N431 Care Plan #1

Lakeview College of Nursing

Justin Pranada

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/25/2020	TS	51	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Truck Driver - Cardinal	Married	dicyclomine
Code Status	**Height**	**Weight**	
FULL	187.5 cm	106 kg	

Medical History (5 Points)

Past Medical History:.

Patient has a history of Stage 4 Lunch Cancer, anemia, ascites, hyperlipidemia, and diabetes.

Past Surgical History:

Patient has had the following procedures:

- Esophagogastroduodenoscopy (6/26/2019)
- Colonoscopy (5/17/2019)
- Bronchoscopy (4/15/2019)

Family History:

Patient's father was diagnosed with heart disease, hypertension, and a heart attack. Patient's mother was diagnosed with diabetes, heart disease, and hypertension.

Social History (tobacco/alcohol/drugs):

Patient has a 1 pack a day, 37-year history of tobacco cigarette smoking – from 13 to 50 years of age. Patient claimed he stopped cigarette smoking 3 weeks prior to admission. Patient rarely consumes alcohol – once or twice per year. Patient claimed to have smoked marijuana between 15 to 18 years of age at about one to two times per week. Patient denied use of any other elicit drugs.

Assistive Devices:

Patient does not use any assistive devices.

Living Situation:

Patient lives at home with his wife.

Education Level:

Patient graduated high school from Arcola high school.

Admission Assessment

Chief Complaint (2 points): Patient came in for shortness of breath.

History of present Illness (10 points):.

The patient is a 51-year-old Caucasian male, presented to the ED on 9/25/2020 complaining of shortness of breath. He stated that he has been feeling tired, having a productive cough, and shortness of breath for one week prior to admission. The patient was sent to the ED after routine blood results for his chemotherapy for his stage 4 Lung Cancer confirmed that his hemoglobin level was at 8.9. The patient denied any fever, chills, nausea, and vomiting. The patient was put on 6L of oxygen via nasal cannula in the ED.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia

Secondary Diagnosis (if applicable): Stage 4 Lung Cancer

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

Pathophysiology

The most common cause of pneumonia is contacting and inhaling infected droplets (Capriotti & Frizzell, 2016). The pathogen enters through the upper airways and access lung tissue (Capriotti & Frizzell, 2016). The pathogens then attach to respiratory tissue and cause an inflammatory response, which spreads down to the lower respiratory tract and alveoli. The inflammation causes vasodilation and attracts neutrophils from the capillaries and into the airspace (Capriotti & Frizzell, 2016). The neutrophils phagocytize the foreign microbes, which then causes overstimulation of the goblet cells that results in excessive production of mucous. The mucous and exudative edema builds up in the patient's lungs, which makes it difficult for the alveoli and capillaries to open and close that causes impaired gas exchange (Capriotti & Frizzell, 2016).

Signs and symptoms

The signs and symptoms of pneumonia can present in a lot of different ways. The onset of symptoms usually presents as a cough that may be productive or not (Capriotti & Frizzell, 2016). Pleuritic chest pain – pain with deep breathes, dyspnea, hemoptysis (bloody sputum), nausea, vomiting, and headache are other hall mark findings of pneumonia (Capriotti & Frizzell, 2016). Mr. S presented to the ED on 9/25/2020 with shortness of breath and a productive cough.

Vital signs and lab findings

The patient may become hypoxic and hypercapnic due to the impaired gas exchange (Hinkle & Cheever, 2018). The patient may also present with elevated white blood cell count (Hinkle & Cheever, 2018).

Diagnostic testing

A chest x-ray is the most common diagnostic test in diagnosing pneumonia (Hinkle & Cheever, 2018). The patient's provider ordered a chest x-ray to be done, which showed a patchy airspace

related to pneumonia. A CBC with differential can suggest whether the cause of pneumonia is bacterial or viral (Capriotti & Frizzell, 2016). Mr. S's CBC was confirmed his history of anemia with low hemoglobin and red blood cells, but there was no significant increase of WBC that can indicate a bacteria infection at the time of admission. ABGs and pulse oximetry can also be used to monitor the patient's oxygenation (Capriotti & Frizzell, 2016).

