N431 Care Plan #3

Lakeview College of Nursing

Joey Runde

Demographics (3 points)

Date of Admission 11-1-2020	**Patient Initials** C.E	**Age** 49 years	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Disabled	**Marital Status** Divorced	**Allergies** Penicillin-Rash
Code Status Full Code	**Height** 5 feet 2 inches	**Weight** 88.3 kg	

Medical History (5 Points)

Past Medical History: Acute respiratory failure with hypoxia, community acquired pneumonia, history of pulmonary embolism, hypothyroidism, paroxysmal atrial fibrillation, tobacco use, chest pain, gastritis, hypotension, low back pain, muscle spasms, right lumbar radiculopathy, right wrist pain, right flank pain

Past Surgical History: Cholecystectomy & tubal ligation

Family History: Mother- COPD, kidney issues (unspecified what issue) Father- the patient did not know her father

Social History (tobacco/alcohol/drugs): The patient denies any use of alcohol. She does have a history of using methamphetamines, and she smoked half a pack of cigarettes for the past 20 years.

Assistive Devices: The patient does not use any assistive devices.

Living Situation: The patient lives at the Haven in Mattoon, Illinois.

Education Level: The patient's highest level of education is high school.

Admission Assessment

Chief Complaint (2 points): Fever, headache, shortness of breath, and chills

History of present Illness (10 points):

The patient came into the emergency room complaining about fever, chills, shortness of breath, and headaches since the morning of 11/1. She complains that her pain is constant and that she does not feel right. C.E states that there is nothing that aggravates her problem. Along with that, she said she has been taking acetaminophen to try to relieve her fever. For the treatment, she is receiving ceftriaxone and azithromycin. Also, she rated her pain at ten on the numeric scale.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia

Secondary Diagnosis (if applicable): Shortness of breath

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

E.C. came into the emergency department due to having some shortness of breath and fever. Later, to find out, E.C. was diagnosed with pneumonia. Pneumonia is an infection that inflames the air sacs in one or both lungs (Mayo Clinic, 2020). Pneumonia commonly takes place from the inhalation of pathogens (Capriotti & Frizzell, 2016). At first, the pathogen will enter the upper airway and enter the lungs' tissues (Capriotti & Frizzell, 2016). After some time, the pathogen will eventually spread to the lower respiratory tract (Capriotti & Frizzell, 2016). White blood cells like neutrophils head to the inflammation site to fight off the infection that is taking place (Capriotti & Frizzell, 2016). Many mucous and exudate start to build up between the alveoli and the capillaries, causing shortness of breath (Capriotti & Frizzell, 2016). Most of the alveoli have trouble opening due to all the exudate around them. Pneumonia ranges from being a mild sickness to being very serious (Capriotti & Frizzell, 2016). Not only does pneumonia affect the lungs, but it also involves multiple body systems. Pneumonia can ultimately cause shortness of breath, decreasing the amount of oxygen in the circulatory system

(Hinkle & Cheever, 2018). The decrease in oxygenated blood cause hypoxia and can cause discoloration to the skin (Hinkle & Cheever, 2018). Also, pneumonia can cause the heart to work harder to help fight the infection (Hinkle & Cheever, 2018). Since the heart is working hard, the heart rate level will become tachycardic (Hinkle & Cheever, 2018). Pneumonia can also affect the gastrointestinal tract causing nausea, vomiting, and diarrhea (Mayo Clinic, 2020).

With pneumonia, there will be plenty of different signs and symptoms taking place in the body. Some of the characters are chest pain, coughing, confusion, fatigue, fever, chills, and headaches (Mayo Clinic, 2020). Along with that, nausea, vomiting, diarrhea, and shortness of breath are common symptoms seen with a patient with pneumonia (Mayo Clinic, 2020). When a patient has pneumonia, they can see a lower than usual red blood cell count, hemoglobin count, and hematocrit count (Hinkle & Cheever, 2018). A patient can also have elevated neutrophils with pneumonia. (Hinkle & Cheever, 2018). Some of the vital signs with pneumonia consist of elevated pulse, elevated temperature, elevation in respirations, and decreased oxygen saturation (Hinkle & Cheever, 2018). To diagnose pneumonia, a physician can order a chest x-ray, a C.T. scan, a CBC, ABG's, and a sputum culture will all help confirm the diagnosis of pneumonia (Capriotti & Frizzell, 2016).

