N431 Care Plan #3

Lakeview College of Nursing

Justin Pranada

Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
11/24/2020	MT	85	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired - teacher	Widowed	Sulfa drugs
Code Status	**Height**	**Weight**	
DNR	170 cm	86.4 kg	

Medical History (5 Points)

Past Medical History: MT's medical history includes history of UTI, anemia, congestive heart failure (CHF), constipation, COPD, fall risk, fibromyalgia, history of falls, history of GI bleed, GERD, hypertension (HTN), left ventricular hypertrophy (LVH), neuropathy, osteoarthritis, atrial fibrillation (Afib), pulmonary edema, and pulmonary hypertension.

Past Surgical History: MT has had the following procedures done:

- Hysterectomy (1990)
- Cholecystectomy (1955)

Family History:

- Father: alcoholism, gout, lung disease, pneumonia
- Mother: gallbladder disease, hypertension

Social History (tobacco/alcohol/drugs): MT denies any use of tobacco products, alcohol, and illicit drugs.

Assistive Devices: MT uses a walker for ambulation and wears a pair of glasses.

Living Situation: She lives at Villas of Holly Brook in town.

Education Level: Graduated college.

Admission Assessment

Chief Complaint (2 points): Shortness of breath (SOB) upon exertion.

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History of present Illness (10 points):

MT is an 85-year-old female who presented to the Emergency Department at SBL on 11/24/2020 with shortness of breath upon exertion. MT stated that around one week ago (9 days) she started to experience shortness of breath with activities. She has been having an increase in sputum production that is yellow in color, and a persistent cough before her admission. She states that activities of daily living causes her to become short of breath. In the ED, her oxygen saturation decreased to 85% and her oxygen flow rate was increased to 4L. Her hemoglobin (Hgb) value on admission was at 8.9. She denied any pain or discomfort during the assessment.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia

Secondary Diagnosis (if applicable): UTI

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

Pathophysiology

Pneumonia is caused by inhaling droplets that contain causative agents like Pneumocystis jiroveci (Capriotti & Frizzell, 2016). On most occasions, the respiratory tract deals with infectious pathogens with ease. In immunocompromised individuals, like the elderly and individuals with COPD, pathogens may have more colonization opportunities in the respiratory tract (Hinkle & Cheever, 2018). When the infectious pathogens slip past the immune system of immunocompromised individuals, they can adhere to the respiratory tissues, specifically in the alveoli (Capriotti & Frizzell, 2016). This event causes an inflammatory response due to the increased numbers of white blood cells, mostly neutrophils, to fight off the infection.

Additionally, the inflammation causes excessive stimulation of respiratory goblet cells, which results in excess production of mucus. The excess mucus in the respiratory tract decreases gas exchange in alveoli, resulting in shortness of breath and activity intolerance (Hinkle & Cheever, 2018). The increase in infectious pathogens and white blood cells increases the body's temperature, known as a fever (Hinkle & Cheever, 2018).

Expected findings, signs & symptoms, patient correlation

Expected findings in pneumonia include a cough that may or may not be productive, fever and chills, chest pain - especially with deep breaths, dyspnea, hemoptysis (bloody sputum), crackles, and activity intolerance (Capriotti & Frizzell, 2016). A patient diagnosed with pneumonia may also present with a headache, abdominal pain, nausea, and vomiting (Capriotti & Frizzell, 2016). Tachypnea, tachycardia, cyanosis, and accessory muscle some signs and symptoms that a patient may also present with (Capriotti & Frizzell, 2016). MT complained of shortness of breath on exertion during her admitting assessment. She had a productive cough and activity intolerance for activities of daily living. Upon physical examination, MT presented with labored breathing with accessory muscle use on 2.5 L of oxygen. Her vital signs were within normal limits: respirations of 20 and oxygen saturation of 95% during the last vital sign check.

Diagnostics, tests, and labs

The primary diagnostic test performed in patients with pneumonia is a chest x-ray (Hinkle & Cheever, 2018). The provider may order a CBC with differential, ABGs, and sputum culture (Capriotti & Frizzell, 2016). MT's chest x-ray was indicative of pneumonia. Her CBC came back with an elevation in white blood cells at 11.7.

