

N321 Care Plan #2

Lakeview College of Nursing

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**Demographics (3 points)**

<b>Date of Admission</b> 2-14-2021	<b>Patient Initials</b> JJ	<b>Age</b> 48	<b>Gender</b> Female
<b>Race/Ethnicity</b> White	<b>Occupation</b> Stay at home mother/Tupperware consultant	<b>Marital Status</b> Married	<b>Allergies</b> Seasonal
<b>Code Status</b> Full Code	<b>Height</b> 5'3	<b>Weight</b> 155 lbs	

**Medical History (5 Points)**

**Past Medical History:** Hypertension, psoriasis, hypothyroidism, GERD, diabetes

**Past Surgical History:** None

**Family History:** Mother-Passed away from cancer when she was a child, father-hypertension, congestive heart failure, diabetes, brother-cancer and hypertension.

**Social History (tobacco/alcohol/drugs):** Client denies drug or alcohol use. Smokes 1 pack/day

**Assistive Devices:** None

**Living Situation:** The patient lives at home with her husband and three children

**Education Level:** Associates Degree in Business

**Admission Assessment**

**Chief Complaint (2 points):** Shortness of breath with productive cough

**History of present Illness (10 points):** Onset: The patient developed a cold a little over a week ago and was transported to the emergency room by her husband early Monday morning.

Location: The patient has a productive cough, shortness of breath, and feels like her chest is congested. Duration: The patient developed a cold over a week ago and has progressively gotten worse. Characteristic Symptoms: The patient states that she feels weak and has a cough that is

producing green sputum. Associated manifestations: The client stated that she has never felt like this in her life and is very anxious. Relieving factors: The patient has been taking over the counter medications to try to relieve her symptoms. Treatment: The client stated that she was trying over the counter cold medicine to help with her cold, but she knew it was not helping when she started to get worse and she has never felt like this before.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** Pneumonia

**Secondary Diagnosis (if applicable):** Uncontrolled Diabetes

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

Pneumonia is an acute bacterial or viral infection that causes inflammation of the alveolar spaces and interstitial tissue of the lungs. The inflammation causes exudate to fill the air spaces, and lung tissue become edematous and gas exchange cannot occur. When gas is not allowed to be exchanged the blood is shunted into the cardiovascular system causing hypoxemia. Signs and symptoms of pneumonia include pain in the chest, productive cough, fever or lower-than-normal body temperature, shortness of breath, nausea, vomiting, diarrhea.

Type 2 diabetes is an impairment in the way the body regulates and uses sugar (glucose) as a fuel. This long-term condition results in too much sugar circulating in the bloodstream.

Eventually, high blood sugar levels can lead to disorders of the circulatory, nervous and immune systems. In type 2 diabetes, there are primarily two interrelated problems at work. Your pancreas does not produce enough insulin — a hormone that regulates the movement of sugar into your cells — and cells respond poorly to insulin and take in less sugar. Signs and symptoms of diabetes are increased thirst, frequent urination, increased hunger, unintended weight loss,

fatigue, blurred vision, slow-healing sores, frequent infections, numbness or tingling in the hands or feet, and areas of darkened skin, usually in the armpits and neck.

The patient presented at the emergency department with shortness of breath that felt like she was suffocating. The patient was very weak and felt like she was suffocating. The patient was given 1.5mg Dilaudid to help ease her chest pain which she reported at a 7 out of 10. The patient was also given a 1-hour nebulizer treatment to help loosen the mucous in her lungs and make it easier for her to breathe since she had a productive cough and difficulty breathing. While in the Emergency Room the physician ordered a cardiac panel, complete metabolic panel, complete blood count, chest x-ray, EKG, and a sputum culture.

The patient had a WBC level of 18,000 which is elevated due to the pneumonia. The patient had an x-ray and sputum culture that did confirm pneumonia. She also had an EKG that confirmed sinus tachycardia caused by the pneumonia. The patient's cardiac panel was within normal limits eliminating MI. After being admitted to the floor, the patient was given 3.375 g Piperacillin/Tazobactam IV every 6 hours which is an IV antibiotic to treat pneumonia. The patient was also given albuterol to relax muscles in the airway and increase air flow to the lungs. The patient was also given Solumedrol to prevent the release of substances in the body that cause inflammation and help her to be less congested and start to breathe better. The patient also had a fever of 101.1 so she was given Tylenol to help reduce it. The patient had a glucose level of 405 in the ER and 225 after being admitted. The patient was given Levemir and Novolog which are forms of insulin to get her glucose back within a normal range.