E.C. received a CBC, a C.T. scan, and sputum culture. The CBC revealed that E.C. had low red blood cells, low hemoglobin, low hematocrit, and elevated neutrophils. Along with that, the patient C.T. scan showed infiltrates, which is a good indicator of pneumonia. Treatment for pneumonia consists of antibiotic therapy, oxygen therapy, and intravenous fluids (Capriotti & Frizzell, 2016). E. C's treatment consisted of ceftriaxone, azithromycin, oxygen therapy, and normal saline fluid.

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

Mayo Clinic (2020, June 13). *Pneumonia. https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes/syc-20354204#:~:text=Pneumonia%20is%20an%20infection%20that,and%20fungi%2C%20can%20cause%20pneumonia.*

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	3.80-5.41	3.77	N/A	The patient has a low red blood cell count because of the inflammatory response to the infection (Mayo Clinic, 2019)
Hgb	11.3-15.2	10.6	N/A	The patient has a low hemoglobin level due to having an infection (Mayo Clinic, 2020).
Hct	33.2-45.3	32.4	N/A	The patient hematocrit level is lower than normal because she has an infection in the body (Hinkle & Cheever, 2018).
Platelets	149-493	198	N/A	Lab was normal
WBC	4-11.7	10.7	N/A	Lab was normal
Neutrophils	1.54-7.04	8.4	N/A	The patient has an increase number in neutrophils due to having pneumonia

				(Hinkle & Cheever, 2018).
Lymphocytes	1.0-4.8	1.8	N/A	Lab was normal
Monocytes	2-8	3.3	N/A	Lab was normal
Eosinophils	0-6.3	0.5	N/A	Lab was normal
Bands	<1.0	N/A	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-	135-145	137	N/A	Lab was normal
K+	3.5-5.1	4.1	N/A	Lab was normal
Cl-	98-107	103	N/A	Lab was normal
CO2	22-29	28	N/A	Lab was normal
Glucose	70-99	104	N/A	The patient has elevated glucose levels due to the illness causing stress on the body (Hinkle & Cheever, 2018).
BUN	6-20	10	N/A	Lab was normal
Creatinine	0.5-0.9	0.79	N/A	Lab was normal
Albumin	3.5-5.2	N/A	N/A	N/A
Calcium	8.6-10.4	7.5	N/A	The patient has a hypocalcemia due to having hypoparathyroidism (Hinkle & Cheever, 2018).
Mag	1.6-2.4	N/A	N/A	N/A
Phosphate	2.5-4.5	N/A	N/A	N/A
Bilirubin	0-1.2	N/A	N/A	N/A

Alk Phos	35-105	N/A	N/A	N/A
AST	0-32	N/A	N/A	N/A
ALT	0-33	N/A	N/A	N/A
Amylase	30-110	N/A	N/A	N/A
Lipase	12-70	N/A	N/A	N/A
Lactic Acid	0.5-2.4	N/A	N/A	N/A
Troponin	0-0.4	N/A	N/A	N/A
CK-MB	0-4.9	N/A	N/A	N/A
Total CK	22-198	N/A	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	0.86-1.14	N/A	N/A	N/A
PT	11.9-15	N/A	N/A	N/A
PTT	25-40	N/A	N/A	N/A
D-Dimer	<500	N/A	N/A	N/A
BNP	<125	N/A	N/A	N/A
HDL	40-80	N/A	N/A	N/A
LDL	85-125	N/A	N/A	N/A
Cholesterol	<170	N/A	N/A	N/A
Triglycerides	50-150	N/A	N/A	N/A
Hgb A1c	<6%	N/A	N/A	N/A

