

N431 Care Plan # 1
Lakeview College of Nursing
Rece Doggett

Demographics (3 points)

Date of Admission 09/19/2020	Patient Initials D P	Age 69 YO	Gender Male
Race/Ethnicity White	Occupation Retired	Marital Status Divorced	Allergies Demerol, Tizanidine
Code Status Full Code	Height 6'0"	Weight 188lb	

Medical History (5 Points)

Past Medical History: A-fib, CAP, carpel tunnel of left wrist, CKD stage III, COPD

Emphysema, Hyponatremia, MI

Past Surgical History: Cholecystectomy, hernia repair, appendectomy, lung surgery, pacemaker insertion, cardiac catheter

Family History: Father – CHF, CAD, MI; Mother - MI

Social History (tobacco/alcohol/drugs): Smoked a pack per day for 56 years. Previously used alcohol. Client states he does not use either anymore.

Assistive Devices: Occasionally uses walker, but not required

Living Situation: Lives with girlfriend in an apartment.

Education Level: Highschool.

Admission Assessment

Chief Complaint (2 points): SOB and Left sided Chest pain

History of present Illness (10 points): D. P. visited the E.D. on 09/19/2020. He has a hx of symptoms that have presented the day of admission. Client is always oxygen dependent and on 2L. D P was experiencing SOB and L sided chest pain. All symptoms started early in the day causing him to seek help. The client did state that he waited a short amount of time to see if the episode would pass on its own before coming into the emergency department. He

denies any of the same symptoms at this time, although, he was complaining of abdominal pain. After this client was seen and treated in SHMC emergency department he was transferred to 4 east for observation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): COPD exacerbation. Client said he had SOB and L sided chest pain earlier in the day. This lasted a couple of hours before D.P. decided he would seek medical attention. He was familiar with the chest pressure from not being able to breathe because it is something he had experienced before, but the chest pain was a new combination with it for this client. The client stated, “There is more pressure in my chest when I try to do housework.” Nothing relieved the clients chest pressure or shortness of breath. Client was treated with a nebulizer and corticosteroids upon admission to the E.D.

Secondary Diagnosis (if applicable): Chest wall pain

Pathophysiology of the Disease, APA format (20 points):

Chronic Obstructive Pulmonary Disease is lung disease that can occur due to genetic and environmental factors. COPD is identified as poor irreversible airflow limitation cause by a combination of chronic bronchitis, emphysema, or hyperreactive airway disease. When COPD occurs, the alveoli in the lungs begin to lose the natural elasticity it needs for gas exchange it also causes over expansion of the lungs. This results in some air still being trapped in the lungs when you exhale that builds up over time causing respiratory acidosis.

The main cause of COPD in developed countries is due to smoking tobacco. With smoking there may be misdiagnosed COPD cases due to the lungs being less functional in

general, if this occurs a more thorough evaluation is performed. Other causes of COPD may include exposure to chemical fumes, or excessive inhalation of dust.

Symptoms may include shortness of breath (especially during physical activity), wheezing, chest tightness, cyanosis in the fingers, frequent respiratory infections, lack of energy, unintended weight loss, and/or edema of the legs, feet or ankles. **Risk factors** for COPD include exposure to tobacco smoke including secondhand smoking, prolonged exposure to dust or chemicals, age, and genetics. COPD can cause complications such as respiratory infections, heart problems, lung cancer, high blood pressure in lung arteries, and depression.

There are **no treatments** for COPD, but there are preventions which include avoid smoking or secondhand smoke and reducing exposure to fumes from chemicals. The goal of a client with COPD is to manage or improve symptoms. The client's reason for having this disease is most likely from his history of smoking. His COPD caused him to be out of breath and then his chest pain began resulting in him seeking medical attention.

