N321 Care Plan #2

Lakeview College of Nursing

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Demographics

Date of Admission 1/16/21	**Patient Initials** A.W.	**Age** 60 years old (9/23/1943)	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Disability (Patient has never worked and has been on disability since she got into a motor vehicle accident in middle school)	**Marital Status** Divorced	**Allergies** *Mushroom Extract Complex* (Anaphylaxis, High Severity, Allergy Reaction Type, 5/5/2018) *Aspirin* (unable to tolerate more than 81 mg, Low Severity, Intolerance Reaction Type, 5/5/2018) *Sulfa Antibiotics* (Diarrhea reaction, Low severity, Intolerance reaction type, 5/5/2018)
Code Status No CPR- Comfort (has ACP docs)	**Height** 5'2"	**Weight** 150 pounds (68.4 kg) BMI: 27.58	

Medical History:

Past Medical History: Patient has a past medical history of allergic rhinitis, carotid stenosis, chronic renal failure, congestive heart failure (CHF), COPD, corneal ulcer, depression, GERD, hypercholesteremia, hypertension, IFG, insomnia, iron deficiency anemia, kidney stones, myocardial infarction, obesity, OSA on CPAP, osteoarthritis, peripheral ulcerative keratitis, PLMD, spinal arthritis, DVT

Past Surgical History: Patient has a past surgical history that includes the removal of a mass from her left breast.

Family History: Patient has a family history that includes lung cancer (her father passed away from it in his 80s), her grandma has a history of heart attack in the past. She denies family history of kidney failure.

Social History (tobacco/alcohol/drugs): Patient reports that she quit smoking about 7 years ago. She quit after 35.00 year of use. She has never used smokeless tobacco. She reports that does not drink alcohol or use drugs. She denies any alcohol use, any drug use.

Assistive Devices: Patient denies the use glasses and hearing aids. Patient denies the use of a walker, wheelchair or cane. Patient uses both upper and lower dentures.

Living Situation: Patient lives alone in a two-story house in close proximity to her daughter. Patient states her daughter, and six grandchildren are planning on moving in with her soon to help her out as well as her help her daughter with her children. Patient states she is looking forward to her grandchild moving in with her. Patient states they range from age 13 to 3 years old.

Education Level: Patient's education extends to 12th grade. Patient stated she graduated from high school. Patient stated although she graduated high school and this was the highest level of education she completed, she graduated later than her peers due to the MVA she got in in middle school and that putting her on disability. Patient stated she was in special education classes thereafter to assist in her education.

Admission Assessment

Chief Complaint: Shortness of breath, productive cough, hemoptysis

History of present Illness: A.W. is a 60 year old female with a past history of significant for COPD, impaired fasting glucose and A1c 5.6, she has been labeled with history of congestive heart failure and her echocardiogram in May of 2019 indicated EF of 59% with grade 1 diastolic dysfunction, history of iron deficiency anemia, history of hypertension, history of GERD, reported history of myocardial infraction, obstructive sleep apnea and history of CPAP use, she presented with symptoms of severe shortness of breath, she also has a productive cough for the

past 1 day, ER impression was COPD exacerbation. Patient has history of lung mass, she underwent CT angiogram of the chest, she was given IV-soul-Medrol, no bronchodilators have been administered. Upon her first evaluation patient is wearing 5 liters of nasal cannula, currently she is saturating at 92%, she is slightly tachycardiac with rate of 101, her blood pressure is 147/72, her respiratory rate is at least 38 and she is visibly tachypneic. A.W. denies any triggers for asthma in the last few days, she reports unable to eat in the past few days, she reports loss of appetite, she was also having nausea and vomiting at home, she had an episode of loose stool at home despite eating less, she denies any loss of taste or smell, denies any rhinorrhea. A.W. reports having productive cough, patient reports she has a dark brough appearing phlegm with few episodes of hemoptysis when asked if she knows above hilar mass, she reports she does not recall but at the same time she feels she has beginning of dementia. Regarding her myocardial infraction she reports not requiring any cardiac stent but she required a PTCA in 2008, MI was at Carle Hospital. Her doctor requires 4 L of oxygen at home, she lives alone at home. She was vomiting at least 4 times within the last 24 hours, she denies having a fever, she does report having chills, she denies chest pain, she has been feeling short of breath with above symptoms for the past 3 days, she denies any abdominal pain, she denies any hematochezia or melena, she denies any past DVT or the PE, when asked specifically to describe her diarrheal episode she reports it was soft bowel movement rather than diarrheal episode. She reports due to her above symptomology she has not been able to take her home medications for the past 2 days, she reports despite using her neb treatments she was unable to find relief that is why she came to the emergency room.

Primary Diagnosis

Primary Diagnosis on Admission: Acute Chronic Respiratory Failure with Hypoxia

Secondary Diagnosis: pneumonia, COPD

Pathophysiology of the Disease, APA format: Pneumonia

Pneumonia is described to be an “inflammation of the lung tissue in which alveolar air spaces fill with purulent, inflammatory cells and fibrin” (Capriotti, 2020). The main cause of pneumonia is an infection by bacteria or virus. The infection can come about from an inhalant, aspiration and infectious agents like fungi. There are different types of pneumonia such as community-acquired, hospital acquired, and ventilator associated. It is more known to effect patients during the colder seasons and in colder climates and effect females more than males. One of the major risk factors doe pneumonia is influenza infection. Viruses commonly change the pulmonary immune defenses and make the lungs vulnerable to bacterial infection. The droplets that enter the airway then slowly progress into the lung tissue. Due to the pathogens sticking to the respiratory epithelium and cause an inflammatory reaction. The acute inflammation then spreads to the lower respiratory tract and alveoli (Capriotti, 2020). Due to the imbalance, “between the organisms residing in the lower respiratory tract and the local and systemic defense mechanisms (both innate and acquired) which when disturbed gives rise to inflammation of the lung parenchyma, i.e., pneumonia” (Jain & Bhardwaj, 2019). This then results in mucosa and exudative edema to accumulate between the alveoli and capillaries. The alveoli attempt to open and close against the purulent exudate, but some are not able to open effectively. This results in crackles in the lungs when listening to a patient’s lung sound.