Treatment of the disease

The primary pharmacological treatment of pneumonia is antibiotics (Hinkle & Cheever, 2018). Alongside antibiotics, analgesics - for pain due to the increasing efforts of breathing, antipyretics - for the fever, and bronchodilators are also used (Hinkle & Cheever, 2018). A pneumococcal vaccine is also used as a preventative measure (Hinkle & Cheever, 2018). Patients with pneumonia may be prescribed oxygen therapy and IV fluids during their inpatient stay (Capriotti & Frizzell, 2016). During the clinical assessment, MT was not on any antibiotics. She was on 2.5 L of oxygen, Tylenol for pain and fever, and albuterol for her bronchodilator.

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	2.79	3.21	Low RBC is indicative of anemia (Hinkle & Cheever, 2018). MT has a history of anemia.
Hgb	12.0-15.5	8.9	9.9	A low Hgb is indicative of anemia (Hinkle & Cheever, 2018). MT has a history of anemia.

Hct	35-45%	27.2	30.6	Low Hct is indicative of anemia (Hinkle & Cheever, 2018). MT has anemia.
Platelets	150-500 K	341	246	Normal lab value
WBC	4.5-11 K	10.3	11.7	An elevated value is indicative of an infection (Capriotti & Frizzell, 2016). MT's urine culture came back positive for Citrobacter koseri, a gram negative bacteria that causes UTI.
Neutrophils	45.3-79%	74.6	62.3	Normal lab value
Lymphocytes	11.8-45.9%	17.7	26.2	Normal lab value
Monocytes	4.4-12.0%	6.2	6.8	Normal lab value
Eosinophils	0.0-6.3%	0.6	4.4	Normal lab value
Bands	0.0-5.0%	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	141	144	Normal lab value
K+	3.5-5.0	4.6	4.4	Normal lab value
Cl-	98-108	99	104	Normal lab value
CO2	22-29	32	32	Gas exchange impairment can increase CO2 and decrease O2 levels in the body (Hinkle & Cheever, 2018). MT has pneumonia and shortness of breath on exertion. She is having difficulty with gas exchange. She is on oxygen therapy.
Glucose	70-100	158	95	Some medications may temporarily increase serum glucose levels (Jones & Bartlett Learning, 2019). MT is on pantoprazole, a PPI that can increase glucose levels. MT does not have a history of diabetes.

BUN	8-25	26	17	An elevated BUN value is indicative of some form of kidney problem (Capriotti & Frizzell, 2016). MT has CKD.
Creatinine	0.6-1.2	1.2	0.98	Normal lab value
Albumin	3.5-5.0	3.5	N/A	Normal lab value
Calcium	8.6-10.4	9.4	N/A	Normal lab value
Mag	1.6-2.4	N/A	N/A	Normal lab value
Phosphate	2.5-4.5	N/A	N/A	Normal lab value
Bilirubin	0.0-1.2	N/A	N/A	Normal lab value
Alk Phos	35-105	63	N/A	Normal lab value
AST	0-35	18	N/A	Normal lab value
ALT	24-36	15	N/A	Normal lab value
Amylase	30-110	N/A	N/A	Normal lab value
Lipase	12-70	N/A	N/A	Normal lab value
Lactic Acid	0.5-2.2	N/A	N/A	Normal lab value
Troponin	0-0.4	0.021	N/A	Normal lab value
CK-MB	0-4.9	N/A	N/A	Normal lab value
Total CK	22-198	N/A	N/A	Normal lab value

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	0-99	237	N/A	Elevated BNP level is indicative of damage to the heart (Capriotti & Frizzell, 2016). MT has CHF.
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	Yellow Cloudy	Yellow Clear	Cloudy coloration of the urine can indicate dehydration (Hinkle & Cheever, 2018). MT stated that she has not been drinking much before her admission to the hospital.
pH	5.0-8.0	7.0	N/A	Normal lab value
Specific Gravity	1.005-1.034	1.012	N/A	Normal lab value
Glucose	Normal	Normal	N/A	Normal lab value
Protein	Negative	Negative	N/A	Normal lab value
Ketones	Negative	Negative	N/A	Normal lab value
WBC	<5	30	N/A	An elevated WBC value in urine is indicative of UTI (Hinkle & Cheever, 2018). MT was admitted for pneumonia and **UTI**.
RBC	0-4	1	N/A	Normal lab value

Leukoesterase	Negative	3+	N/A	An elevated Leukoesterase value in urine is indicative of UTI (Hinkle & Cheever, 2018). MT was admitted for pneumonia and **UTI**.