**Pathophysiology References (2) (APA):**

Caprotti, T. (2020) *Davis advantage for pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis. Company

Swearingen and Wright. (2019) *All-in-One Nursing Care Planning Resource Guide* (5 edition) Elsevier

Type 2 Diabetes. (2021, January 20). *MayoClinic*. Retrieved from <https://www.mayoclinic.org/diseases-conditions/type-2-diabetes/symptoms-causes/syc-20351193>

**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	F 4-5.5million M 4.5-6 million	5.0 million		

<b>Hgb</b>	F 12-15g/dL M 14-16 g/dL	12.0 g/dL	11g/dl	Hemoglobin that is slightly low can be normal in some patients, especially women because of menstruation. (Hinkle and Cheever). The patient could be on her period or just normally have slightly low hemoglobin.
<b>Hct</b>	F 42-52% M 35-47%	40.0%	40%	
<b>Platelets</b>	150,000- 400,000 cells/ mm <sup>3</sup>			
<b>WBC</b>	4,500-11,000 cells/mm <sup>3</sup>	18,000 cell/mm <sup>3</sup>	14,000	White blood cells increase during infection and inflammation. (Hinkle and Cheever, 2018) The patient had been diagnosed with pneumonia.
<b>Neutrophils</b>	45%-75%			
<b>Lymphocytes</b>	20%-40%			
<b>Monocytes</b>	4%-6%			
<b>Eosinophils</b>	<7%			
<b>Bands</b>	0.0-3.0%			

**Chemistry Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Lab</b>	<b>Normal Range</b>	<b>Admission Value</b>	<b>Today's Value</b>	<b>Reason For Abnormal</b>
<b>Na-</b>	135-145 mEq/L	158mEq/L	133	Dehydration can cause low sodium levels. (Hinkle and Cheever). The patient is probably slightly dehydrated.
<b>K+</b>	3.5-5.0 mEq/L	2.3mEq/L	3.6	Serum Potassium levels are decreased in severe bacterial pneumonia. (Hinkle and Cheever) The patient has a productive cough and sputum was positive for staph aureus which is an indication of pneumonia.
<b>Cl-</b>	97-107 mEq/L	108mEq/L		Dehydration is associated with increased Chlorine levels. (Hinkle and Cheever). The patient reported feeling weak and short of breath, so she probably has not been eating or drinking well.

<b>CO2</b>	21-31 mmol/L			
<b>Glucose</b>	70-100	405	225	Diabetes Mellitus is associated with elevated glucose levels when it is not controlled. (Hinkle and Cheever, 2018) The patient has uncontrolled type 2 diabetes mellitus.
<b>BUN</b>	5-25 mg/dL	28	18	Dehydration is associated with elevated BUN levels because urea and nitrogen are building in the body and not being excreted. (Hinkle and Cheever, 2018) The patient presented with weakness and shortness of breath, so she is probably slightly dehydrated.
<b>Creatinine</b>	.6-1.3 mg/dL	0.9	0.1	Inadequate protein intake can cause low creatinine levels. (Hinkle and Cheever) The patient probably has not been eating or drinking properly.
<b>Albumin</b>	3.5-5.2 gm/dL			
<b>Calcium</b>	8.7-10.2 mg/dL	9.0mEq/L		
<b>Mag</b>	1.3/3.0 mg/dL	2.2mg/dL		
<b>Phosphate</b>	2.5/4.5 mg/dL	2.6mg/dL		
<b>Bilirubin</b>	.1-1.4 mg/dL			
<b>Alk Phos</b>	40-120 U/L			
<b>AST</b>	10-30 U/L	25		
<b>ALT</b>	10-40 U/L	16		
<b>Amylase</b>	30-110 U/L			
<b>Lipase</b>	0-160 U/L			
<b>Lactic Acid</b>	0.5-2.2 mmol/L	3.6mmol/L		Lactic Acid increases when blood oxygen levels are decreased. (Hinkle and Cheever). The patient was breathing rapidly and her blood