Most patients with pneumonia present with a sudden onset of symptoms. Some of these symptoms range from a cough, which can be productive meaning sputum follows, fever and

chills, chest pain that intensity with deep breaths, difficulty breathing, bloody sputum, decreased exercise tolerance develops as well. With a physical examination, the patient will have difficulty breathing which will result in the patient using accessory muscles with breathing, tachycardia and possibly cyanosis. Crackles are also heard with auscultation of the lungs. Pneumonia is diagnosed based on what is seen on an x-ray. Sputum culture and sensitivity can exhibit the organism and antibiotic susceptibility. Ultrasounds and thoracocentesis are also useful.

For the treatment of pneumonia, antibiotics therapy and oxygenation are priority. Fowler's position and oxygen on a nasal cannula or mask are also used for treatment for pneumonia. The patient may also need IV fluids if they are poor hydrated. Preventive measures that can be taken in older adults, infants and children is getting the pneumococcal vaccine.

This patient also has a history of COPD, which increased her susceptibility to pneumonia. This patient has an extensive history of smoking cigarettes. Although this patient stopped smoking 6 years ago, "social habits such as smoking and use of alcohol or illicit drugs are also factors that increase risk for pneumonia" (Capriotti, 2020).

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives 2nd Edition* (2nd ed., p. 562). Philadelphia: F A Davis.

Jain, V., & Bhardwaj, A. (2019, February 22). *Pneumonia Pathology*. Nih.gov; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK526116/

Laboratory Data

COMPLETE BLOOD COUNT

Lab	Normal Range	Admission Value 1/16/21 1609	Today's Value 1/28/21 0417	Reason for Abnormal Value
RED BLOOD CELLS (carry oxygen)	F: 3.80-5.30	4.74	3.90	
HEMOGLOBIN (oxygen-carrying protein in RBCs)	F: 12-15.8	**10.4**	**8.8**	Upon admission, it was discovered that this patient has pneumonia is known to cause anemia due the change of the hemoglobin molecule and it no longer being able to give off oxygen which causes a decrease in hemoglobin molecules being produced. This patient also has a history of COPD. Repeated exacerbations could further inhibit erythropoiesis, and as a result a significant decrease in hemoglobin levels can occur in severe COPD. This patient also has a history of iron deficiency anemia. Without enough iron, your body can't produce enough of a substance in red blood cells that enables them to carry oxygen, hemoglobin.
HEMATOCRIT (the proportion of RBCs to the fluid component, plasma in your blood)	F: 36-47	**32**	**27**	With iron deficiency anemia, red blood cells are smaller and paler in color than normal. In anemia, the body does not have the capacity to deliver enough oxygen to tissues and organs.
PLATELETS (help with blood clotting)	150,000-450,000	217,000	175,000	
WHITE BLOOD CELLS (fight infection)	4,000-10,000	8,000	10,000	
NEUTROPHILS (type of WBC that the bone marrow creates; move to areas of infection and neutralize that area)	40-60	**77.8**	**91.4**	This patient has an increased level of neutrophils due to infection of her respiratory tract because of pneumonia. With pneumonia, this causes an underlying neutrophil accumulation during lower respiratory tract bacterial infection.

LYMPHOCYTES (B cells: produce antibodies to attack bacteria T-cells: kill infected cells	20-40	**12.5**	**4.4**	This patient presents with low lymphocytes due to the infection with pneumonia. This patient also has a history of hypercholesteremia. LDL tends to deposit cholesterol on the walls of the arteries. White blood cells try to digest low density lipoproteins, but this process changes them into toxins. More and more white blood cells are attracted to the area where the change is occurring, and the artery wall can become inflamed.
MONOCYTES (fight infection; help remove dead tissues; destroy cancer cells)	2-8	7.9	4.1	
EOSINOPHILS (participating in immediate allergic reactions)	1-4	1.1	1.0	
BANDS (immature form of neutrophils; produced in excess during infection to help fight disease)	3-7	N/A	N/A	This lab was not shown within the patient's chart.

Chemistry

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
NA- (Control BP and blood volume; needed for muscle and nerves to work)	135-145	136	135	
K+ (helps your nerves to function and muscles to contract; heartbeat stay regular; move nutrients into cell and waste products out of cell)	3.5-5.0	4.9	3.7	
Cl-	95-105	95	95	

(helps keep the amount of fluid inside and outside of your cells in balance; maintain blood volume, BP and pH)				
CO2 (regulates the pH of blood, stimulates breathing, and influences the affinity hemoglobin has for oxygen)	23-30	**31**	**36**	This patient's bicarbonate in her blood is elevated due to her vomiting. Upon admission, this patient stated she had been vomiting for 4 days prior to coming to the ER. Another explanation for the elevation in this lab is due to dehydration. This patient's BUN was also elevated which is indicative of dehydration within the body. This patient also has a history of chronic renal failure. Chronic renal failure causes reduced tubular bicarbonate reabsorption and insufficient renal bicarbonate production in relation to the number of acids synthesized by the body and ingested with food.
Glucose (for energy)	70-110	**128**	108	Hyperglycemia while hospitalized in normal, if the patient's glucose levels are slightly elevated like this patients. The physiologic and emotional stress leads to activation of counterregulatory hormones such as cortisol ad epinephrine. The release of inflammatory cytokines causes an increase in peripheral insulin resistance and hepatic glucose production. This patient also has a history of impaired fasting glucose and obesity which can both elevate glucose levels.
BUN (measures the amount of nitrogen in your blood that comes from the waste product urea; indicates how well your kidney are working)	10-20	**37**	**31**	This patient presents and still as an elevated BUN while hospitalized due to her being dehydrated. Patient stated she was vomiting for 4 days straight prior to being admitted. As seen in the labs, the patient's BUN levels are decreasing being of the IV fluids she is getting while in hospitalized. Dehydration is known to increase BUN levels due to reduced renal blood flow.
CREATININE (to be filtered and eliminated in urine)	0.6-1.5	1.5	0.96	
ALBUMIN (helps keep fluid in your bloodstream so it doesn't	3.5-5.0	N/A	N/A	