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	Positive	N/A	Citrobacter koseri is a rare causative agent of UTIs in adults (Capriotti & Frizzell, 2016). MT was admitted for pneumonia with **UTI**.
Blood Culture	Negative	Negative	N/A	Normal lab value
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (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

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1) Chest x-ray (CXR): This diagnostic test allows for the visualization of the chest cavity that includes the heart and lung fields (Hinkle & Cheever, 2018).

Diagnostic Test Correlation (5 points):

1) Chest x-ray (CXR): MT received a CXR to visualize her lung fields and help the provider figure out what is causing her to have SOB. The CXR was indicative of Pneumonia.

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	Proventil	Feosol	Prinivil	Lopressor	Prilosec

	albuterol	ferrous gluconate	lisinopril	metoprolol	pantoprazole
Dose	2.5 mg	324 mg	20 mg	100 mg	40 mg
Frequency	Q6H; PRN	TID	Daily	Daily	Daily
Route	Inhalation	PO	PO	PO	PO
Classification	Bronchodilator	Antianemic; supplement	Antihypertensive ; vasodilator	Antianginal; antihypertensive	Antiulcer; PPI
Mechanism of Action	Acts on beta 2 receptors on the smooth muscles and cause relaxation.	Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendotheli al cells of the bone marrow, liver, and spleen.	May reduce BP by inhibiting conversion of angiotensin I to angiotensin II.	Inhibits stimulation of beta 1 receptor sites in the heart resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand.	Interferes with gastric acid secretion by inhibiting the proton pump in gastric parietal cells.
Reason Client Taking	COPD; pulmonary edema	Anemia	Hypertension	Hypertension	GERD; hx of GI bleed
Contraindications (2)	Hypersensitivity; allergic reactions	Hemolytic anemia; hemosiderosis	Concurrent aliskiren use in pt with diabetes or pt with renal impairment; Hypersensitivity to lisinopril.	Acute heart failure; cardiogenic shock	Rilpivirine containing therapy; hypersensitivity to pantoprazole
Side Effects/Adverse Reactions (2)	Tremor; tachycardia	Hypertension; dyspnea	Hyponatremia; weight gain or loss	Angina; nausea	Hyperglycemia; dyspnea
Nursing Considerations (2)	Administer pressurized inhalations of albuterol during second half of inspiration; Use cautiously in patients with cardiac disorders	Dilute and administer with a straw; Give 1 hour before or 2 hours after meals for the best absorption.	Lisinopril should not be given to a patient who is hemodynamicall y unstable after an acute MI; Use caution in patients with fluid volume deficit, heart	Use cautiously in patients with angina; assess EKG of patients who take metoprolol because they may be at risk for AV block	Expect to monitor PT or INR during therapy if patient is taking oral anticoagulant; Monitor patient for bone fractures

			failure, or renal failure.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor the patient's serum potassium levels, this medication can induce hypokalemia.	Monitor the patient for hypersensitivity reactions for at least 30 minutes after administration; Monitor the patient's blood pressure before administration for a set baseline.	Monitor the patient's blood pressure before administering the medication.	Monitor the patient's blood pressure before administration. Take caution when administering blood pressure is below the patient's baseline.	Monitor PT or INR because pt is taking eliquis; the patient's eliquis order was discontinued upon admission.
Client Teaching needs (2)	Educate the client how to use an inhaler; Instruct client to wash mouthpiece with water once a week and let it air-dry.	Notify the provider if you experience dyspnea; notify your provider if you experience diarrhea	Notify your provider if you experience orthostatic hypotension; lisinopril helps control your blood pressure, it does not cure high blood pressure.	Notify the provider if your HR goes below 60bpm; Do not stop the drug abruptly.	Swallow pantoprazole whole; Notify provider if therapeutic effect does not occur after 2 weeks.