Treatment

Antibiotic therapy and oxygenation are the priorities in treating pneumonia (Capriotti & Frizzell, 2016). Keeping the patient at a High-Fowler's position is recommended (Capriotti & Frizzell, 2016). Mr. S was positioned in semi-fowlers with a continuous pulse oximeter on. He transferred over to the chair where he sat in high-followers where his oxygen saturation dropped below normal limits at 88%.

Pathophysiology References (2) (APA):

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

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health; Lippincott Williams & Wilkins.

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	3.9-5.0	2.91	3.26	Low RCB is indicative of anemia

				(Hinkle & Cheever, 2018).
Hgb	12.0-15.5	8.9	9.4	Low Hgb is indicative of anemia (Hinkle & Cheever, 2018).
Hct	35-45%	27.4	29.5	
Platelets	150-500 K	203	243	
WBC	4.5-11 K	9.4	6.5	
Neutrophils	45.3-79%	70.4	63.8	
Lymphocytes	11.8-45.9%	13.7	16.5	
Monocytes	4.4-12.0%	10.5	16.4	Indicative of infection (Capriotti & Frizzell, 2016).
Eosinophils	0.0-6.3%	5.0	2.7	
Bands	0.0-5.0%	6.0	6.0	

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-	135-145	138	140	
K+	3.5-5.0	3.5	4.0	
Cl-	98-108	111	106	
CO2	22-29	20	29	
Glucose	70-100	115	86	Use of proton pump inhibitors can cause a slight elevation in glucose (Jones & Bartlett Learning, 2019).
BUN	8-25	34	31	Indicative of dehydration (Capriotti & Frizzell, 2016).
Creatinine	0.6-1.2	0.62	0.49	Indicative of dehydration (Capriotti & Frizzell, 2016).
Albumin	3.5-5.0	2.5	2.4	Low albumin can be indicative of poor nutrition (Hinkle & Cheever, 2018).
Calcium	8.6-10.4	7.8	8.1	

Mag	1.6-2.4	1.7	1.7	
Phosphate	2.5-4.5	3.8	3.8	
Bilirubin	0.0-1.2	0.5	0.3	
Alk Phos	35-105	230	230	May be caused by chronic use of hepatotoxic medication (Hinkle & Cheever, 2018).
AST	0-35	48	29	May be caused by chronic use of hepatotoxic medication (Hinkle & Cheever, 2018).
ALT	24-36	44	29	May be caused by chronic use of hepatotoxic medication (Hinkle & Cheever, 2018).
Amylase				
Lipase				
Lactic Acid	0.5-2.2	1.1-1.3	1.1-1.3	
Troponin	0-0.4	0.023	0.023	
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	0.86-1.14	N/A	N/A	
PT	11.9-15	N/A	N/A	
PTT				
D-Dimer				
BNP	0-99	171	171	May be indicative of cancer related inflammation (Hinkle & Cheever, 2018).

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	Yellow Clear	Yellow Hazy	Yellow Hazy	
pH	5.0-8.0	5.0	5.0	
Specific Gravity	1.005-1.034	1.019	1.019	
Glucose	Normal	Normal	Normal	
Protein	Negative	Negative	Negative	
Ketones	Negative	Negative	Negative	
WBC	<5	1	1	
RBC	0-4	4	4	
Leukoesterase	Negative	Negative	Negative	

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		7.39	7.39	

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				
Blood Culture		Negative	Negative	
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest x-ray (CXR)

Diagnostic Test Correlation (5 points): The chest x-ray that was ordered for Mr. S showed patchy airspace in his right lung that is indicative of pneumonia (Corbett & Banks, 2019).

Diagnostic Test Reference (APA):

Corbett, J. V., & Banks, A. D. (2019). *Laboratory tests and diagnostic procedures: with nursing diagnoses.* Pearson.