leak into other tissues)				
CALCIUM (stored in bones and teeth; supports structure; carries massages between the brain and body parts)	8.5-10.0	9.3	8.7	
MAGNESIUM (required for energy production)	1.5-2.5	2.1	1.6	
PHOSPHATE (build and repair bones and teeth, help nerves function, and make muscles contract)	2.8-4.5	N/A	N/A	This lab was now shown with in this patient's chart.
BILIRUBIN (orange-yellow pigment that occurs normally when part of your red blood cells break down)	0-0.3	0.1	0.3	
ALK PHOS (mostly found in the liver, bones, kidneys, and digestive system. When the liver is damaged, ALP may leak into the bloodstream)	20-90	**111**	84	Hypercholesteremia can cause damage to the liver if poorly managed. This patient has an extensive history of high cholesterol. This patient also has osteoarthritis and spinal arthritis as well as which can cause an elevation in alkaline phosphate. Bone ALP is a major regulator of bone mineralization. Moderately high levels of alkaline phosphate indicate condition such as heart failure. Impaired perfusion from decreased cardiac output can affect liver enzymes causing it to be elevated.
AST Checks for liver damage	5-40	16	12	
ALT Test for liver cell damage	7-56	25	20	
Amylase Test for disease of the pancreas	30-110	N/A	N/A	
Lipase Helps your body digest fats; normal to have a small amount in body; protein that helps your	0-160	N/A	N/A	

body absorb fats (for pancreas)				
Lactic Acid Substance made by muscle tissue; high disrupt a person's acid pH balance; lactic acidosis caused by not enough oxygen in cells/ tissues	0.5-2.2	1.7	N/A	

Other Tests

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR Measures the time for the blood to clot	0.8- 1.1 2-3 is therapeutic range for people of warfarin	**1.2**	**1.2**	This patient's INR is closely within normal range, so it does not pose a risk at this current time but should be something both nurses and doctors monitor closely for an elevation. This patient does have a history of blood clot and is currently taking warfarin twice a day every 12 hours to prevent another formation of a blood clot, so it is normal for a patient on warfarin to have a slightly elevated INR.
PT Monitor blood-thinning medicines	11-13.5 seconds	**14.1**	**13.8**	This patient presented with an elevated PT because this patient is currently taking heparin. This patient could also potentially have some sort of liver issues with the elevated lipid panels.
PTT Screening test that helps evaluate a person's ability to form blood blots; number of seconds it takes for a clot to form in a sample of blood	25-35 seconds	**28**	**68**	This patient has an elevated PTT because of her blood clot, it takes the blood longer to clot.
D-Dimer Blood test used to rule out a blood clot; protein fragment from the breakdown of a blood clot	Negative	**8,027**	N/A	This patient presented with an abnormal and dangerously elevated d-dimer because it was founded that she did in fact have a blood clot.
BNP Measures protein that is made by your heart and blood vessels (higher in	Less than 100	N/A	N/A	

heart failure)				
HDL Measures the level of good cholesterol in the blood	60	N/A	N/A	
LDL Measures the amount of "bad" cholesterol in the blood; increases risk of hardening of the arteries	Less than 100	N/A	N/A	
Cholesterol	Less than 200	N/A	N/A	
Triglycerides	Less than 150	N/A	N/A	
Hgb A1c Measures your average blood sugar levels over the past 3 months; commonly used to diagnose prediabetes and diabetes	Below 5.7%	N/A	N/A	
TSH Thyroid stimulating hormone; located near your throat; the thyroid makes hormones that regulate the way your body uses energy	0.4-4	N/A	N/A	

Urinalysis

Lab Test	**Normal Range**	**Value on Admission** **1/16/21 at 0848**	**Today's Value**	**Reason for Abnormal** *An updated urinalysis was not administered*

				to this patient, besides the one taken upon admission to the ED on 1/16/21 at 0848.
COLOR & CLARITY	Colorless-Yellow, Clear	Yellow	N/A	
pH	6-8.0	**5.5**	N/A	Patient presents with a slightly low pH in her urinalysis use to her history of diarrhea. Patient states she has had diarrhea along with vomiting the past 4 days prior to going to the ED. Patient was tested for C-DIFF, results were negative. Diarrhea is the most common cause of external loss of alkali resulting in metabolic acidosis.
SPECIFIC GRAVITY (test compares the density of urine to the density of water; help determine how well your kidneys are diluting your urine)	1.005-1.030	1.015	N/A	
GLUCOSE	Negative	Negative	N/A	
PROTEIN	0-8	**Trace**	N/A	Patient has a history of chronic renal failure. Conditions that damage the kidney can also increase the production of protein in the urine. Hypertension can also cause protein in the urine, which this patient has a history of. High blood pressure can weaken the blood vessels in the kidneys. This decreases their ability to reabsorb to protein, which flows into the urine.
KETONES (fuels for the body that are made when glucose is in short supply)	Negative	Negative	N/A	
WBC	0-4	0-2	N/A	
RBC	0-3	**2-5**	N/A	Due to this patient's history of renal failure, it is normal for red blood cells to appear in her urine although not healthy. This patient also has a history of kidney stone which can cause hematuria. Healthy kidneys make a hormone called erythropoietin. EPO sends a signal to the body to make more red blood cells. If your kidneys are not working as well as they

				should, they can't make enough EPO.
LEUKOESTERASE	Negative	Negative	N/A	

Cultures

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
URINE CULTURE	Negative	Negative	N/A	
BLOOD CULTURE	Negative	No growth within 5 days	N/A	
SPUTUM CULTURE	Negative	Respiratory lower	N/A	Negative for Bordetella after testing with firm array RP be confirmed by an alternate method of clinically noted.
STOOL CULTURE	Negative	Occult blood (abnormal) 1/24/21 @ 1419	N/A	Patient's results were negative when tested for C-Diff due to her reported diarrhea for 4 days straight.
MRSA	Negative	Negative	N/A	Patient's results were negative for MRSA.

Diagnostic Imaging

All Other Diagnostic Tests:

Exam: Angio Percutaneous IVC Filter Placement (1/19/2021 1020)

Findings:

- Successful inferior vena cava filter placement
- Resume anticoagulation once safe
- Remove filter once patient tolerates anticoagulation

Exam: XR Chest Single View Portable (1/16/21 0848)
Findings:

- Superimposed cardiac monitoring leads and tubing are present
- The heart remains normal in size.
- There is remonstration of a right hilar mass.
- The lungs remain hazy with bronchial wall thickening and mild, patchy, irregular infiltrates. Aeration of the lower lungs has improves since 1/15/2020.