Labs and test results that are expected to be abnormal are O₂ levels and CO₂ levels. This client's ABGs were not drawn during his trip to the emergency department, but they did draw heart enzyme labs showing an increased troponin I. It is common to have a reading as low as 86 or 87% O₂ sat on a pulse oximeter. This client did not drop below 90% during clinical time. X-rays are a tool used by doctors to diagnose the disease with. The x-ray will show a cloudy image which is also similar in pneumonia. D. P. had an x-ray that shows bilateral pulmonary emphysema with COPD noted and scarring in the L mid lung.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Cnrm, P. H. J. L. R. N., & PhD Rn, C. K. H. (2013). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing (Brunner and Suddarth's Textbook of Medical-Surgical)* (Thirteenth, North American ed.). Philadelphia, Pennsylvania: LWW.

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	4.4 – 5.8	4.85	4.58	
Hgb	13 – 16.5	12.7	12.1	Due to rate continuing to fall while hospitalized this is most likely due to the medications the client is taking. (Hinkle, Cheever, 2017)
Hct	38 – 50	39.2	37.1	Due to rate continuing to fall while hospitalized this is most likely due to the medications the client is taking. (Hinkle, Cheever, 2017)
Platelets	140 – 446	234	217	
WBC	4 – 12	8.6	15.4	Elevated WBC may be due to nosocomial infection or medications.
Neutrophils	48 - 60	76.3		High neutrophil count is usually due to a bacterial infection. (Capriotti, Frizzell, 2016)
Lymphocytes	18-42	12.0		Low lymphocyte and high neutrophil counts are usually linked to bacterial infections. However, if lymphocyte count is chronically low it may indicate other types of infection such as cancer. (Capriotti, Frizzell, 2016)
Monocytes	4-12	8.9		
Eosinophils	0.0 - 8	1.9		
Bands	0 -1	0.9		

Chemistry **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
Na-	133 – 144	140	137	
K+	3.5 – 5.1	4.3	4.6	
Cl-	98 – 107	101	98	
CO2	21 – 31	33	34	COPD
Glucose	70 – 99	100	127	Glucose levels are abnormal when a person undergoes infection.
BUN	7 – 25	11	19	
Creatinine	0.5 – 1.2	0.78	0.75	
Albumin	3.5 – 5.7	3.8		
Calcium	8.6 – 10.3	9.1	9.2	
Mag	1.6 – 2.6	1.8		
Phosphate				
Bilirubin	0.2 – 0.8	0.6		
Alk Phos	34 - 104	100		
AST	13 - 39	20		
ALT	7 – 52	12		
Amylase				
Lipase				
Lactic Acid				

Troponin	0.0 – 0.05	0.056		Evidence of heart damage.
CK-MB				
Total CK				

Other Tests **Highlight All Abnormal Labs**—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				
PT	0.8 – 1.1			
PTT				
D-Dimer				
BNP	0 - 100	276		This test is used to diagnose heart failure. (Capriotti, Frizzell, 2016)
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

Urinalysis **Highlight All Abnormal Labs**—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
Color & Clarity	No UA in chart			
pH				
Specific Gravity				

Glucose				
Protein				
Ketones				
WBC				
RBC				
Leukoesterase				

Arterial Blood Gas **Highlight All Abnormal Labs**—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	No ABG in chart			
PaO2				
PaCO2				
HCO3				
SaO2				

Cultures **Highlight All Abnormal Labs**—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	No cultures were performed on this client.			
Blood Culture				

Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Hinkle, J. L., & Cheever, K. H. (2017). *Brunner & Suddarth's textbook of medical-surgical nursing*. LWW.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

EKG – used for analyzing the electrical impulses of the heart and can show if an active heart attack is occurring or previous heart attacks that have caused damage to the heart.

This is related to the clients chest pain.

Chest X-rays are used to show if there is any consolidation in the lungs. This test can also be used to chest the placement of certain procedures such as chest tubes or intubation placement. With this client, the test was primarily to see if the clients COPD has worsened or if other infections were present in the lungs.

Diagnostic Test Correlation (5 points):

The EKG showed previous heart history complications and to see if any cardiac issues were occurring at the time.

The x-ray was showed evidence that the clients COPD is progressing and there is scarring in the left mid lung.

Diagnostic Test Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Hinkle, J. L., & Cheever, K. H. (2017). *Brunner & Suddarth's textbook of medical-surgical nursing*. LWW.

