N321 Care Plan #1

Lakeview College of Nursing

Jenna Helton

Demographics (3 points)

Date of Admission 9/26/2020	**Patient Initials** P. P.	**Age** 59 years old	**Gender** Female
Race/Ethnicity White; Caucasian	**Occupation** CCAR- Retired	**Marital Status** Divorced	**Allergies** NKA
Code Status DNR	**Height** 152 cm	**Weight** 26.5 kg	

Medical History (5 Points)

Past Medical History:

- COPD
- Respiratory Acidosis
- SOB
- Anxiety
- Chronic Respiratory failure with hypoxia
- Impaired Gas Exchange
- Impaired Immobility
- Impaired Skin Integrity
- Intellectual Disability
- Left Rotator Cuff Tear
- MDD
- Osteoporosis
- Rheumatoid Osteoporosis

Past Surgical History:

- Abdominal Hernia- no known date or time noted

Family History:

- COPD- Father, Mother, and two Brothers
- Dental Disease- Mother

Social History (tobacco/alcohol/drugs):

Patient is retired from work and has received education at CCAR. She states that she lives at home alone and is divorced. The patient also states that she has her daughter for support. Patient drinks beer 1-2 times per week. Patient is a former smoker and quit smoking in January of 2017. She had smoked 2 packs of cigarettes per day for the past forty years. Patient denies use of any drugs. Patient does not use any assistive devices.

Assistive Devices:

Patient does not use any assistive devices.

Living Situation:

Patient is retired from work. She states that she lives at home alone and is divorced. Patient does have a daughter that comes and visits her.

Education Level:

Patient received her education through CCAR. She has a learning and intellectual disability**.**

Admission Assessment

Chief Complaint (2 points):

- Shortness of breath

History of present Illness (10 points):

A pleasant fifty-nine year-old woman presented to Sarah Bush Lincoln Hospital's ED on 9/26/2020 with complaints of shortness of breath. Her complaints started that day around 0900 on 9/26/2020. She states she was home alone on when the shortness of breath began. Patient

states that she can't catch her breath. She states "I am in no pain, but I have anxiety when I couldn't breathe very well." Patient states that her shortness of breath worsens when she stands, walks, or moves a lot. When the patients lays in bed or sits down, her breathing improves. She hasn't taken any medication for her shortness of breath or anxiety.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):. COPD

Secondary Diagnosis (if applicable):. Respiratory Acidosis

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

Chronic Obstructive Pulmonary Disease, also known as COPD, is described as a feature of three different disorders, which is a poor reversible air exchange. These include chronic bronchitis, emphysema, and hyperreactive airway disease (Capriotti & Frizzell, 2016). Emphysema is known to trap carbon dioxide into the alveoli in which the alveoli have trouble releasing the carbon dioxide (Capriotti & Frizzell, 2016). This can contribute to bronchospasms as the alveoli are stuck in a hyperextended position (Capriotti & Frizzell, 2016). In addition to emphysema, the airflow limitations can also be the cause of the narrowing, smooth muscle hypertrophy, and excessive mucous build up on the bronchioles (Capriotti & Frizzell, 2016). This makes the lungs work harder, cause the patient to have trouble breathing and cause permanent damage. Inflammation to the bronchioles causes thickening of the walls and constriction of the lumens, in which macrophages, neutrophils, T lymphocytes, cytokines, leukotrienes, interleukins, and tumor necrosis factors will come to that cite (Capriotti & Frizzell, 2016). Among people with severe COPD, their lungs and alveolis may be in worse condition. This can include hypoxia, chronic bronchitis, and poor ventilation (Capriotti & Frizzell, 2016). Resistance in the main pulmonary artery, also known as pulmonary hypertension, can increase

resistance in the right ventricle of the heart (Capriotti & Frizzell, 2016). This can lead to right ventricular failure, which is call cor pulmonale (Capriotti & Frizzell, 2016).