Diagnostic Test Correlation:

1. IVC filters help reduce the risk of pulmonary embolism by trapping large clots and preventing them from reaching the heart and lungs (Molvar, 2012). They are used in patients who do not respond to or cannot be given conventional medical therapy such as blood thinners.

2. A single view chest x-ray was order for this patient due to her history of shortness of breath, fever with chills, history of COPD and prior smoker. This patient also presented to the ED the day of admission with a reported fever. This test was ordered to monitor the progress of potentially medical conditions like heart failure.

Diagnostic Test Reference:

Molvar, C. (2012). Inferior Vena Cava Filtration in the Management of Venous Thromboembolism: Filtering the Data. *Seminars in Interventional Radiology*, *29*(3), 204–217. https://doi.org/10.1055/s-0032-1326931

Current Medications

Brand/Generic	Acetaminophen (Tylenol)	Albuterol (Proventil,	Alprazolam (Xanax)	Atorvastatin (Lipitor)	Enoxaparin (Lovenox)

		Ventolin)			
Dose	650 mg (tablet)	2.5 mg/ 3 mL 0.083%	0.25 mg	20 mg	70 mg
Frequency	Every 6 hours PRN	Every 6 hours PRN	2x Daily PRN	Nightly	Every 12 hours
Route	Oral	Nebulizer solution	Oral	Oral	SubQ Injection
Classification	Analgesic, Antipyretics	Bronchodilators	Benzodiazepines	HMG-CoA reductase inhibitors; statins	Anticoagulants
Mechanism of Action	Inhibits the COX pathway in the central nervous system but not peripheral tissues	Acts on beta-2 adrenergic receptors to relax the bronchial smooth muscle. It also inhibits the release of immediate hypersensitivity mediators from cells, especially mast cells	Acts on the brain and nerves to produce a calming effect and helps relieve panic and anxiety symptoms. It works by enhancing the effects of a certain natural chemical in the body (GABA)	Prevents the conversion of HMG-CoA to mevalonate, statin medications decrease cholesterol production in the liver	Binds and accelerates the activity of antithrombin III, an enzyme which causes blood to clot by acting on a blood protein called fibrogen. It also inhibits coagulation factors Xa and IIa
Reason Client Taking	Mild pain or more severe pain	Wheezing, short of breath	Anxiety	Used along with a proper diet to help lower LDL and triglycerides and raise HDL in the blood	Prevent formation of blood clot while being hospitalized due to decrease mobility
Contraindications (2)	Acuter liver failure, caloric undernutrition, inflammation of the liver due to hepatitis c virus	Diabetes, ketoacidosis, hypertension, excess body acid, overactive thyroid gland	pre-existing respiratory depression, COPD or sleep apnea	Liver failure, alcoholism, untreated decreased level of thyroid hormones, decreased kidney function	Bleeding Operation on the spine Eye surgery
Side Effects/Adverse Reactions (2)	Nausea, stomach pain, itching	Nervousness or shakiness, headache, throat or nasal irritation	Light-headedness, tiredness, dizziness, drowsiness	Joint pain, nausea, stomach pain or discomfort	Pain, bruising, fever, bleeding
Nursing Considerations (2)	Consult physician if needed for longer than 10 days Avoid using multiple preparations containing acetaminophen	Listening to lung sounds Obtaining blood pressure and heart rate prior and during use of albuterol If patient has a productive cough, it's important to assess amount, color and consistency of sputum	Avoid alcohol and other CNS depressants because of the increased risk of sedation and adverse effects Instruct patient to report severe or prolonged headache, blurred vision, rash, weight gain, or GI problems (nausea, vomiting, diarrhea, constipation)	Monitor liver function test prior to initiation of therapy Monitor renal function	Monitor for signs of bleeding Administer in subcutaneous tissue

Brand/Generic	**Escitalopram (Lexapro)**	**Gabapentin (Neurotoxin)**	**Guaifenesin SR (Mucinex)**	**Hydralazine (Arecoline)**	**Montelukast (Singular)**
Dose	20 mg	300 mg	600 mg	10 mg	10 mg
Frequency	Daily	Nightly	2x Daily	Every 4 hours PRN	Daily
Route	Oral (Tablet)	Oral (Capsule)	Oral (Tablet)	IV	Oral (Tablet)
Classification	Antidepressants; SSRIs	Anticonvulsants	Expectorants	Vasodilators	LTRAs
Mechanism of Action	Increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance	Altering electrical activity in the brain and influencing the activity of chemicals called neurotransmitters, which send messages between nerve cells	Acts by loosening mucus in the airways and making coughs more productive. It is used for relief of wet cough and chest congestion	Lowers blood pressure by exerting a peripheral vasodilating effect through a direct relaxation of vascular smooth muscle	Works by blocking the action of leukotriene D4 in the lungs resulting in decreased inflammation and relaxation of smooth muscle.
Reason Client Taking	Depression	Nerve pain: patient has a history of a history of restless leg syndrome	Cough; excessive mucous	Hypertension	Allergies; prevent asthma attack
Contraindications (2)	low amount of magnesium, sodium and potassium in the blood, an increased risk of bleeding, manic behavior	Muscle disorders, chronic kidney disease, myasthenia gravis, muscle disorder	Diabetes, glaucoma, enlarged prostate, hypertension, overactive thyroid gland	Heart attack, stroke, low blood pressure, CAD	suicidal thoughts, depression, inflammation of blood vessels in the skin, anxiety disorder.
Side Effects/Adverse Reactions (2)	Dizziness, sweating, nausea, constipation, yawning, decreased sex drive	Tiredness, shaking (tremor), blurred/ double vision	Constipation, difficulty sleeping, nausea	Nausea, vomiting, diarrhea	Headache, heartburn, stomach pain, tiredness, diarrhea