**Current Medications (10 points, 1 point per completed med)
*10 different medications must be completed***

Home Medications (5 required)

Brand/Generic	Allopurinol Zyloprim	Warfarin Coumadin	Omeprazole Prilosec	Furosemide Lasix	Digoxin Lanoxin
Dose	100 mg	7.5mg M-F 3.5 Sat & Sun	10mg Capsule	20mg tab	125 mcg
Frequency	Daily	Daily	Daily	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Uricosuric drug	Anticoagulant	Proton Pump Inhibitor	Diuretic	Cardiac glycoside
Mechanism of Action	Prevent ischemic reperfusion	Prevents blood from clotting	Proton pump inhibitor	Increase urinary output	Increase cardiac output
Reason Client Taking	Gout	A-fib	GERD	COPD, fluid retention	CHF or a- fib control
Contraindications (2)	Hypersensitivity to zyloprim or its properties, decreased renal or liver function	Active bleeding, endocarditis or pericarditis	Hypersensitivity to drug, Gastric cancer	Anuria, hypersensitivity	Heart blocks, v- fib, v-tach
Side Effects/Adverse Reactions (2)	Pruritus, N/ V	Hemorrhage, N/V/D,	Headache, diarrhea	Drowsiness , orthostatic hypotension	Cardiac toxicity, GI disturbances

Nursing Considerations (2)	Alcohol use, Ensure proper fluid intake	Drug interactions, Previous cardiac hx or stroke hx	Drug interaction with benzodiazapines, coordinate H pylori testing for long term use	Use cautiously with hx of electrolyte imbalance, assess allergies to sulfas	Ensure there are no contraindicated conditions, obtain baseline ecg
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check kidney function, Assess client intake	Previous surgeries or wounds, Dental hygiene	Assess GI function and check MAR for drug interactions	Assess allergies, Assess electrolyte levels	Check heart enzymes, assess cardiac functions
Client Teaching needs (2)	Follow dosage instructions, Explain adverse effects, Educate on why to avoid alcohol	Teach signs of bleeding to prevent it, take drug at same time every day to ensure therapeutic effects	Take 1 hour before meals, Pills should not be crushed or chewed.	Tell client they will need to maintain 2-3 L of fluid intake, tell client taking in the morning to avoid nocturia	Explain reasoning for taking, teach client how to take a full 60 second pulse and not to take digoxin if it is less than 60 BPM

Hospital Medications (5 required)

Brand/Generic	Albuterol	Methylprednisolone sodium succinate Solu-medrol	Ipratropium Atrovent	Budesonide-formoterol SYMBICORT	Ferrous S Iron Sup
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Dose	2-3 Puffs	40mg	3mL	80 – 4.5 mcg/act	325 (65 mg)
Frequency	TID	Every 8H	4H	BID	Daily
Route	Aerosol solution	IV	Aerosol	Inhaled	PO
Classification	Adrenergic agonist	Anti-inflammatory	Bronchodilator	Bronchodilator	Trace element mineral
Mechanism of Action	Bronchodilator, binds with receptors to help open airways	Binds to glucocorticoid receptors to reduce inflammation	Opens airways and prevents bronchospasms	Opens airways and prevents bronchospasms	Normalizes production
Reason Client Taking	Prevent bronchospasms, open airways	Immune and inflammatory disorder (asthma and dyspnea)	SOB	SOB	Provide RBC product
Contraindications (2)	Hypersensitivity to albuterol, Hypersensitivity to albuterol components	Fungal infections, hypersensitivity to methylprednisolone	Glaucoma, enlarged prostate	HTN, Prolonged QT in EKG	Hemochromatosis, hemolytic
Side Effects/Adverse Reactions (2)	Anxiety, Angina	Ataxia, edema, adrenal insufficiency	Bladder px, bloody/cloudy urine	Chest pain, irregular heart beat	Fever, dysuria
Nursing Considerations (2)	Administer during second half of inspiration, Use cautiously in patients with cardiac Hx.	Should not be used with traumatic brain injuries due to high chance of death, use cautiously with clients that have congestive heart failure.	Check drug-drug interactions.	Check EKG to ensure not prolonged QT, Black box warning.	Give supps with full water or not crush capsules, be given 2 hours after
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check heart rate, listen to breath sounds	Check heart rate, listen to breath sounds	Ability to use inhaler, assess for adverse effects	Check heart rhythm, check heart enzymes	
Client Teaching needs (2)	Tell client this medication will increase HR and help them breathe easier, Explain how it opens airway if needed.	Tell client this medication will increase HR and help them breathe easier, Explain how it opens airway if needed.	How to use inhaler, hold breath for 10 seconds after administration of drug	Do not use more than prescribed, report sore throat, worsening of symptoms	How to take medication, help with levels, take supplements, hours after meal for absorption