TSH	0.5-5	N/A	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	Yellow, Clear	Light Yellow, Clear	N/A	Lab was normal
pH	5.0-8.0	6.5	N/A	Lab was normal
Specific Gravity	1.005-1.034	1.025	N/A	Lab was normal
Glucose	Normal	Normal	N/A	Lab was normal
Protein	Negative, Normal	Trace	N/A	The patient has trace protein in her urine due the fever she had (Mayo Clinic, 2020).
Ketones	Negative	Negative	N/A	Lab was normal
WBC	<5	1	N/A	Lab was normal
RBC	0-3	7	N/A	The patient has elevated red blood cells in the urinalysis because she is on antibiotics and an anticoagulant (Healthline, 2019).
Leukoesterase	Negative	Negative	N/A	Lab was normal

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	7.35-7.45	N/A	N/A	N/A
PaO2	80-100	N/A	N/A	N/A
PaCO2	35-45	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A

SaO2	95-100	N/A	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	Negative	N/A	N/A	N/A
Blood Culture	Negative	Negative	N/A	Lab was normal
Sputum Culture	Negative	Negative	N/A	Lab was normal
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (APA):

ATI (2019). *Content mastery series review module: RN adult medical surgical nursing* (11th ed.). Assessment Technologies Institute, LLC.

Healthline. (2019, December 2). *Why are there red blood cells in my urine?* *https://www.healthline.com/health/rbc-in-urine#test*

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

Mayo Clinic. (2019, August 16). *Anemia.* https://www.mayoclinic.org/diseases-conditions/anemia/symptoms-causes/syc-20351360

Mayo Clinic. (2020, September 22). *Low hemoglobin count causes.* https://www.mayoclinic.org/symptoms/low-hemoglobin/basics/causes/sym-20050760

Mayo Clinic (2020, April 21). *Protein in urine.* https://www.mayoclinic.org/symptoms/protein-in-urine/basics/causes/sym-20050656

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's comprehensive handbook of laboratory and diagnostic tests with nursing implications* (7 ed.). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. The patient received a CT scan of the lower abdomen and pelvis due to having abdominal pain.
2. The patient received a CT scan of the chest due to having a fever, a cough, and some shortness of breath.

Diagnostic Test Correlation (5 points):

1. The patient had an abdominal CT scan done to see if any underlying causes were causing the pain. A CT scan produces imaging to scan the multiple layers of tissues in the abdomen (Hinkle & Cheever, 2018). The patient's CT scan came back negative and shown no evidence of acute intraabdominal pathology.
2. A CT scan is a critical diagnostic test for pneumonia. A CT scan of the chest produces such imaging in which the lungs are scanned to distinguish the area's adequate tissue density (Hinkle & Cheever, 2018). C.E.'s C.T. scan was positive for pneumonia, and it revealed patchy bilateral infiltrates.

Diagnostic Test Reference (APA):

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

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

Home Medications (5 required)

Brand/Generic	Cardizem/ diltiazem	Tylenol/ acetaminophen	Singulair/ montelukast	Ultram/ tramadol	Synthroid/ levothyroxine
Dose	30 mg	1000 mg	10 mg	50 mg	100 mcg
Frequency	1 tablet BID	2 tablets every 6 hours PRN	1 tablet daily	1 tablet every 6 hours PRN	1 tablet daily
Route	PO	PO	PO	PO	PO
Classification	Calcium Channel Blocker	Analgesic/ Antipyretic	Leukotriene Modifiers	Opioid Agonists	Thyroid Drugs
Mechanism of Action	Obstructs the movement of calcium into conductive and contractile myocardial cells by inhibiting the influx of calcium through its channels, causing a slower conduction through SA and the AV nodes.	Acetaminophen acts directly on the hypothalamus to increase vasodilation and sweating.	Prevents cysteinyl leukotrienes from binding to its receptors reducing the bronchoconstriction and ultimate inflammation caused by leukotrienes.	Relieves pain by binding to receptors in the brain, spinal cord, and peripheral tissues.	Increases the metabolic rate in the body tissues, increasing oxygen consumption, respiratory rate, and heart rate.
Reason Client Taking	A-Fib	Fever/ Mild Pain	Allergies	Pain	Hypothyroidism
Contraindications	1.Severe	1.Impaired	1.Hypersensitivity	1.Respiratory	1.Thyrotoxicosis