Nursing Considerations (2)	Advise patient to avoid alcohol and other CNS depressants because of the increased risk of sedation and adverse effects. Advise patient that GI problems may occur	Monitor for therapeutic effectiveness; may not occur until several weeks following initiation of therapy. Assess safety: Vision, concentration, and coordination may be impaired by gabapentin.	Increase fluid intake to help loosen mucus; drink at least 8 glasses of fluid daily. Contact physician if cough persists beyond 1 wk.	Monitor blood pressure Patients should weigh themselves twice weekly and assess feet and ankles for fluid retention.	Assess respiratory status Assess liver function tests

Medications Reference (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert

http://www.ismp.org/. Jones & Bartlett Learning. (2019). 2019 Nurse's Drug

Handbook. Burlington, MA

Assessment

GENERAL:	Patient is an elderly Caucasian female. She appears to be alert and

Alertness: **Orientation:** **Distress:** **Overall appearance:**	orientated to situation and person, time and place. When asked what year and month it was, the patient answered correctly. Patient knew exactly where she was and for what. Patient denies use of devices like glasses and hearing aids. The only assistive device the patient uses is both upper and lower denture. Patient denies the use of any other assistive devices like a walker, wheelchair or cane. Patient appears to be well groomed and in no acute distress, well-developed and not ill-appeared. Patient was calm and cooperative. Patient appears stated age. **Patient denies fatigue, weight changes, fevers, chills, night sweats currently.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is warm, pink and dry. No rashes or lesions or erythema. Patient has no drainage. Patient has bruising to right upper groin region. Bruise is dry, intact and open to air and has no present drainage. Patient states it is from her heparin injections. Patient is not pale or ashy. Patient's nails are without clubbing and cyanosis. Skin turgor normal mobility, quick to return to original state. Patient had no wounds at the time of this assessment. Patient's feet are dry, ashy and flaky bilaterally. Patient encouraged to moisture feet daily. Patient's Braden score is a 20 sensory perception 4 (no impairment), moisture 4 (rarely moist), activity 3 (walks occasional), mobility 3 (slightly limited), nutrition 3 (adequate), friction shear 3 (no apparent problem). **Patient denies rashes, lesions, non-healing sores, hair changes, purities.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head and neck are symmetrical. Trachea is midline without deviations, thyroid is not palpable, no nodules noted at the time of assessment. Bilateral carotid pulses are palpable and strong. No swollen lymph nodes in the head or neck region. Bilateral sclera white, bilateral cornea clear. Bilateral conjunctiva pink, no visible discharge in eye bilaterally. Bilateral lids are pink and dry without lesion. PERRLA bilaterally, red light reflux present bilaterally. EOMs intact bilaterally. Septum is midline. Bilateral frontal sinuses are nontender and to palpation. Bilateral auricles moist and pink without lesions noted. Dentition is good, oral mucous overall is moist and pink without lesions noted. Patient wears upper and lower dentures. Patient's hair is thick, grey and even distribution. Oropharynx is clear. No discharge present right and left ear. External right and left ear normal. Normal range of motion and neck supple. Patient denies use of hearing aids. **Patient denies experiencing headaches, head injury, blurry vision, double vision, earache, drainage, nasal congestion, nose bleeds, nasal drainage, dry mouth, sore throat, swallowing difficulty at the time of the assessment.**

CARDIOVASCULAR: **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:**	Clear S1 and S2 sounds heard without the presence of murmurs, gallops or rubs. PMI at 5th intercostal space at MCL. All extremities warm, pink and dry. Peripheral pulses are 1+ throughout bilaterally. Patient does not present with edema bilaterally throughout. Capillary refill less than 3 seconds in fingers bilaterally throughout. Patient's capillary refill in toes are more than 3 seconds, approximately 10 seconds toes bilaterally throughout. No neck vein distention noted in this patient. Patient states she is often times short of breath with activity due to her COPD. Patient is currently on 4 liters of oxygen, nasal cannula with humidifier. Patient states she is also on oxygen at home and is compliant with its use. **Patient denies chest pain, palpitations, diaphoresis, PND, Orthopnea, claudication.**
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Respirations are irregular, uneven and unsymmetrical and labored bilaterally. Lung sounds are unclear throughout bilaterally. Wheezing heard in right upper lung. No crackles or rhonchi noted. Bilateral unequal air entry. **Patient admits to wheezing and cough with an increase in productive sputum. Patient states her sputum is sometimes bloody as well as brown. Anterior, lateral, unclear and unequal bilaterally.**
GASTROINTESTINAL: **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:**	Patient is on a regular diet while being hospitalized. Patient describes her diet as being "ok". Patient states her daughter prepares a majority of her meals. Patient states a typically dinner for her consist of pizza and breadsticks. Patient is considered overweight as evidenced by her BMI of 27.4 and appearance. While hospitalized, eats well and shows no signs of difficulty eating. Patient uses no assistive devices to aide in eating. Patient does not require set up help with each meal. Patient is 5'2". Patient weights 150 pounds. Patient's abdomen is soft, flat, nontender, no masses noted upon light and deep palpation of all the four quadrants. Patient's abdomen is soft, nontender, no masses noted upon palpation or all four quadrants. Bowel sounds are normoactive in all four quadrants. Patient swallows' food without difficulty and has no indicators of nutrition risks. Patient's last bowel movement was 1/27/21. Patient described bowel movement as being brown and "normal for me". Patient stated she is not having any difficulty having a bowel movement. Patient describes her recent bowel movement as being "soft". Patient is passing flatus and tolerating full liquids well. Patient admits that prior to admission, she had loose diarrhea stool for 4 days was nauseous and vomiting. While ambulating patient in the halls during the shift, the patient got very dizzy and lightheaded and felt nauseous. Patient states she sometimes feels like this when ambulating at home. Patient was encouraged to walk slowly and take slow and deep breaths. **Patient denies nausea, vomiting, diarrhea, abdominal pain, heartburn, jaundice, hematochezia, melena at the time of the assessment. Patient states last episode of nausea and vomiting was the day of her**