Hospital Medications (5 required)

Brand/Generic	**Lasix** furosemide	**Tylenol** acetaminophen	**Colace** docusate sodium	**Singulair** montelukast	**K-Tab** potassium chloride
Dose	40 mg (1 tablet)	500 mg	40 mg	10 mg	20 mEq
Frequency	Q12H	Q6H; PRN	BID	Daily	Daily
Route	IVP	PO	PO	PO	PO
Classification	Loop diuretic	Analgesic; antipyretic	Laxative; stool softener	Anti Allergen; antiasthmatic	Electrolytes
Mechanism of	Inhibits sodium	Acts on the	Acts as a	Prevents	Potassium is

Action	and water reabsorption in the loop of Henle and increases urine formation. By reducing intracellular and extracellular fluids, the medication reduces blood pressure and decreases cardiac output.	temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2.	surfactant that softens stool by decreasing surface tension between oil and water in feces.	bronchoconstriction by blocking the effects of cysteinyl leukotrienes.	naturally found in the body. Potassium chloride is used to prevent and treat hypokalemia caused by fluid and electrolyte loss such as hemorrhage, diarrhea, and vomiting.
Reason Client Taking	Hypertension; fluid volume overload; treatment for hyperkalemia	Mild to moderate pain; fever d/t pneumonia	Constipation	Pulmonary edema	Decreased oral intake of fluids
Contraindications (2)	Anuria; hypersensitivity	Hypersensitivity; severe hepatic impairment	Fecal impaction; undiagnosed abdominal pain.	Suicidal ideation; depression	Dehydration; severe heart block
Side Effects/Adverse Reactions (2)	Dehydration; arrhythmias	Hepatotoxic; hypotension	Nausea; vomiting	Fever; cough	Angina; bradycardia
Nursing Considerations (2)	Be aware that patients who are allergic to sulfonamides may be allergic to furosemide; monitor the patient for hypokalemia due to decreased oral intake.	Monitor for renal dysfunction; Do not exceed recommended dosage.	Assess for laxative abuse syndrome; assess for laxative dependence.	Montelukast is not for acute asthma attack or status asthmaticus; monitor patient for neuropsychiatric effects.	Administer with plenty of fluids; may enhance hyperkalemic effects of aliskiren
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain the patient's weight before and after furosemide therapy to monitor fluid loss. Monitor blood pressure and hepatic and renal functions.	Check liver function labs before administration; Check renal function.	Assess the client for hypersensitivity; assess for symptoms that may indicate appendicitis.	Monitor the patient for pulmonary symptoms. Monitor the patient's respirations.	Monitor the patient's potassium levels.

Client Teaching needs (2)	Take this medication at the same time everyday; Take your last dose several hours before going to bed, you don't want to be getting up consistently when you are trying to sleep.	Tablets can be crushed; Take the medication as prescribed.	Do not use docusate when you are experiencing abdominal pain; Notify your provider if you notice any rectal bleeding.	Take this medication daily as prescribed; This medication is not intended for acute asthma attacks.	Drink plenty of fluids; eat green leafy vegetables.

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was awake and oriented to person, place, time, and situation (x4). The patient responded to the questions asked appropriately. She looked well nourished and in a good mood. She showed no signs of distress during assessment.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Braden Score: 20 (not a skin risk) Her skin was appropriate in color for race, intact, warm, and dry to touch with good skin turgor. There were no rashes or wounds noted or reported by the patient. No drains are present.

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normocephalic and midline with no deviations. MT's neck is short with trachea in midline. MT exhibited PERRLA and the six cardinal fields of gaze. The tympanic membrane is pearly, grey in color, and intact bilaterally. There was no drainage in the patient's ears. MT's nose showed no deviated septum. MT's nose showed equal turbinates, bilaterally. The skin around her nostrils are intact and shows no signs of breakdown caused by the nasal cannula. Her oral mucosa was pink, moist, and intact with teeth present. Tongue was pink in color. No abnormalities 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 regular rate and rhythm. Pedal pulses were strong and graded at 2+ bilaterally. Her capillary refill was less than 3 seconds. No murmurs, edema, or JVD noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient's respirations were labored at 18 breaths/min with clear signs of accessory muscle use. Fine crackles were present in all lung fields, bilaterally. The patient's chest moved with each respiration with no chest wall deformities observed. Her O2 sat was noted at 92% on 2.5L via nasal cannula at the time of assessment. The head of the bed was raised to high-fowler's because the patient was complaining of dyspnea. The nurse also increased the oxygen's flow rate to 4L. The patient had no productive cough with sputum at the time of assessment.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:**	Ht: 170 cm Wt: 83.4 kg Last BM: 11/27/2020