(2)	hypertension 2.Acute myocardial infarction	hepatic function 2.Impaired renal function	to montelukast 2.Severe asthma	depression 2.Increased intracranial pressure	2.Addisons disease
Side Effects/Adverse Reactions (2)	1.Dizziness 2.Bradycardia	1.Anxiety 2.Abdominal pain	1.Headaches 2. Nausea	1.Drowsiness 2.Pupil constriction	1.Tachycardia 2.Cardiac dysrhythmias
Nursing Considerations (2)	1.Assess the patient for signs and symptoms of heart failure. 2.Expect to discontinue drug if adverse skin reactions start to take place.	1.Monitor renal function on patients with long term use. 2.Do not exceed recommended dosages of acetaminophen.	1.Montelukast is not for acute asthma attacks. 2. Monitor patient for adverse reactions, such as eosinophilia, cardiac and pulmonary symptoms, and vasculitis.	1.Avoid giving to patients with acute abdominal conditions because it may disrupt the assessment of the abdomen. 2.Be aware that excessive use of tramadol may lead to abuse and addiction.	1.Be aware that levothyroxine treatment is not to be used for obesity. 2.Give oral levothyroxine at least 4 hours before or after magnesium containing antacids.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1.Monitor patient's blood pressure 2.Monitor patient's pulse	1. Monitor creatinine 2. Monitor AST, ALT, and bilirubin	1.Assess the patient for suicidal tendencies 2. Assess the patient for a relief of allergy symptoms.	1. Monitor the patient's respirations 2.Monitor the patients pain level	1.Monitor thyroid function tests. 2.Asses the patient who is receiving anticoagulants; she may require a dosage adjustment
Client Teaching needs (2)	1.Urge the patient to report chest pain and difficulty breathing. 2.Advise the patient how to monitor her blood pressure and heart rate.	1.Instruct the patient to read manufacturer's label before taking medication. 2. Teach the patient to recognize signs of hepatoxicity such as bleeding and bruising.	1.Advise the patient to take montelukast daily as prescribed, even when she feels well. 2.Instruct the patient to report an increased bleeding tendency or severe skin reaction to the provider.	1.Caution the patient to not stop tramadol abruptly. 2.Instruct the patient to avoid hazardous activities until the drugs CNS effects are known.	1.Inform the patient that levothyroxine replaces a hormone that is normally produced by thyroid gland. 2.Instruct the patient to take the drug at least 30 minutes before breakfast.

Hospital Medications (5 required)