	admission on 1/16/21. Patient stated she has not vomited since. Patient states she felt nauseous today while ambulating. Patient's last bowel movement was 1/28/21. Patient's bowel movement was described as being brown and soft. _____
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient's urine appears to be yellow, clear and absent of foul odor. Patient has a normal stream of urine and consent flow. Patient's genitals appear to be intact, no abnormalities noted. Patient had one episodes of incontinence. Patient voids spontaneous without difficulty. Patient voided once during my shift and was not incontinent. Patient's urine was clear yellow, no malodor and not cloudy. Patient stated she has no difficulty urinating or starting urinary flow. Patient wears a depend at night due to her sometimes incontinence. **Patient denies burning or pain, hematuria, flank pain while urinating.**
MUSCULOSKELETAL: **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 x☐** **Needs support to stand and walk☐**	Patient appeared to be alert LOC. Patient arousal level was she opened her eyes spontaneously. Patient is a one assist with a gait belt and oxygen nasal cannula (4L). Patient required queing or set up assistance. Patient demonstrated active range of motion bilaterally throughout. Patient's fall risk score is a 10 (2 – age greater than 65, 8 – unsteady gait or weakness). Patient's bed alarm and chair alarm is maintained, non-skid shoes/ slippers, when out of bed, ambulated encouraged and dorsiflexion/ plantar flexion and anticoagulant therapy initiated. Patient maintains fair balance with a standby assist and gait belt. When ambulating patient in the halls, patient swayed a little to one side; patient explained this was due to her COPD and dizziness. Patient ambulated approximately 15 feet in the hallway before stating she felt dizzy and nauseous. Patient was encouraged she walk slower and take a break. Patient's oxygen dropped to 78% after ambulating. After deep breathing and resting for approximately 5 minutes, patient's oxygen saturation increased to 92%. Patient reports a decrease and absence of nauseous. Patient remained in recliner and slept. Patient displayed signs of difficulty breathing. Patient is a standby assist. Patient needed cueing and set up assistance. Patient was encouraged to engage in as much as she can independently, all personal objects within reach. Patient's general motor response was normal. At home, patient is completely independent with ambulating, feeding, dressing, bathing and all activities of daily living.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	Patients speech was logical, well-paced, spontaneous and clear. Patient's mood and behavior was cooperative, calm and talkative. Patient's memory was normal. PERRLA bilaterally. Patient's hand grip and ankle strength were strong bilaterally. Patient is alert and orientated to situation and person, time and place. Patient is full concisions and alert. Patient displays no signs of confusion. CAM score negative. No acute, inattention, altered LOC, disorganized thinking.

Sensory: **LOC:**	
PSYCHOSOCIAL/CULTURAL: **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 stated she copes with life stressors by just relaxing. Patient appears to be developmental delayed. Patient stated in high school she was in special education courses due to the motor vehicle accident she was in that left her disabled. Patient states she is not religious. Patient has one child who is her daughter. Patient states her daughter does not live too far from her. Patient states in the near future, her daughter along with her 6 grandchild will be moving in with her to help her out as well as her help her daughter out with watching her children. Patient appears to be excited and states she is excited to be able to spend more time with her grandchild as it will keep her busy.

Vital Signs, 2 sets

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	84	111/55 (right arm)	18 (use of accessary muscle)	99.8 (oral)	93% (4L nasal cannula)
1145	75	115/61	16	98.2	97% (4L nasal cannula)

		(right arm)	(use of accessary muscle)	(oral)	

Pain Assessment, 2 sets

Time	Scale	Location	Severity	Characteristics	Interventions
0700	6/10	Left lower back due to poor poster while sleeping the previous night	mild	Sharp	Patient refused pain medication. Patient stated she wanted to wait until pain increased. Patient was reminded to control pain prior to it increasing or reaching a 10/10. Patient continued to refused pain medication. Pain was closely monitored afterwards.
1145	6/10	Left upper chest area due to mass	Moderate	Between sharp and dull	Patient refused pain medication. Patient stated she wanted to wait until pain increased. Patient was reminded to control pain prior to it increasing or reaching a 10/10. Patient continued to refused pain medication. Pain was closely monitored afterwards.

IV Assessment

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:**	Peripheral IV Line – Single Lumen 1/16/21 median cubital vein (basilic vein) right 20 gauge; 1 in length Site preparation/ miniatous: dressing, dry intact Indication/ daily review: medication therapy

Signs of erythema, drainage, etc.: **IV dressing assessment:**	Securement: sterile tap strips Flushed without difficulties No signs or symptoms of erythema, drainage, infiltration

Intake and Output

Intake (in mL)	**Output (in mL)**
250 mL water (breakfast) 200 mL diet coke (lunch) 100 mL diet coke (lunch)	Patient voided once during the shift from 0700-1200. Patient was incontinent during the night. Patient's depend was filled with urine. Patient voided in toilet when performing morning care. Patient's urine was clear and yellow, no foul odor. Patient denies any difficulties with voiding. Patient voided in the toilet (amount was unmeasured). Patient is not on strike input and output.

Nursing Care

Summary of Care

Overview of care:

Patient up in chair a majority of the shift. Patient ambulated to the bathroom at 0700. Patient was short and breath. Patient was incontinent, depends changed. Patient urinated on the toilet.

Patient's urine was yellow and clear and no foul odor present. Patient remained up in the chair watching television and resting. Patient's vitals were then obtained at approximately 0700 and again at 1100.

Procedures/testing done:

Patient's blood sugar was obtained by the prior shift. Compared to admission, most of patient's lab values have decreased although when compared to the normal range, is still considered elevated. This shows improvement in patient's condition. Some of patient's lab values still need to be closely monitored and supervised. For example, since admission, patient's PTT has increased from 28 seconds to 68 seconds.

Complaints/Issues:

Patient still has complaints of shortness of breath with activity. Patient does not anticipate that improving much since she is aware her COPD is chronic and something she will deal with lifelong. Patient states that her main complaint and issue upon admission was her vomiting and diarrhea. Patient states those issues and been address and decreased a lot.

Vital signs (stable/unstable):

Patient's vital signs were within normal range, there were no abnormalities present. Although patient's respirations were within normal range, this patient is visibly having a difficult time breathing and using accessary muscles to breath effectively due to her COPD and pneumonia.

Tolerating diet, activity, etc.:

Patient ate her breakfast at approximately 0800 after toileting. Patient required no assistance with feeding. Patient tolerated food good. Patient ate 50% of breakfast meal and drank 600 mL of fluids throughout the shift.