The signs and symptoms of COPD are similar to emphysema, chronic bronchitis, and asthma. These include dyspnea, couch, wheezing, hypoxia, and cyanosis (Capriotti & Frizzell, 2016). If the patient has right ventricular failure due to pulmonary disease, then they may also experience jugular venous distention, ascites, hepatosplenomegaly, and ankle edema (Capriotti & Frizzell, 2016). Respiratory distress is also a good indicator of someone with COPD. These can include the use of intercostal distress and accessory muscles, and clubbing of the fingers (Capriotti & Frizzell, 2016). Barrell shaped chest or increased anterior-posterior diameter is also an indication of COPD (Capriotti & Frizzell, 2016). A patient that has COPD may experience vital signs with low oxygen status. Nurses will also need to pay attention to respiratory rate, rhythm, and depth, which can show prolonged exhalation and pursing of the lips, and tactile fremitus (Capriotti & Frizzell, 2016).

The patient's provider may want testing to be done to diagnose COPD. These include pulmonary function tests, a CBC, chest x-ray, ECG, and ABGs (Capriotti & Frizzell, 2016). In persons with mild COPD, all tests should come back normal except the pulmonary function test (Capriotti & Frizzell, 2016). In persons with severe COPD, all tests may have abnormal findings (Capriotti & Frizzell, 2016).

There is treatment for COPD, but maintenance of the disease may be more effective. This can include not smoking, medication to help with coughing and wheezing, pulmonary rehabilitation, avoiding lung infections, and the use of oxygen (Chronic Obstructive Pulmonary Disease (COPD), 2020). This particular patient is on three liters of nasal cannula oxygen, has stopped smoking for about three years, and takes medications like roflumilast and albuterol. This

patient has had testing done, which include a chest-x-ray and CBC. Her CBC values came back normal, but her chest x-ray showed her lungs were hyperextended.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: Introductory concepts and clinical perspectives* (1st ed.). F.A. Davis Company.

Chronis obstructive pulmonary disease (COPD). (2020). Centers for Disease Control and Prevention. https://www.cdc.gov/copd/features/copd-symptoms-diagnosis-treatment.html

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	**4.5-6.3**	**5.07**		
Hgb	**14-18**	**14.0**		
Hct	**41-51**	**43.6**		
Platelets	**140-440**	**298**		
WBC	**4-10-6.9**	**6.9**		
Neutrophils	**2-6.9**	**5.9**		
Lymphocytes	**0.6-3.4**	**2.7**		
Monocytes	**0-8**	**1.6**		
Eosinophils	**0-0.5**	**0.2**		
Bands	**N/A**	**N/A**		

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-	**N/A**	**N/A**		
K+	**N/A**	**N/A**		
Cl-	**N/A**	**N/A**		
CO2	**N/A**	**N/A**		
Glucose	**N/A**	**N/A**		
BUN	**N/A**	**N/A**		
Creatinine	**N/A**	**N/A**		
Albumin	**N/A**	**N/A**		
Calcium	**N/A**	**N/A**		
Mag	**N/A**	**N/A**		
Phosphate	**N/A**	**N/A**		
Bilirubin	**N/A**	**N/A**		
Alk Phos	**N/A**	**N/A**		
AST	**N/A**	**N/A**		
ALT	**N/A**	**N/A**		
Amylase	**N/A**	**N/A**		
Lipase	**N/A**	**N/A**		
Lactic Acid	**N/A**	**N/A**		

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	**N/A**	**N/A**		
PT	**N/A**	**N/A**		
PTT	**N/A**	**N/A**		
D-Dimer	**N/A**	**N/A**		
BNP	**N/A**	**N/A**		
HDL	**N/A**	**N/A**		
LDL	**N/A**	**N/A**		
Cholesterol	**N/A**	**N/A**		
Triglycerides	**N/A**	**N/A**		
Hgb A1c	**N/A**	**N/A**		
TSH	**N/A**	**N/A**		

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	**N/A**	**N/A**		
pH	**N/A**	**N/A**		
Specific Gravity	**N/A**	**N/A**		
Glucose	**N/A**	**N/A**		
Protein	**N/A**	**N/A**		
Ketones	**N/A**	**N/A**		
WBC	**N/A**	**N/A**		
RBC	**N/A**	**N/A**		
Leukoesterase	**N/A**	**N/A**		

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	**N/A**	**N/A**		
Blood Culture	**N/A**	**N/A**		
Sputum Culture	**N/A**	**N/A**		
Stool Culture	**N/A**	**N/A**		

Lab Correlations Reference (APA):

Sarah Bush Lincoln Health Center (2020). Reference (lab values). Mattoon, IL.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- **Chest X-Ray**

  The x-ray's note stated the heart size was normal, lungs were hyperexpanded, no visualized pneumothorax or pleural effusion, and osseous structures are intact.