				oxygen levels were low.
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**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
<b>INR</b>	>1.1			
<b>PT</b>	M9.6-11.8 F9.5-11.3			
<b>PTT</b>	30-40 seconds			
<b>D-Dimer</b>	<250 ng/mL	150		
<b>BNP</b>	<100pg/mL			
<b>HDL</b>	<60 mg/dl		55	
<b>LDL</b>	<130 mg/dL		130	High fat diets and smoking can cause elevated LDL levels. (Hinkle and Cheever). The patient is overweight and smokes.
<b>Cholesterol</b>	<200 mg/dL		300	High fat diets and smoking can cause elevated cholesterol levels. (Hinkle and Cheever). The patient is overweight and smokes.
<b>Triglycerides</b>	150 mg/dL		188	High fat diet can cause elevated triglyceride levels. (Hinkle and Cheever). The patient is overweight.
<b>Hgb A1c</b>	Diabetic <7% Nondiabetic 4-5.6%	12.2%		Hemoglobin A1c tells you your average level of blood sugar over the past 2 to 3 months. (Hinkle and Cheever). The patient has uncontrolled diabetes.
<b>TSH</b>	.4-1.4 mu/L	12.0		High TSH levels can mean your thyroid is not making enough thyroid hormones. (Hinkle and Cheever). The patient has a previous diagnosis of hypothyroidism.

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	Clear/yellow			
pH	4.5-8			
Specific Gravity	1.005-1.035			
Glucose	Negative			
Protein	Negative			
Ketones	Negative			
WBC	None or rare			
RBC	None or rare			
Leukoesterase	None or rare			

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			
Blood Culture	Negative			
Sputum Culture	Negative	Staphylococcus aureus		Staphylococcus aureus is a common bacterium that causes pneumonia. (Hinkle and Cheever) The patient has pneumonia.
Stool Culture	Negative			

Lab Correlations Reference **(1)** (APA):

Caprotti, T. (2020) *Davis advantage for pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis. Company

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

### **Diagnostic Imaging**

#### **All Other Diagnostic Tests (5 points):**

Chest X-ray, Right and Left Lower Lobes. Showed diffuse bilateral pulmonary infiltrates in both lower lobes.

EKG shows sinus tachycardia.

The cardiac panel showed normal ranges of troponin, ck-mb, and creatine kinase.

#### **Diagnostic Test Correlation (5 points):**

The patient had a productive cough and difficulty breathing so the chest x-ray helps the doctor diagnose pneumonia and determine the extent and location of the infection. The EKG and cardiac panel are used to indicate heart function. The patient had an elevated heart rate upon arrival at the emergency room. The EKG confirms sinus tachycardia and is a sign of pneumonia.

The cardiac panel was ran to eliminate an MI.

**Diagnostic Test Reference (1) (APA):**

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

Pneumonia. (2020, June 13). *MayoClinic*. Retrieved from <https://www.mayoclinic.org/diseases-conditions/pneumonia/diagnosis-treatment/drc-20354210>

**Current Medications (10 points, 1 point per completed med)  
\*10 different medications must be completed\***

**Home Medications (5 required)**

<b>Brand/Generic</b>	Lisinopril/Prinivil	Multi Vitamin	Pantoprazole/ Protonix	Synthroid/ Levothyroxine	Insulin detemir/ Levemir
<b>Dose</b>	20mg	1 tablet	40mg	50mcg	30 units
<b>Frequency</b>	Daily	Daily	Every Morning	Daily	Every evening
<b>Route</b>	PO	PO	PO	PO	Subcutaneous injection
<b>Classification</b>	Anti- Hypertensive	Vitamin/ Mineral	Proton pump inhibitor	Thyroid Hormone Replacement	Anti-Diabetic