Physician notifications/ Future plans for patient:

The plan for this patient is to be discharge tomorrow (1/28/21) home on palliative care. Patient will be on medication to effectively manage pain. Patient will also go home with subq heparin to be taken twice a day every 12 hours to prevent the reoccurrence of a blood clot. Patient is to follow up with doctor post discharge.

Discharge Planning

Discharge location:

Upon discharge, patient will be returning home. Patient's daughter lives close to her so she will provide her with assistance if needed. Patient has plan for palliative care and comfort measures. Patient declined home hospice and agreed to palliative care.

Home health needs (if applicable):

Patient will not require home health care upon discharge, as she is fully independent in her care along with her having the assistance of her daughters if she does happen to require more assistance.

Equipment needs (if applicable):

Patient will not require equipment needs upon discharge. Patient already has oxygen and CPAP at home.

Follow up plan:

Post discharge for this patient will include a follow up phone call along with follow up with primary doctor.

Education needs:

Use of inhaler, deep breathing exercise and blood pressure monitoring, when to seek medical attention for new symptoms, how to take new medications or home medication and side effects or changes, safe medication disposal, fall risk prevention, increase fluid to decrease mucous, remain active to prevent another DVT, follow medication regimen to prevent readmission

Nursing Diagnosis

Nursing Diagnosis	Rational	Intervention	Evaluation
1. Impaired gas exchange **related to** decreased lung compliance, ventilation-perfusion inequality **as evidenced by** visual disturbances, decreased dyspnea,	This is in relation to the patient having chronic obstructive pulmonary disease (COPD). In COPD patients, the alveoli's ability to inflate and deflate	**1.** Monitor respiratory rate, depth, and effort, oxygen saturation, including use of accessary muscles, nasal flaring, and abnormal breathing pattern	**1.** Goal partially met. Respiratory rate and oxygen saturation values within expected range on 1/28/21 from 0700 to 1200. Patient still uses accessary muscles and

hypoxia, restlessness, tachycardia, hypercarbia, abnormal rate, rhythm, depth of breathing, nasal flaring	becomes compromised and the walls of the air sacs become permanently damaged, this means oxygen cannot feed into the bloodstream and carbon dioxide cannot leave the blood stream as effectively. Visual disturbances effects gas exchange because it lowers retinal arterial oxygen levels which means less oxygen is getting to the retina. Overtime, this damages the retina and topic nerve and cause issue with visions. This patient has an extensive history of visional disturbances like corneal ulcer, peripheral ulcerative keratitis and cataracts in both eyes. Patient also stated she has a difficult time breathing with activity and even at rest. Patient wears 4 L of oxygen, nasal cannula with humidifier. Patient appears to be hypoxic. Patient's oxygen saturation level dropped from 93% to 78% after ambulating in the hallway. After deep breathing exercises and resting for approximately 5 minutes, patient's O2 returned back to 92%. Patient's lab results displayed she is hypercarbia. Patient's CO2 was elevated on admission at 31 and as elevated since admission to 36. Patient's depth and rate of breathing was irregular. Patient used accessary muscle when breathing.	throughout shift from 0700 to 1200 on 1/28/21. **2.**Provide frequent oral hygiene at least four times during shift from 0700 to 1200 on 1/28/21. If the client's mouth is dry and painful, provide oral hygiene hourly while awake.	nasal flaring while breathing. Patient's depth and effort of breathing is still poor due to her COPD. Goal is still ongoing. Goal would be modified to patient's vital signs will remain within expected range. Since COPD is chronic and this patient is on palliative care, the likelihood of improvement is unrealistic. Patient will most likely always have dyspnea with activity and at rest. **2.** Goal met. Patient was encouraged and complied with increase in fluid intake and oral hygiene on 1/28/21 before end of shift at 1200. Patient drank a total of 600 mL fluid (coke and water) for breakfast and throughout shift. By providing liquids it helps moisten the wall of the lungs which helps gas pass across the walls. It ensures oxygen rich blood is taken away from the lungs and carbon dioxide rich blood is taken to the lungs, so fluids are important.

2. Activity intolerance **related to** imbalance between oxygen supply and demand, fatigue, energy shift to meet muscle needs for breathing to over air way obstructions **as evidenced by** current diagnosis of COPD, shortness of breath during activity and when resting, use of accessory muscle, patient stating she feels dizzy and nauseous when ambulating in the hallway on 4L of oxygen, sudden drop in oxygen saturation with activity	This is in relation to the patient having a history of COPD, iron deficiency anemia and obesity. With ambulating patient in the hallways for approximately 15 feet, patient complained of being short of breath while bring on 4L of oxygen. Patient stated she also felt dizzy and nauseous. Patient had to take a break and take a seat in the middle of her walk due to her increase dizzy. Patient appeared to be visibly short of breath and using accessory muscle. Patient was swayed to the left due to her dizziness while ambulating. Patient stated this occurs sometimes at home. Patient was reminded to stay slow and short walks to decrease dizziness.	**1.** Schedule and provide rest periods in a calm peaceful environment during care throughout shift from 0700-1200 on 1/28/21 to promote adequate rest and decrease stimuli. 2. Assess the patient's baseline cardiopulmonary status by checking her heart and pulse oximetry before initiating activity on 1/28/21 by 0700 to assess if there is an increase in oxygen demands during physical activity.	**1.** Goal met. While ambulating, patient realized she was getting dizzy and took a rest period on 1100 on 1/28/21. **2.** Goal partially met. Patient's vital signs (pulse oximetry, heart rate and respiration) were within normal range after she rested and regained her breath approximately 5 minutes after her walk during the shift at 1100 on 1/28/21. Although patient's oxygen saturation decreases dramatically, her heart rate remained within normal range.
3. Ineffective tissue perfusion **related to** peripheral interruption of venous blood flow, increased coagulability of blood, exchange problems, impaired transport of oxygen across alveolar or capillary membrane, decreased hemoglobin concentration in	This nursing diagnosis is prevenient to the patient being she a history of a DVT. Patient is also obesity which increases her likelihood for developing a DVT. Patient also has some generalized weakness which causes her to rest more. Patient is also short of breath a lot due to her COPD which causes her to rest a majority of the day, so	**1.** Assess for signs and symptoms of DVT such as swelling, pain or tenderness, increased warmth and changes in skin color that results in redness throughout shift from 0700 to 1200 on 1/28/21. **2**. Administer anticoagulants (subcutaneous low molecular weight heparin) as prescribed once throughout shift on	**1.** Goat met. Patient displayed no signs and symptoms of DVT throughout shift from 0700 to 1200 on 1/28/21. Patient denies pain or tenderness in lower extremities. When assessing patient's lower extremities, there were no signs of swelling, tenderness or increased warmth and skin color changes bilaterally throughout. 2. Goal met. Patient was