Brand/Generic	Lovenox/ enoxaparin	Neurontin/ gabapentin	Zoloft/ sertraline	Rocephin/ ceftriaxone	Zithromax/ azithromycin
Dose	40mg/ 0.4 mL	800 mg	100 mg	2000 mg/ 100 mL	500 mg/ 250 mL
Frequency	Once Daily	2 capsules QID	1 tablet daily	200 mL per hour once every 24 hours	250 mL per hour every 24 hours
Route	Subcutaneous injection	PO	PO	IV piggyback	IV piggyback
Classification	Low-molecular-weight heparin	Gamma-aminobutyric acid structural analogs	SSRIs	Cephalosporin	Antibiotic
Mechanism of Action	Combines with antithrombin III to inactivate clotting factors IX, X, XI, and XII; inhibit the conversion of prothrombin to thrombin; and prevent thrombus formation.	Gabapentin binds to sites in the brain that have a high affinity for gabapentin. Along with that it inhibits postsynaptic responses and block post tetanic potentiation.	Blocks the reabsorption of the neurotransmitter serotonin in the brain.	Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglycan strands and the cells die.	Binds to a ribosomal subunit of susceptible bacteria, blocking peptide translocation and stopping RNA-dependent protein synthesis.
Reason Client Taking	To prevent DVT's and pulmonary embolisms	Neuropathic pain	Depression and anxiety	Pneumonia	Pneumonia
Contraindications (2)	1.GI ulcerations 2.Intracranial bleeding	1.Hypersensitivity to gabapentin 2.Respiratory Impairment	1.Sensitivity to sertraline 2.The use of MAO inhibitors	1.Solutions containing lidocaine 2.Calcium containing IV solutions	1. Hepatic dysfunction 2.Hypersensitivity to azithromycin
Side Effects/Adverse Reactions (2)	1.Epistaxis 2.Anemia	1.Arthritis 2.Hypertension	1.Alopecia 2.Bronchospasm	1.Hearing loss 2.Diarrhea	1.Thrombocytopenia 2.Angioedema
Nursing Considerations (2)	1.Use enoxaparin	1. Gabapentin capsules may be	1.Sertraline should not be	1.Watch patient closely	1.Obtain culture and sensitivity results if

	with severe caution with patients at risk for hemorrhaging. 2.Test stool for occult blood as ordered.	opened and mixed with applesauce. 2.Give drug at least 2 hours after an antacid	given to patients with bradycardia, hypokalemia, and acute myocardial infarction. 2.Monitor the patient closely for evidence of GI bleeding.	for evidence of gall bladder disease. 2.Assess the patient for development of clostridium difficile.	possible before beginning therapy. 2.Be aware that laboratory abnormalities may occur during azithromycin therapy.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1.Monitor the patient's serum potassium level 2.Assess the patient for bleeding.	1.Monitor the renal function in the patient 2. Assess the patient for suicidal thinking and behavior.	1. Monitor the patients liver enzymes. 2.Monitor the patients BUN and creatinine levels.	1.Monitor BUN 2.Monior the patient's CBC	1.Monitor liver enzymes closely 2.Assess the patients bowel elimination
Client Teaching needs (2)	1.Advise the patient to notify the provider if bleeding occurs. 2.Avise the patient that NSAID's will increase chances of bleeding while taking enoxaparin.	1.Urge the patient to keep follow-up appointments with prescriber to check progress. 2.Advise the patient to not stop the drug abruptly.	1.Advise the patient to consult prescriber before taking any OTC product, especially NSAIDs. 2.Advise the patient this drug could lead to an acute closure glaucoma.	1.Tell the patient to report evidence of super infection. 2.Urge the patient to report watery diarrhea to the provider.	1.Tell the patient to report signs and symptoms of an allergic reaction such as itching. 2.Educate the patient to ask the provider before starting an antacid.

Medications Reference (APA):

Frandsen, Geralyn. (2020). *Abrams clinical drug therapy: Rationales for nursing practice*. S.l.: Wolters Kluwer Medical.

Jones & Bartlett Learning. (2019). *Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	E.C was A & O x 4 and was under some slight stress due to the severe pain that she was dealing with. Overall, the patient's appearance was really good for her age.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patients skin color was normal for her ethnicity. The skin was warm, dry, elastic, and returned when turgor was assessed. The patient did not have any apparent bruises, wounds, drains, or rashes on her body. E. C's Braden score was a 20.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patients head was normocephalic without any lesions or masses. E. C's trachea was midline on her neck and all lymph nodes were palpated. Her ears were intact and the tympanic membrane was visible and pearly gray. Along with that, her nose was intact and she did not have any visible nasal drainage. All of the patient teeth were intact and PEERLA was 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:**	The patients had S1 and S2 sounds upon auscultation of the heart. She did not have any murmurs or gallops. The rhythm and rate of the heart is normal. The pedal pulses and the radial pulses were palpated and graded at a +3. The patient's capillary refill was under 3 seconds. Also, there was no apparent neck vein distention and no edema located.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient's respiratory sounds were auscultated in all lobes and had expiratory wheezes in all lobes. The patient did not have any rhonchi or crackles upon auscultation. Also, she did not use accessory muscles to facilitate breathing.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:**	The patient is on a regular diet right now and at home. E.C weighs 88.3 kilograms and she is 5 feet and 2 inches tall. The patient had active sounds in all four quadrants and her last bowel