Diagnostic Test Correlation (5 points):

Patient presented to Sarah Bush Lincoln Hospital's ED with shortness of breath and no pain. The x-ray was ordered to aid in diagnosing COPD exacerbation. Chest X-rays can also show enlarged lungs, air pockets, or flattened diaphragm (Chronic Obstructive Pulmonary Disease (COPD), 2019). Per the chest x-ray, the patient did have hyperextended lungs.

Diagnostic Test Reference (APA):

Chronic Obstructive Pulmonary Disease (COPD). (2019). RadiologyInfo.org. https://www.radiologyinfo.org/en/info.cfm?pg=copd#:~:text=Chest%20x%2Dray%3A%20This%20exam,bullae)%20or%20a%20flattened%20diaphragm.

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

Home Medications (5 required)

Brand/Generic	**Ventolin/ albuterol**	**Symbicort/ budesonide -formoterol**	**Celexa/ citalopram**	**Atarax/ hydrOXYzine**	**Roxanol/ morphine**
Dose	2 puffs 180 mcg	2 puffs 160 mcg-4.5 mcg	20 mg- 1 tab	50 mg- 1 tab	10 mg- 0.5 mL
Frequency	PRN- Q4H	BID	Daily	TID	PRN- Q6H
Route	Inhalation	Inhalation	PO	PO	PO
Classification	Bronchodilator	Antiasthmatic and anti-inflammatory	Antidepressant	Anxiolytic, antiemetic, antihistamine, sedative-hypotic	Opioid Analgesic
Mechanism of Action	Albuterol attaches to beta2 receptors to bronchial cell membranes which stimulates adenylate cyclase to ATP then to cAMP. This	Stops inflammatory cells and mediator. This decreases influx into nasal passages, bronchial wall, and intestines.	Blocks serotonin reuptake by adrenergic nerves. This will increase serotonin levels at nerve synapses, which may increase	Competes with histamine for histamine1 receptor on surfaces of effector cells.	Binds and activates opioid receptors in the brain and spinal cord to euphoria and analgesics.

	then leads to relax bronchial smooth-muscle cells and stops histamine release.		mood and reduce depression.		
Reason Client Taking	To prevent exercise-induced bronchospasm	To provide maintenance therapy in COPD	Anxiety	Anxiety	Pain, anxiety associated with air hunger
Contraindications (2)	Hypersensitivity to albuterol and its components	Status asthmaticus or other acute asthma episodes and recent septal ulcers or nasal surgery or trauma.	Pimozide therapy and use within 14 days of MAO inhibitor therapy.	Prolonged QT interval and breastfeeding	Respiratory depression and upper airway obstruction.
Side Effects/Adverse Reactions (2)	Pulmonary edema and metabolic acidosis	Respiratory tract infection and bronchospasm	Suicidal Ideation and upper respiratory tract infection	Hallucinations and pruritus	Apnea and bronchospasm
Nursing Considerations (2)	Administer albuterol during second half of inspiration. Be aware that drug tolerance can occur.	Monitor child's growth rate. Adverse effects can occur with a diagnosis of osteoporosis.	Monitor patient for possible serotonin syndrome for agitation and chills. Be aware that this therapy can convert depression into mania in predisposed	Don't give subQ or IV, because it can lead to tissue necrosis. Observe for oversedation if patient takes another CNS depressant.	Morphine can lead to abuse and addiction. Use extreme caution when administering morphine to patients with hypoxia due to a decrease in respiratory

			people.		drive.

Hospital Medications (5 required)