blood **as evidenced by** +1 peripheral pulses, dry skin, presence of repository distress, history of dvt, tenderness	she does not ger exacerbated.	1/28/21 from 0700 to 1200.	administered a unit of heparin once during the shift on 1/28/21 at 0800. Patient is prescribed heparin twice a day every 12 hours. Patient understood why she was taking heparin. Patient stated it was because she did not want to develop another blood clot.

Other References (APA):

Ackley, B. J., Ladwig, G. B., & Makic, M. B. (2017). Nursing diagnosis handbook: An evidence-based guide to planning care (11th ed.). St. Louis, MO: Elsevier

Concept Map (20 Points)

Subjective Data

- Patient also stated she has a difficult time breathing with activity and even at rest
- Patient is also short of breath a lot due to her COPD which causes her to rest a majority of the day, so she does not ger exacerbated.
- Some weakness

Objective Data

- History of COPD and DVT and visual disturbances and obesity
- Patient wears 4 L of oxygen, nasal cannula with humidifier.
- Patient's oxygen saturation level dropped from 93% to 78% after ambulating in the hallway. After deep breathing exercises and resting for approximately 5 minutes, patient's O2 returned back to 92%.
- Patient's lab results displayed she is hypercarbia. Patient's CO2 was elevated on admission at 31 and as elevated since admission to 36.
- Patient's depth and rate of breathing was irregular.
- Patient used accessary muscle when breathing.

Patient Information

A.W. is a 60 year old female with a past history of significant for COPD, impaired fasting glucose and A1c 5.6, she has been labeled with history of congestive heart failure and her echocardiogram in May of 2019 indicated EF of 59% with grade 1 diastolic dysfunction, history of iron deficiency anemia, history of hypertension, history of GERD, reported history of myocardial infraction, obstructive sleep apnea and history of CPAP use, she presented with symptoms of severe shortness of breath, she also has a productive cough for the past 1 day, ER impression was COPD exacerbation. Patient has history of lung mass, she underwent CT angiogram of the chest, she was given IV-soul-Medrol, no bronchodilators have been administered. Upon her first evaluation patient is wearing 5 liters of nasal cannula, currently she is saturating at 92%, she is slightly tachycardiac with rate of 101, her blood pressure is 147/72, her respiratory rate is at least 38 and she is visibly tachypneic. A.W. denies any triggers for asthma in the last few days, she reports unable to eat in the past few days, she reports loss of appetite, she was also having nausea and vomiting at home, she had an episode of loose stool at home despite eating less, she denies any loss of taste or smell, denies any rhinorrhea. A.W. reports having productive cough, patient reports she has a dark brough appearing phlegm with few episodes of hemoptysis when asked if she knows above hilar mass, she reports she does not recall but at the same time she feels she has beginning of dementia.

Nursing Diagnosis/Outcomes

1. Impaired gas exchange **related to** decreased lung compliance, ventilation-perfusion inequality **as evidenced by** visual disturbances, decreased dyspnea, hypoxia, restlessness, tachycardia, hypercarbia, abnormal rate, rhythm, depth of breathing, nasal flaring
   a. Goal partially met. Respiratory rate and oxygen saturation values within expected range on 1/28/21 from 0700 to 1200. Patient still uses accessary muscles and nasal flaring while breathing. Patient's depth and effort of breathing is still poor due to her COPD. Goal is still ongoing. Goal would be modified to patient's vital signs will remain within expected range. Since COPD is chronic and this patient is on palliative care, the likelihood of improvement is unrealistic. Patient will most likely always have dyspnea with activity and at rest.
   b. Goal met. Patient was encouraged and complied with increase in fluid intake and oral hygiene on 1/28/21 before end of shift at 1200. Patient drank a total of 600 mL fluid (coke and water) for breakfast and throughout shift. By providing liquids it helps moisten the wall of the lungs which helps gas pass across the walls. It ensures oxygen rich blood is taken away from the lungs and carbon dioxide rich blood is taken to the lungs, so fluids are important.
2. Ineffective tissue perfusion **related to** peripheral interruption of venous blood flow, increased coagulability of blood, exchange problems, impaired transport of oxygen across alveolar or capillary membrane, decreased hemoglobin concentration in blood **as evidenced by** +1 peripheral pulses, dry skin, presence of repository distress, history of dvt, tenderness
   a. Goat met. Patient displayed no signs and symptoms of DVT throughout shift from 0700 to 1200 on 1/28/21. Patient denies pain or tenderness in lower extremities. When assessing patient's lower extremities, there were no signs of swelling, tenderness or increased warmth and skin color changes bilaterally throughout.
   b. Goal met. Patient was administered a unit of heparin once during the shift on 1/28/21 at 0800. Patient is prescribed heparin twice a day every 12 hours. Patient understood why she was taking heparin. Patient stated it was because she did not want to develop another blood clot.

Nursing Interventions

1. Monitor respiratory rate, depth, and effort, oxygen saturation, including use of accessary muscles, nasal flaring, and abnormal breathing pattern throughout shift from 0700 to 1200 on 1/28/21.

2.Provide frequent oral hygiene at least four times during shift from 0700 to 1200 on 1/28/21. If the client's mouth is dry and painful, provide oral hygiene hourly while awake.

1. Assess for signs and symptoms of DVT such as swelling, pain or tenderness, increased warmth and changes in skin color that results in redness throughout shift from 0700 to 1200 on 1/28/21.

2. Administer anticoagulants (subcutaneous low molecular weight heparin) as prescribed once throughout shift on 1/28/21 from 0700 to 1200.