sputum being coughed up

Patient presented to the emergency department with a cough and generalized weakness. Patient had been dealing with this for 1 week. The cough is productive as the patient's sputum is coughed up. The patient is currently on antibiotics and antivirals due on chemotherapy.

Nursing interventions
Encourage fluids to loosen up secretions
Place patient in high fowlers to promote breathing
Routinely monitor WBC count
Assess temperature every 4 hours
Gait Belt used in any case the patient needs to get up
Bed alarm set up for the patient
Encourage patient to express feelings of anxiety
Educate patient on different coping skills specific to him
Educate patient on proper hand washing techniques
Educate patient on importance of taking the whole prescribed medication of antibiotics