Medications Reference (APA):

Aschenbrenner, D. S., & Venable, S. J. (2009). *Drug therapy in nursing*. Lippincott Williams & Wilkins.

Jones & Bartlett Learning. (2018). *2019 Nurse’s Drug Handbook* (18th ed.). USA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Client AO x4 Understands and follows commands Dressed appropriately in hospital gown</p>
<p>INTEGUMENTARY (2 points): Skin color: Pink Character: Dry Temperature: Warm Turgor: <3 seconds Rashes: None Bruises: All over body Wounds: Minor abrasion Braden Score: 23 Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Bruises present on clients arms, legs, and abdomen due to blood thinners.</p>
<p>HEENT (1 point):</p>	

Head/Neck: Ears: Eyes: Nose: Teeth:	Normal Cephalic, erect No drainage from eyes, nose, or ears Teeth in moderate condition. Missing a few teeth.
CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): abnormal Peripheral Pulses: 2+ throughout Capillary refill: Rapid Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema: None	S1, S2, and S3 (swooshing) sounds present. abnormal rhythm – clients hx of a-fib
RESPIRATORY (2 points): Accessory muscle use: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character	Client does use accessory muscles minimally. Clear vascular breath sounds
GASTROINTESTINAL (2 points): Diet at home: Normal Current Diet: Normal Height: 6'0" Weight: 188 lb. Auscultation Bowel sounds: Normoactive Last BM: Previous to arrival Palpation: Pain, Mass etc.: Inspection: Distention: None Incisions: Previous surgical incisions. Scars: See right Drains: None Wounds: No current open wounds Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Normoactive bowel sounds in all 4 quadrants Multiple scars throughout abdomen and chest.
GENITOURINARY (2 Points): Color: Yellow Character: clear Quantity of urine: Unspecified Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Client states he has urinated a lot, but never gave a specific number of voids or measurement.

<p>Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Full Supportive devices: Walker PRN Strength: Client at full strength ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 8 Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Client stated he did not want to use the walker because he does not use it at home.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Understands commands Mental Status: Alert Speech: Clear Sensory: Normal LOC: None</p>	
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>D. P. mentioned he has 2 children he has not seen since they were 5 years old. He does not attend any local church. The client does like to watch television and movies to pass the time.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1245	67	120/66	18	98.8 Oral	97% 2L NC
1500	64	121/70	20	98.1 Oral	90% 2L NC

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1245	Numerical	None	Denies	None	None
1500	Numerical	Abdomen	3/10	Aching, dull	Nurse notified

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18G Location of IV: Left forearm Date on IV: 09/19/2020 Patency of IV: Functional Signs of erythema, drainage, etc.: Bleeding at IV site IV dressing assessment: Stable, but there is bleeding at insertion site	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Unspecified at least 1360 mL according to chart and drinks given	Client stated he has urinated many time, but is not measuring.

Nursing Care

Summary of Care (2 points)

Overview of care: Client is following and will continue to follow plan of care

Procedures/testing done: EKG, lab draws, chest X-ray

Complaints/Issues: SOB, L-sided chest pain

Vital signs (stable/unstable): Stable, but O2 was starting to lower from beginning to end of day

Tolerating diet, activity, etc.: Normal diet and exercise.

Physician notifications: None

Future plans for patient: Continue plan of care and activity as tolerated

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): Maintain O2 sat with personal tank.