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:**	movement was on 11/1/2020. The patient did have not have any pain upon palpation or a mass on her abdomen. Also, there was no distention, incision, drains, or wounds on her abdomen. She did have a scar from when she had her gall bladder removed. E.C does not use a nasogastric tube, an ostomy bag, or a feeding tube.
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 did not have an odor and the color was light yellow and clear. E.C has been able to urinate at an adequate amount and does not report any pain while urinating. She is not on dialysis and does not have a catheter.
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☐**	The patient had feeling in all parts of her body and no signs of discoloration of the skin. She has a full range of motion in all limbs and does not use any supportive devices. Along with that, she has good strength and does not need assistance with her activities of daily living. She is a low risk for falls and her fall score is a 35. The patient has great activity and can walk on her own when she needs to. She is very independent, does not need assistance with equipment, and does not need support to stand.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:**	The patient is able to move all her extremities well and has equal strength in all limbs. PERLA is noted and her mental status is normal for her age. E.C is A & O x 4 and she can talk very clear. She has sensory in her whole body and she is 100% conscious.

Speech: **Sensory:** **LOC:**	
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):**	The patient is taking hydrocodone and acetaminophen to help cope with her pain. She is well developed for her age and she is a catholic. E.C lives at the Haven in Mattoon, Illinois.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0745	79 BPM	110/71 mmHg	16 BPM	36.0℃	95%
1100	84 BPM	117/79 mmHg	16 BPM	36.1℃	94%

Vital Sign Trends:

The patient's vital signs at 0745 were all in normal ranges. The vital signs at 1100 were also normal, except for her oxygen saturation. Her oxygen saturation level was 94%. The lower than average level of her oxygen saturation is expected due to her having pneumonia.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0745	Numeric	Back & Neck	10	Achy	acetaminophen & hydrocodone
0900	Numeric	Back & Neck	7	Achy	acetaminophen & hydrocodone

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** Right peripheral forearm **Date on IV:** 11/1/2020 **Patency of IV:** No signs of infiltration or phlebitis **Signs of erythema, drainage, etc.:** The IV site has no signs of erythema or drainage **IV dressing assessment:** The IV site is dry, clean, and intact	NaCl 0.9%-1000mL given as an IV drip at a continuous infusion at 100 mL/hour ceftriaxone 2000mg/100 mL given IV piggyback at 200 mL/hour every 24 hours azithromycin 500mg/250mL given IV piggyback at 250 mL/hour every 24 hours

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
3900 mL	1850 mL

Nursing Care

Summary of Care (2 points)

Overview of care: The patient's vital signs were first taken at 0745. E. C's vital signs were all normal. After taking the patient's vital signs, I administered her oral medications and gave her the enoxaparin shot. She was very compliant and took all of her medicines. Once the medications were administered, I did a full assessment of her, and everything was within normal limits except she did have expiratory wheezes. The wheezes were expected since she has pneumonia. Lastly, the patient's vital signs were retaken at 1100, and they were all normal except the oxygen saturation.

Procedures/testing done: The patient did not receive any procedures or testing during my shift.

Complaints/Issues: The patient did have complaints about the pain she was dealing with. After giving her the pain medication, she felt a lot better.

Vital signs (stable/unstable): Overall the patients vital sign was stable except her oxygen saturation. Her oxygen saturation was slightly lower than normal at 94%.

Tolerating diet, activity, etc.: The patient is tolerating her regular diet and activity well. She ate most of her breakfast and she is able to get up and move on her own without assistance.

Physician notifications: The physician did not give any notifications during my shift.