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

Home Medications (5 required)

Brand/Generic	**Tylenol** acetaminophen	**Vicodin** hydrocodone acetaminophen	**Ambien** zolpidem	**Prilosec** omeprazole	**Vitamin D2** ergocalciferol
Dose	100 mg 2 tablets	1 tablet	10 mg 1 tablet	20 mg 1 tablet	1 capsule
Frequency	Q4H; PRN	BID; PRN	HS; PRN	BID	Once weekly
Route	PO	PO	PO	PO	PO
Classification	Antipyretic	Opioid analgesic	Antianxiety	Antiulcer	Antihypocalcemic
Mechanism of Action	Acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.	Binds to opioid receptor sites to produce pain relief	May potentiate the effects of GABA and other inhibitory neurotransmitters.	Interferes with gastric acid secretion by inhibiting the proton pump in gastric parietal cells.	Binds to specific receptors on intestinal musosa to increase calcium absorption from intestine.
Reason Client Taking	Pain/Fever	Pain – Lung Cancer	Sleep aid	GERD	Hypocalcemia
Contraindications (2)	Hypersensitivity; sever hepatic impairment	Acute or severe bronchial asthma; respiratory depression	Severe hepatic impairment; ritonavir therapy	Rilpivirine containing therapy; hypersensitivity to omeprazole	Hypercalcemia; vitamin D toxicity
Side Effects/Adverse Reactions (2)	Hepatotoxic; hypotension	Hypotension; hypokalemia	Ataxia; arthralgia	Diarrhea; edema	Erythema; urticaria

Nursing Considerations (2)	Check liver function labs before administration; monitor for renal dysfunction	Extreme caution in COPD; Monitor pt with a seizure hx	Administer medication just before bedtime; zolpidem will produce anticonvulsant effects at high doses	Give before meals; Watch for diarrhea	Check to be sure patient receives enough calcium; Store durg at room temperature and away from heat and direct light
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor AST, ALT, bilirubin, and creatinine		Zolpidem is withdrawn abruptly - monitor patient for withdrawal symptoms	Monitor pt's urine output because omeprazole may cause acute interstitial nephritis	Monitor patient's calcium levels
Client Teaching needs (2)	Tablets may be crushed or swallowed whole; Take the medication as directed		Take the drug as directed; Notify provider immediately if AE show up	Take the drug before eating; notify the provider if diarrhea occurs	Do no take any other vitamin D supplementation; take missed dose as soon as possible

Hospital Medications (5 required)

Brand/Generic	**Eliquis** apixaban	**Prilosec** pantoprazole	**Rayos** prednisone	**Zofran** ondansetron	**Mucinex** guaifenesin
Dose	5 mg 1 tablet	20 mg 1 tablet	40 mg 2 tablets	4 mg 1 tablet	200 mg 10 mL
Frequency	BID	BID	Daily	Q8H; PRN	Q4H; PRN
Route	PO	PO	PO	PO	PO

Classification	Antithrombolytic	Antiulcer	Anti-inflammatory	Antiemetic	Expectorant
Mechanism of Action	Inhibits free and clot-bound factor Xa and prothrombinase activity.	Interferes with gastric acid secretion by inhibiting the proton pump in gastric parietal cells.	Binds to intracellular glucocorticoid receptors and suppresses inflammatory and immune response.	Antagonizes serotonin receptors.	Increases fluid and mucus removal from the upper respiratory tract by increasing the volume of secretions and reducing their adhesiveness and surface tension.
Reason Client Taking	Prophylactic	GERD	SOB	Nausea	Productive cough
Contraindications (2)	Bleeding; severe hypersensitivity	Rilpivirine containing therapy; hypersensitivity to pantoprazole	Hypersensitivity; fungal infection	Prolonged QT wave; hypersensitivity	Hypersensitivity; allergy
Side Effects/Adverse Reactions (2)	Bleeding; rash	Hyperglycemia; dyspnea	Insomnia; restlessness	Diarrhea; constipation	Nausea; vomiting
Nursing Considerations (2)	Should not be given to patients with severe hepatic dysfunction; Do not administer 48 hours before invasive procedure	Expect to monitor PT or INR during therapy if patient is taking oral anticoagulant; Monitor patient for bone fractures	Administer in the morning to match the body's cortisol secretion schedule; Be aware that prolonged use may cause hypothalamic-pituitary-adrenal suppression	Caution in hepatic impairment; monitor pt for s/s of hypersensitivity	Watch for evidence of more serious conditions; give medication as prescribed and as appropriate
Key Nursing Assessment(s)/L	Assess coagulation	Monitor PT or INR	Make sure other	Ondansetron cannot be	Monitor if the patient is