Equipment needs (if applicable): Already owns O2 tank

Follow up plan: Continue to follow up with PCP

Education needs: Early identification for COPD flare ups and prevention education.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Impaired gas exchange related to COPD as evidenced by low oxygen saturation</p>	<p>COPD is a chronic condition that reduces the elasticity of the lungs and retaining air in the lungs upon expiration.</p>	<p>1. Check pulse oximeter frequently and ensure to stay between 88-94% with COPD</p> <p>2. Position the client in high fowlers.</p>	<p>Client maintained a proper O2 sat without dropping below 90%. Client stayed in high fowlers because it was easier to breathe and the level of comfort.</p>

<p>2. At risk for bleeding related to medication use as evidenced by bleeding at IV site and multiple bruises</p>	<p>With the client having a high PT level the client is prone to excessive bleeding which can be life threatening.</p>	<p>1. Look for signs of bleeding and possible environmental hazards.</p> <p>2. Evaluate use of medications that raise the risk of bleeding such as warfarin.</p>	<p>Client has no current signs of active bleeding and knows how to monitor for bleeding in gums, urine, or feces. Client understands that being off the cardiac medications may take a couple of days to leave his system.</p>
<p>3. Decreased cardiac output related to heart failure as evidenced by BNP lab and showing signs of heart failure</p>	<p>Heart failure can not be cured. Improving symptoms and preventing progression of the disease is all that you can do.</p>	<p>1. Monitor BP, HR, and condition before administering any cardiac medicines</p> <p>2 Assess BNP to evaluate extent of damage to the heart and volume of blood left in ventricles.</p>	<p>Client BNP was abnormally high. There is no cure for heart failure so the client must be educated on improving cardiac output. Client verbalized understanding in the need to take cardiac and to take radial pulse for 1 minute before taking meds.</p>
<p>4. Knowledge Deficit related to unfamiliarity with information as evidenced by the client stating “I don’t understand why this keeps happening.”</p>	<p>The client has had multiple visits to many different facilities due to his COPD and chest pain. Helping the client understand what can cause and prevent these problems can help improve quality of life.</p>	<p>1. Assess motivation to learn.</p> <p>2. Identify the information and priority of what information the client needs educated on.</p>	<p>Client was very welcoming to the new information when asked if he wanted additional information on his condition. D. P. understands that there are multiple conditions that affect this heart and attempted to connect the diagnoses.</p>

Other References (APA):

Swearingen, P. L., & Wright, J. (2018). *All-in-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health* (5th ed.). USA: Mosby.

Concept Map (20 Points):

Subjective Data

Client stated SOB and L-sided chest px. He mentioned the feeling of a little bit of chest pressure but wanted to wait to see if the episode would pass. After D.P. realized it was getting worse, he thought it would be a good idea to seek medical attention.

Nursing Diagnosis/Outcomes

Impaired gas exchange - Client will maintain an O2 saturation of 88 - 94% until discharge.
At risk for hemorrhage - Client will monitor for signs of bleeding and bruising.
Decreased Cardiac output - We as a team will improve cardiac output and prevent symptoms of heart failure from progressing.
Knowledge deficit - Client will verbalize understanding of information presented upon discharge and other times for teaching opportunity

Objective Data

D.P has trouble maintaining activity for prolonged periods of time. Vitals are stable with a O2 saturation appropriate for client's condition. Client has many bruises all over his body. Prothrombin time was elevated outside of the recommended therapeutic range.

Patient Information

D.P. is a 69 YO Male with a hx of COPD, GERD, CAD, MI, CKD stage III, and A-fib. He was admitted for COPD exacerbation and chest pain.

Nursing Interventions

- 1 A) Check pulse oximeter frequently and ensure to stay between 88-94% with COPD
- 1 B) Position the client in high fowlers.
- 2 A) Look for signs of bleeding and possible environmental hazards.
- 2. B) Evaluate use of medications that raise the risk of bleeding such as warfarin.
- 3 A) Monitor BP, HR, and condition before administering any cardiac medicines
- 3 B) Assess BNP to evaluate extent of damage to the heart and volume of blood left in ventricles.
- 4 A) Assess motivation to learn.
- 4 B) Identify the information and priority of what information the client needs educated on.