Future plans for patient: The future plans for this patient are to finish all of her antibiotics and get her back to her home at the Haven.

Discharge Planning (2 points)

Discharge location: The patient is going to be getting discharged to the Haven.

Home health needs (if applicable): The patient will need to likely finish the rest of her antibiotics at home and will need a prescription for pain medications to help control her pain.

Equipment needs (if applicable): The patient does not need any equipment.

Follow up plan: The patient will need to schedule a follow up with her primary provider to reassess her lungs and to make sure the infection has diminished.

Education needs: Educate the patient on how often she should take her antibiotics and how to take them. Also, she needs to finish all of her antibiotics to help kill all the pathogens in the body. Along with that, she needs education to drink a lot of fluids and to still get plenty of rest.

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	• Explain why the nursing		• How did the patient/family respond

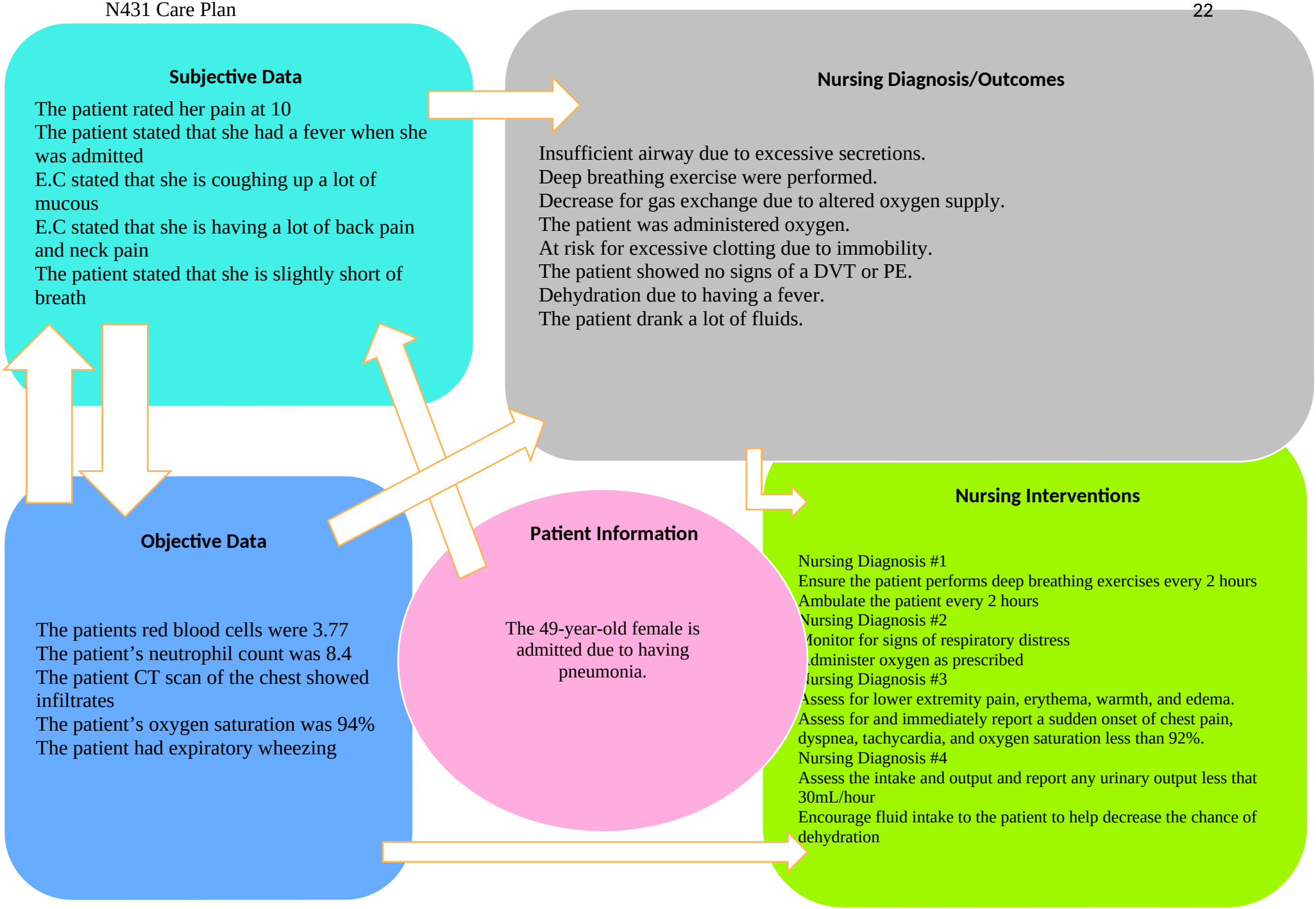
"related to" and "as evidenced by" components	diagnosis was chosen		to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Potential for insufficient airway clearance related to excessive tracheobronchial secretions and as evidence by the client saying she is coughing up a lot of mucus.	Excessive secretions	1. Ensure that the patient performs deep breathing exercises every two hours. 2.Ambulate the patient every two hours	1.The patient performed deep breathing exercises during my assessment. 2.The patient ambulated when she had to go to the bathroom
2. Decrease for gas exchange related to altered oxygen supply and as evidenced by the client's oxygen saturation falling below 95%.	Low oxygen saturation levels	1. Monitor for and promptly report signs of respiratory distress. 2.Administer oxygen as prescribed.	1.The patient never showed signs of respiratory distress. 2.The patient was administered with oxygen when she needed it.
3. At risk for excessive clotting related to immobility and as evidenced by client sitting in her bed all the time.	Risk for excessive clotting	1. Assess for lower extremity pain, erythema, warmth, and edema. 2 Assess for and immediately report sudden onset of chest pain, dyspnea, tachycardia, and oxygen saturation less than 92%.	1.The patient did not have any signs of a clot when assessing her lower extremities. 2.The patient did not show any signs of chest pain, dyspnea, tachycardia, and low oxygen during my shift.
4. Dehydration related to increased insensible loss occurring with a fever and as evidenced by the client saying she had a fever when she was	Risk for dehydration	1.Assess the intake and output and be alert to report any urinary output lower than 30mL/hour. 2. Encourage fluid intake to the patient to decrease the chance of	1.The patient's intake and output were recorded and she was able urinate at an adequate rate. 2.The patient agreed to drink a lot of fluid to help with dehydration.