ab(s) Prior to Administration	factors before administration	because pt is taking eliquis	medications do not interfere with prednisone	taken with cefepime (Mr. S has cefepime IV piggy PRN for pneumonia)	having product cough before administration
Client Teaching needs (2)	Take the medication as directed; Do not stop taking unless instructed by provider	Swallow pantoprazole whole; Notify provider if therapeutic effect does not occur after 2 weeks	Take medication with food to decrease GI upset; Take drug as directed	Take drug as directed; place disintegrating tablet on your tongue immediately after opening and let it dissolve before swallowing	Take each dose with a glass of water; notify your provider about fever, headache, or rash

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's drug handbook* (18th ed.).

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was awake. The patient was alert and oriented to person, place, time, and situation (x4). The patient responded to questions appropriately. The patient looked well nourished. No visible signs of distress noted or reported by the patient.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Braden Score: 22 (minimal risk for skin break down) The skin was intact, warm, and dry to touch. Good skin turgor noted. No rashes, bruises, or wounds noted or reported by the patient. There are no drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normocephalic and midline, with no deviations. The patient's eyes exhibited PERRLA and the six cardinal fields of gaze. The tympanic membrane is intact and pearly grey, bilaterally. There was no drainage in the patient's ears. His nose showed equal turbinates bilaterally with no deviated septum noted. The patient's oral mucosa was intact, pink, and moist with teeth present; no abnormalities were noted.
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:**	S1 and S2 were heard with tachycardia. Regular rate and rhythm noted. Peripheral pulses palpable in radial and pedal sites; graded at 2+ bilateral. The patient's capillary refill was less than 3 seconds. There was no edema or JVD noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Respirations were even and unlabored at 16 breaths/min at the time of assessment. The patient's lungs are clear to auscultation in all lobes with no accessory muscle use. His chest moved with respiration and no chest wall deformities noted.

	The patient had a productive cough with green sputum.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **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:**	Ht: 187.5 cm Wt: 106 kg Last BM: 10/4/2020 The patient had no special diet at home; heart healthy diet in the hospital. Upon assessment, the patient's abdomen was soft, non-distended, round, and moved with respirations. Active bowel sounds were auscultated in the RLQ after listening for 1 minute in all four quadrants. Re-auscultation of all 4 quadrants was done for 5 minutes each, initial results remained the same. There was no organomegaly noted. There was no distention, incision, scar, drain, or wound noted. No feeding tubes in use.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	The patient's urine was clear and yellow in color in bedside urinal measured at 250 mL. There was no bladder distention noted. There was no dysuria reported. The patient does not have a catheter or on dialysis.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	Fall Score: 60 (high fall risk) The patient was able to perform active range of motion in both upper and lower extremities. The Patient's strength was equal bilaterally in all four extremities. The patient needs assistance (1 assist) for getting out of bed. The patient needs stand-by ambulation assist. There was no joint swelling noted. There was no assistive device in use.

NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient moves all extremities well. PERRLA is noted. His strength is equal in both arms and legs. His mental status is appropriate for his age. Mr. S. speaks English as his primary language; he can speak clearly and fluently. The patient's sensory was intact; he was able to respond appropriately when sensory tests were done. No change in LOC noted.
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):**	Mr. S. lives at home with his wife. He has an active social life when not working. He likes to drive around in his spare time and when he needs to think. No practice of religion was mentioned. Mr. S did not mention any children or extended family when asked.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	102	121/78	16	36.8	93%
1100	100	114/70	18	36.9	88%

Vital Sign Trends: The patient's vital signs stayed similar during the time of patient care. His O2 saturation dropped below normal limits and his nurse was informed. Mr. S. was due for his respiratory therapy and interventions were implemented for his O2 saturation.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric	None	None	None	None
1100	Numeric	Lower back	1/10	Tight from lying down	Had patient sit in the chair