Brand/Generic	Binosto/ alendronate	Singulair/ montelukast	Daliresp/ roflumilast	Elixophyllin/ theophylline	Incruse Ellipta/ umeclidinium
Dose	70 mg- 1 tab	10 mg- 1 tab	250 mcg- 0.5 tabs	300 mg- 1 tab	1 puff 62.5 mcg/inhale
Frequency	Q week	Daily	Daily	Daily	Daily
Route	PO	PO	PO	PO	Powdered Inhalation
Classification	Bone Resorption Inhibitor	Antiallergen or anitasthmatic	Antipulmonic obstructive agent	Bronchodilator	Bronchodilator
Mechanism of Action	Slows down activity of cells cause bone loss, even after menopause and increases bone mass. May act as inhibiting osteoclast activity on newly formed bone resorption surfaces**.**	Cysteinyl leukotrienes bind to receptors in bronchial airways, and increase endothelial membrane permeability	Increase AMP in lung cells by inhibiting a major cyclic enzyme in lung tissue to improve pulmonary function.	Inhibits phosphodiesterase enzymes which cause bronchodilation. May also antagonize adenosine and prostaglandins receptors.	Inhibits M3 receptor in smooth muscle to cause bronchodilation.
Reason Client Taking	To treat postmenopausal osteoporosis	To prevent exercise-induced broncho-constriction	To reduce the risks of COPD exacerbation in patients with severe COPD associated with chronic	To treat symptoms of COPD like shortness of breath	To prevent long-term maintenance treatment of airflow obstruction in chronic obstructive pulmonary disease

			bronchitis and a history of exacerbations		(COPD), including chronic bronchitis and/or emphysema.
Contraindications (2)	Hypocalcemia and Esophageal abnormalities	Depression and anxiety	Bronchospams and liver impairment	Peptic ulcer disease and uncontrolled seizure disorder	Severe hypersensitivity to milk proteins and hypersensitivity to umeclidinium or its components
Side Effects/Adverse Reactions (2)	Asthma exacerbation and dysphagia	Pulmonary eosinophilia and suicidal ideation	Muscle Spams and depression	Increased urine output and hypercalcemia	Paradoxical bronchospasm and dyspepsia
Nursing Considerations (2)	Monitor patient's serum calcium level before, during, and after treatment. Ensure patient is getting enough calcium in their diet before, during, and after treatment.	Medication should not be substituted for inhaled or oral corticosteroids. Watch patient closely for suicidal tendencies especially when changing or starting doses.	Monitor patient's for significant weight loss. Monitor patient closely for suicidal ideations because it can increase depression	This drug does not bind well with body fat, so be aware of ideal body weight. Frequently assess heart rate and rhythm because it can exacerbate existing arrythmias.	This drug should not be initiated in patients who are experiencing a rapidly deteriorating or potentially life-threatening episode of COPD. Don't administer umeclidinium for relief of acute symptoms. This is not a rescue inhaler.

Medications Reference (APA):

2020 nurse's drug handbook (19th ed.). (2020). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented x4. Patient does have mild anxiety and shortness of breath. Overall, the patient is well-groomed and able to take care of herself. She does need help with walking to the restroom.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient states she is Caucasian and presents with fair skin tone. Skin has normal elasticity, warm to touch. No abnormal texture. Hair is short and brown. There is skin turgor. No rashes are present. Bruises are noted on both forearms due to IV sites. No notable wounds. Braden Score: 20
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is midline with nod deviations. Hair is brown and short. Ears show no abnormal drainage, tympanic membrane visible and pearly gray. PEERLA is noted. Patient does not use glasses. Nose shows no deviated septum, turbinates equal bilaterally. Oral mucosa is pink and moist with no notable abnormalities. Patient has no teeth. Gums are pink and no notable blood or sores.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Patient is being treated with telemetry. Patient is noted to be in normal sinus rhythm on admission and current date. Heart sound auscultated on aorta, pulmonic, Erb's point, tricuspid, and mitral. S1 and S2 heart sounds noted. Radial and pedal pulses assessed. Pulses are present bilaterally. Capillary refill is less than 2 seconds. Patient has no signs of edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Patient uses accessory muscle when breathing. Patient states shortness of breath. Trachea is midline. No deviations. Patient presents with

	productive cough. Anterior and posterior lungs were auscultated. Lung sounds were coarse bilaterally. No wheezes were present. Noted bilaterally. Patient uses albuterol, Symbicort, and umeclidinium inhalation for COPD. Patient is currently on 3 L on nasal cannula. Patient does use oxygen at home.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet:** **Height: 152 cm** **Weight: 26.5 kg** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient states that she is on a regular diet when she is at home. She is on a regular diet at the hospital. Bowel sounds are present in all four quadrants. Patient denies pain on palpation. Patient denies any tender areas on abdomen. No masses are present. No ostomy, nasogastric tubes, or feeding tubes are present. No distention is present. No scars are presented. No drains are present. No wounds are presented, but since she is at risk for infection and impaired skin integrity, she needs to be turned every two hours. Patient's last BM was 9/28/2020. Patient denies any rapid or current weight loss. Patient had an abdominal hernia but with no known date. Patient is 152 cm and weighs 26.5 kg.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient is able to ambulate to the toilet x2. No dialysis or catheter is present. No genital abnormalities noted. Urine is clear and yellow. Patient denies pain, hesitancy or urgency with urination. No abnormal odor. Patient is on I&O's.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:**	Fall Score: 60 Patient exhibits active range of motion bilaterally. Patient shows no sign of neurovascular deficit. Patient is a fall risk. Patient lays in the bed and gets up with assistance to the restroom x2. Patient needs support to stand and walk. Patient denies the use of a walker, wheelchair, or cane. Patient denies the use of any