admitted.		dehydration.	

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
The patient rated her pain at 10
The patient stated that she had a fever when she was admitted
E.C stated that she is coughing up a lot of mucous
E.C stated that she is having a lot of back pain and neck pain
The patient stated that she is slightly short of breath
Nursing Diagnosis/Outcomes
Insufficient airway due to excessive secretions.
Deep breathing exercise were performed.
Decrease for gas exchange due to altered oxygen supply.
The patient was administered oxygen.
At risk for excessive clotting due to immobility.
The patient showed no signs of a DVT or PE.
Dehydration due to having a fever.
The patient drank a lot of fluids.
Objective Data
The patients red blood cells were 3.77
The patient's neutrophil count was 8.4
The patient CT scan of the chest showed infiltrates
The patient's oxygen saturation was 94%
The patient had expiratory wheezing
Patient Information
The 49-year-old female is admitted due to having pneumonia.
Nursing Interventions
Nursing Diagnosis #1
Ensure the patient performs deep breathing exercises every 2 hours
Ambulate the patient every 2 hours
Nursing Diagnosis #2
Monitor for signs of respiratory distress
Administer oxygen as prescribed
Nursing Diagnosis #3
Assess for lower extremity pain, erythema, warmth, and edema.
Assess for and immediately report a sudden onset of chest pain, dyspnea, tachycardia, and oxygen saturation less than 92%.
Nursing Diagnosis #4
Assess the intake and output and report any urinary output less that 30mL/hour
Encourage fluid intake to the patient to help decrease the chance of dehydration