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	20 gauge Central line: port right upper chest PICC: single, right upper arm NS, infusion of PRN cefapime 2,000 mg IV rider, and PRN heparin flush 3 mL IV push for maintenance of patency. Started on 10/4/2020 for both Patent with dry and intact dressing. No signs of erythema or drainage noted.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
88.6 mL	500 mL

Nursing Care

Summary of Care (2 points)

Mr. S was admitted to the ED on 9/25/2020 with a chief of complaint of shortness of breath. He was put on 6L of oxygen via nasal cannula and was ordered for a chest x-ray to where to they found patchy airspace in the right lung. Upon physical assessment, Mr. S's vital signs are as follows: 102 bpm, 121/78 mm Hg, 16 rr, 36.8 C, 93%. Mr. S has a medical history of lung cancer and anemia. Mr. M does not have any complaints regarding his treatment. The patient is tolerating the heart healthy diet well.

Discharge Planning (2 points)

The patient will be discharged home with his wife. The patient will need to adhere to his prophylactic medications and therapy. The patient may need an assistive device for walking due

to his high risk for falls. The patient will need to continue with his chemotherapy for his Lung Cancer.

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 related to altered oxygen supply and alveolar-capillary membrane changes occurring with the inflammatory process and exudate in the lungs as evidenced by shortness of breath	The main priority is securing airway, we have to make sure that the patient can breath properly.	**1.** Monitor for and promptly report signs and symptoms of respiratory distress. **2.** Auscultate breath sounds Q2-4H or as indicated by patient's condition. Report significant findings.	**Not applicable**
2. Decreased Immunity related to Lung Cancer chemotherapy as evidenced by recent respiratory infection.	The patient is very susceptible to infections due to chemotherapy for his stage 4 lung cancer.	**1.** Before administering chemotherapy, ensure that blood counts are within accepted limits. **2.** Assess each body system.	**Not applicable**
3. Risk for injury related to high	The patient needs assistance with	**1.** Identify the individual's risk for	**Not applicable**

fall risk as evidenced by fall score of 60	transferring and ambulation.	falls. **2** Reduce contributing factors for falls.	
1. Potential for insufficient airway clearance related to the presence of excessive secretions occurring with infection	Patient had a productive cough and was continuously reaching for a bag to spit in.	**1.** Auscultate breath sounds Q2-4H and report changes in the patient's ability to clear pulmonary secretions. **2.** Assist the patient into a position of comfort, usually semi-Fowler's position.	**Not applicable**

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health.* Elsevier.

Concept Map (20 Points):

Subjective Data

Mr. S was going to his routine chemotherapy where he was complaining of SOB. He was sent to the ED with SOB and diagnosed with pneumonia.

Nursing Diagnosis/Outcomes

Decreased gas exchange related to altered oxygen-carbon dioxide alveolar-capillary membrane changes occurring with the inflammatory process and exudate in the lungs as evidenced by shortness of breath
Outcome: Pt exhibits five of the following: temperature below 37.7 C, heart rate less than 100, rr less than 24, systolic bp of 90 or more, O2 sat of 92% or higher.
Decreased Immunity related to Lung Cancer chemotherapy as evidenced by recent respiratory infection.
Outcome: Patient understands safety measures to minimize infections.
Risk for injury related to high fall risk as evidenced by fall score of 60.
Outcome: Patient exhibits use of safety measures to minimize injury.
Potential for insufficient airway clearance related to the presence of excessive secretions occurring with infection.
Outcome: The patient demonstrate effective cough. After interventions, the patient's airway is free of excessive secretions.

Objective Data

Mr. S had a chest x-ray done, which showed a patchy airspace related to pneumonia.

Patient Information

Mr. S is a 51 year-old gentleman with stage 4 Lung Cancer and presented to the ED with SOB.

Nursing Interventions

Monitor for and promptly report signs and symptoms of respiratory distress.

2. Auscultate breath sounds Q2-4H or as indicated by patient's condition. Report significant findings.
Before administering chemotherapy, ensure that blood counts are within accepted limits.

. Assess each body system.
dentify the individual's risk for falls.

2 Reduce contributing factors for falls.
Auscultate breath sounds Q2-4H and report changes in the patient's ability to clear pulmonary secretions.

2. Assist the patient into a position of comfort, usually semi-Fowler's position.