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:**	The patient was not on any special diet at home; she was on a heart failure diet during her inpatient stay. Her abdomen was soft and nondistended with active bowel sounds in the all four quadrants after auscultating for 2 minutes. The abdomen was round and moved with respirations. There was no organomegaly noted. No distention, incision, scar, drain, or wound noted. No feeding tubes in use. No mass palpated. No discomfort reported.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Upon assessment, the patient's urine was clear and yellow in the toilet. No distention of the bladder noted. The patient did not report any changes in voiding or dysuria. Patient was not on dialysis. No catheter noted.
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 has a history of falls. The patient was able to perform active range of motion in both upper and lower extremities, bilaterally. She exhibited equal strength in all four extremities. The patient is a 1 assist for getting out of bed, transfers, and ambulation. The patient requires a walker for ambulation. Use of gait belt is also required.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	MT speaks English as her primary language and responded appropriately for her age. She is alert and oriented x4. MT moved all extremities well (MAEW). PERRLA was noted. MT's strength is equal bilaterally in all four extremities. Sensory and judgement are intact. Her mental status is appropriate for her age.

Sensory: **LOC:**	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):**	MT is Methodist and has very strong beliefs . She talks highly of her sister and brother in law who lives in Minnesota. She states that they visit her in town quite often and loves when they visit. She did not mention other family members. MT's developmental level is appropriate for her age.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	81 bpm	150/71 mm Hg	18 bpm	36.2 C	92%
1100	80 bpm	132/78 mm Hg	20 bpm	36.4 C	95%

Vital Sign Trends: MT's vital signs were stable during the shift. Her pulse, respiratory rate, and oxygen saturation were within normal limits. She is on the lower end for temperature due to poor circulation related to CHF. Her oxygen saturation is still on the lower end of normal range being on 2.5L of oxygen. Her blood pressure decreased after administration of antihypertensives at 09:00 med pass.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	0-10	N/A	0	N/A	N/A
1100	0-10	N/A	0	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 IV is a patent 20 gauge saline lock in the right forearm started on 11/29/2020. No signs of erythema or drainage present. The dressing is clean, dry, and intact.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
16 oz (big cup) **480 mL** - cranberry/water mixture	900 mL

Nursing Care

Summary of Care (2 points)

Overview of care:

The first set of vitals were taken at 0800. Her blood pressure was elevated at 150/71 mm Hg and it is to be expected with her history of hypertension (HTN). MT's chest x-ray was indicative of pneumonia in both lung fields. MT had minimal dyspnea despite being on 2.5L of oxygen delivered via nasal cannula. Her oxygen saturation upon assessment was 92%. MT complained of dyspnea during medication administration so the nurse and student adjusted the bed to a high-fowler's position. After 09:00 medications were administered, MT urinated more due to the Lasix. A head-to-toe assessment was performed and minimal fine crackles in the lung fields, bilaterally were heard. The last set of vitals were taken at 11:00 and they were a HR of 80 bpm, reparations of 20 breaths per minute, oxygen saturation of 94%, blood pressure of 132/78 mm Hg, and a temperature of 36.4 C.

Procedures/testing done:

MT had a chest x-ray performed to evaluate what may be causing her to have shortness of breath. The results showed that she has pneumonia in her lungs, bilaterally.

Complaints/Issues:

MT did not complain of any pain or discomfort during the shift. She complained about having a hard time to breathe. Nonpharmacological interventions were implemented - position changes.

Vital signs (stable/unstable):

Her vital signs were stable and showed appropriate expected outcomes after medication administration - blood pressure decreased after antihypertensive medications were administered.

Tolerating diet, activity, etc.:

MT is on a heart failure diet and is tolerating it well. She is up with 1 assist and ambulates with a walker.

Physician notifications:

There were no physician instructions ordered during the time of clinical. The nurse was asked and she informed that MT will need to notify her provider for future infections or COPD exacerbations.