Independent (up ad lib) ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐**X**	other assistive devices around her home except oxygen.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is awake in bed. She is A&O x4. Patient has intellectual and learning disabilities. She has a hard time of making words due to loss of teeth. Patient speaks English and at a normal pace. Patient MAEW for current age and condition. Patient's strength is bilaterally equal. Patient shows no signs of neurological damage.
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):**	Patient presents energized and awake. Patient stayed awake throughout assessment. Patient explains that she sleeps well at night. Daughter is not present at the bedside. Patient denies the use of drugs. Patient currently drinks 1-2 beers a week. Patient is a former smoker of forty years and smoked 2 packs of cigarettes per day. Patient states her education level is through CCAR. She lives alone and is divorced. Patient appears to have a good support with her daughter. Patient has no religious preferences. Patient is retired.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
06:35 9/28/2020	93	97/60 mmHg	18	36.4 C	99 3 L Nasal Cannula
08:45 9/28/2020	110	104/61 mmHg	18	36.3 C	98 3 L Nasal Cannula

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
06:35 9/28/2020	0	N/A	N/A	N/A	N/A
08:45 9/28/2020	0	N/A	N/A	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	The size of the patient's 2 IVs are 20's. One IV is located on the Left AC and the other is on the Right AC. The one on the Right is dated 9/26/2020. The one on the Left is dated 9/27/2020. Both IVs were able to flush with no resistance. There were no signs of erythema or drainage at the IV sites. No phlebitis. Infiltration present. Catheter present. Dressing was clean, dry and intact. Patient was no on any fluids or IV medications during assessment.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
200 mL- whole milk	200 mL- voided

Nursing Care

Summary of Care (2 points)

Overview of care:

Procedures/testing done:

Complaints/Issues:

Vital signs (stable/unstable):

Tolerating diet, activity, etc.:

Physician notifications:

Future plans for patient:

Patient was sitting up in bed awake and watching tv throughout the day. Patient remained in her room throughout the day. Patient did complain that her stomach was upset due to medication. She requested chocolate pudding because it relieves any stomach upset that may occur from the medications. No medications were given to her to help relieve any discomfort. Vital signs are stable. Patient did not receive any procedures or testing done on 9/28/2020. Patient complied with treatment and dietary restrictions. She was able to get out of bed to use the restroom but needed assistance by the nurse and the care partner. Physician's notifications are to be discharged today, 9/28/2020. Future plans for the patient are to go home.

Discharge Planning (2 points)

Discharge location:

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan:

Education needs:

Patient will be discharged on 9/28/2020. She will be going home to Mattoon, IL with herself. Patient would benefit sleeping with pillows behind her head and at an elevated position. This will help improve her breathing. She will be sent home with oxygen. Patient should be educated on how to maintain her COPD. Patient is retired. She may benefit from assistance at home when needed. Patient will need to follow up with Dr. Emenecker within one week of discharge. Patient may need to be reeducated on how

to properly use her inhaler medications. Respiratory therapy may also benefit this patient after discharge. The patient may need oxygen at home with all the equipment to maintain a proper O2 status.

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Decreased Gas Exchange. This is related to her COPD as evidenced by 3 L of O2 continuously.	This is in relation to her lungs holding onto carbon dioxide and not wanting to be exhaled.	1. Deliver humidified oxygen and monitor patient's response. 2. Auscultate breath sounds every 2-4 hours and report significant findings.	2. Goal Met. The patient stated "My breathing has improved since being on oxygen". Patient's O2 stats were at 98% and 99%. 3. Goal Not Met. The patient was glad to have the nurse in the room checking on her every two hours for assessment. The status of the goal was to get her lungs from crackling to clear.
2. Fatigue with Decreased Exercise Tolerance. This is related to her COPD as evidenced by her laying in bed for the whole day and only moving to go to the	This is in relation to her not having energy to get up and walk around due to poor nutritional status and poor oxygen exchange.	1. Monitor the patient's respiratory response to exercise or activity, including O2 stats. 2. Maintain prescribed activity	1. Goal Not Met.The patient did have trouble walking to the restroom and had to stop to take a break. The goal for the patient is

restroom.		level and explain rationale to the patient.	to go to the restroom without taking breaks and improving shortness of breath. 2. The patient was glad to get out of bed and walk a little bit. The goal is to walk around without any assistance.
3. Weight Loss. This is related to her COPD as evidenced by her weight being 26.5 kg.	This is in relation to her decrease in intake and weight being under normal range.	1. Request consultation with a dietitian as indicated. 2. Assess food and fluid intake.	3. Goal Partially Met. The patient was pleased to have the dietitian in her room to discuss nutritious foods. The goal for this patient is to eat high caloric foods, but in small quantities until her weight increases. 4. Goal Partially Met.The patient didn't mind the nurse or care partner calculating her food and fluid intake. As the patient's weight increases, her dietitian won't have to make as frequent visits.

Other References (APA):

Swearingen, P. L. & Wright. J. D. (2019). *All-in-one nursing care planning resource* (5th ed.). Elsevier.

N321 Care Plan

Concept Map (20 Points):

N321 Care Plan

Subjective Data

The patient states her shortness of breath started at 0900 on 9/26/2020. She states that she is in no pain but had anxiety when she couldn't breathe very well. Patient states that her shortness of breath worsens when she stands, walks, or moves a lot. When the patients lays in bed or sits down, her breathing improves.

Nursing Diagnosis/Outcomes

1. Decreased Gas Exchange. This is related to her COPD as evidenced by 3 L of O2 continuously.
   a. Goal Met. The patient stated "My breathing has improved since being on oxygen". Patient's O2 stats were at 98% and 99%.
   b. Goal Not Met. The patient was glad to have the nurse in the room checking on her every two hours for assessment. The status of the goal was to get her lungs from crackling to clear.
2. Fatigue with Decreased Exercise Tolerance. This is related to her COPD as evidenced by her lying in bed for the whole day and only moving to go to the restroom.
   a. Goal Not Met. The patient did have trouble walking to the restroom and had to stop to take a break. The goal for the patient is to go to the restroom without taking breaks and improving shortness of breath.
   b. Goal Not Met. The patient was glad to get out of bed and walk a little bit. The goal is to walk around without any assistance.
3. Weight Loss. This is related to her COPD as evidenced by her weight being 26.5 kg.
   a. Goal Partially Met. The patient was pleased to have the dietitian in her room to discuss nutritious foods. The goal for this patient is to eat high caloric foods, but in small quantities until her weight increases.
   b. Goal Partially Met. The patient didn't mind the nurse or care partner calculating her food and fluid intake. As the patient's weight increases, her dietitian won't have to make as frequent visits.

Nursing Interventions

1. Deliver humidified oxygen and monitor patient's response.
2. Auscultate breath sounds every 2-4 hours and report significant findings.
3. Monitor the patient's respiratory response to exercise or activity, including O2 stats.
4. Maintain prescribed activity level and explain rationale to the patient.
5. Request consultation with a dietitian as indicated.
6. Assess food and fluid intake.

Objective Data

Vitals:
B/P: 97/60 mmHg
RR: 18
Temp: 36.4 C
Sp02%: 99
Pulse: 93
Her diagnostic tests show all levels of labs are within normal range. She has had a chest x-ray, which showed her lungs being hyperextended.

Patient Information

A fifty-five year-old woman came to the hospital via ambulance. She has medical history of COPD, Respiratory Acidosis, SOB, Anxiety, Chronic Respiratory failure with hypoxia, Impaired gas exchange, impaired skin integrity and immobility, intellectual disability, Left rotator cuff tear, MDD, osteoporosis, and rheumatoid osteoporosis. She has a surgical history of abdominal hernia. She has no history of using drugs, but has a history of drinking 1-2 beers per week and has smoked 2 packs of cigarettes a day for the past forty

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