Future plans for patient:

The patient will need to be able to perform activities of daily living before being discharged back to the assisted living. She will need to have an improvement in her oxygen saturation before being discharged by her provider.

Discharge Planning (2 points)

Discharge location:

MT will be discharged back to Villas of Holly Brook when she feels that she is strong enough to go back.

Home health needs (if applicable):

MT will need to adhere to her medications and with her provider's orders. She will need to adhere to her heart failure diet to reduce CHF exacerbation.

Equipment needs (if applicable):

MT is required to use a walker when ambulating

Follow up plan:

MT will need to follow up with her provider for CHF exacerbation and experience shortness of breath.

Education needs:

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. Impaired gas exchange related to pneumonia as evidenced by an oxygen saturation of 85% on admission.	MT is having shortness of breath due to increased production of sputum in her lungs.	1. Educate and encourage MT to use an incentive spirometer. 2. Encourage deep breathing and coughing when indicated.	**Goal:** MT's oxygen saturation will be maintained between 95-100% with oxygen or on room air. During clinical, MT's oxygen saturation stayed at or above 95% on 2.5 L of oxygen at rest.
2. Fall risk related to advanced age as evidenced by fall score of 60, decreased mobility, and	MT has a history of falls and a fall score of 60.	1. Ensure that MT is wearing appropriate footwear.	**Goal:** MT will be able to ambulate from the bed to her chair safely while using her

the use of a walker for ambulation.		2. Eliminate causative factors like floor rugs and loose cords.	walker with assistance from the staff. MT was able to transfer to the bathroom with her walker and 1 care partner.
3. Risk for infection related to advanced age as evidenced by pneumonia and UTI.	MT has developed pneumonia and a UTI before her admission to SBL. She is also immunocompromised with COPD.	1. Eliminate causative agents. 2. Use standard precautions when caring for MT.	**Goal:** MT will not develop further infections during her stay. The care providers are very cautious with implementing standard precautions when caring for MT.
4. Activity intolerance related to pneumonia as evidenced by shortness of breath on exertion.	MT experiences shortness of breath on exertion.	1. Slowly implement activities of daily living to what MT can tolerate. 2. Ambulate as much as indicated.	Goal: MT will be able to perform activities of daily living like dressing herself. MT was able to walk to the bathroom to void with assistance from a care partner.

Other References (APA):

Carpenito, L. J. (2017). *Handbook of nursing diagnosis*. Philadelphia: Wolters Kluwer.

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

Stated that she experience SOB on exertion one week before admission.
Cannot perform activities of daily living without having to catch breath.
She did not report any pain during assessment.

Objective Data

Blood pressure of 151/71 and 132/78
O2 saturation of 92% and 95%
Fine crackles in the lungs
Elevated white blood cells
Chest x-ray indicated pneumonia
CBC indicated anemia

Patient Information

MT, an 85-year-old female who presented to the ED at SBL on 11/24/2020 with SOB on exertion. She was diagnosed with pneumonia and a UTI.

Nursing Diagnosis/Outcomes

1. Impaired gas exchange related to pneumonia as evidenced by an oxygen saturation of 85% on admission.
Outcome: MT's oxygen saturation will be maintained between 95-100% with oxygen or on room air.

2. Fall risk related to advanced age as evidenced by fall score of 60, decreased mobility, and the use of a walker for ambulation.
Outcome: MT will be able to ambulate from the bed to her chair safely while using her walker with assistance from the staff.

3. Risk for infection related to advanced age as evidenced by pneumonia and UTI.
Outcome: MT will not develop further infections during her stay.

4. Activity intolerance related to pneumonia as evidenced by shortness of breath on exertion.
Outcome: MT will be able to perform activities of daily living like dressing herself.

Nursing Interventions

1. Educate and encourage MT to use an incentive spirometer.
2. Encourage deep breathing and coughing when indicated.
3. Ensure that MT is wearing appropriate footwear.
4. Eliminate causative factors like floor rugs and loose cords.
5. Eliminate causative agents.
6. Use standard precautions when caring for MT.
7. Slowly implement activities of daily living to what MT can tolerate.
8. Ambulate as much as indicated.