<b>Mechanism of Action</b>	Relax and dilate blood vessels to lower blood pressure.	Adds vitamins that may be lacking in the diet.	Decreases the amount of acid produced in the stomach.	Replaces a hormone normally produced by your thyroid gland to regulate the body's energy and metabolism.	Manmade form of insulin that lowers glucose levels in the blood
<b>Reason Client Taking</b>	To lower her blood pressure.	Dietary supplement	GERD	The client has hypothyroidism	To control her diabetes.
<b>Contraindications (2)</b>	1.High potassium diet  2. Alcohol use	1.Antacids 2.Milk	1.Digoxin 2.Warfarin	1.uncontrolled adrenal gland disorder 2.history of heart attack	1.Hypokalemia 2. Kidney or liver disease
<b>Side Effects/Adverse Reactions (2)</b>	1.Dry mouth 2. Blurred vision	1Headache 2.Upset stomach	1.Chest pain 2.Hyperglycemia	1.Weakness 2.Shortness of breath	1.Fluid retention 2. Weight gain
<b>Nursing Considerations (2)</b>	1.Do not take if you are or may become pregnant. 2. Monitor blood pressure often especially the first two weeks of therapy.	1.Take with a full glass of water 2.Consult physician before starting any medication even over the counter supplements.	1.Monitor for bone fracture 2.Monitor patient output.	1.Do not use for treatment of obesity. 2.Regular thyroid function tests	1. Store open vials in a refrigerator or at room temperature and use within 42 days. 2.Rotate injection sites.

**Hospital Medications (5 required)**

<b>Brand/ Generic</b>	Toradol/ Ketorolac	Tylenol/ Acetaminophen	Ipratropium Bromide/ Albuterol	Solumedrol/ methylprednisol one	Piperacillin/ Tazobactam
<b>Dose</b>	30mg	650mg	3mL	125mg	3.375g
<b>Frequency</b>	Every 8hrs	Every 4- 6hrs PRN	Every 6hrs	Every 6hrs	Every 6 hours
<b>Route</b>	IV	PO	Inhalation	IV	IV
<b>Classificati on</b>	Nonsteroid al Anti- inflammato ry drug	Antipyretic	Bronchodilator	Corticosteroid	Antibiotic
<b>Mechanis m of Action</b>	Reduces hormones that cause inflammati on and pain in the body.	Pain reliever and fever reducer	Relaxes muscles in the airways and increases air flow to the lungs.	A steroid that prevents the release of substances in the body that cause inflammation.	A combination penicillin that is used to treat many different infections caused by bacteria
<b>Reason Client Taking</b>	The patient is experiencin g chest pain	The client was running a fever	To help the patient breathe	The patient is having difficulty breathing due to pneumonia	To treat pneumonia
<b>Contraindi cations (2)</b>	1.Stomach ulcer 2.Severe kidney disease	1.Liver Disease 2.Pregnancy	1.Sensitivity to peanuts 2.Sensitivity to soybeans	1.Fungal infections 2.Alcohol	1.Penicillin allergy 2.Cephalosporin allergy
<b>Side Effects/Ad verse Reactions (2)</b>	1.Swelling 2.Rash	1.Dark urine 2.Excessive sweating	1.Wheezing 2.Increased thirst	1.Shortness of breath 2.Bloody or tarry stools	1.Headache 2.nausea
<b>Nursing Considerat</b>	1.Take with a meal or	1.Can be passed through breast	1.Maximum effect may take	1.Protect patients from	1.Call physician if you have bloody or watery diaherra

<b>ions (2)</b>	snack. 2.Avoid alcohol	milk. 2.Chewable tablets must be chewed.	up to 2 weeks. 2.Rinse mouth after each treatment.	falling 2.Inject IM form deep into gluteal muscle	2.Take as prescribed
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**Medications Reference (1) (APA):**

Jones & Bartlett Learning. (2020). *2020 Nurse’s Drug Handbook*. Burlington, MA

*Drugs.com* (n.d.) Retrieved from <https://www.drugs.com/>

**Assessment**

**Physical Exam (18 points)**

<b>GENERAL (1 point):</b> <b>Alertness:</b> <b>Orientation:</b> <b>Distress:</b> <b>Overall appearance:</b>	Alert and Oriented to person place and time.  The patient is well groomed but pale and anxious.
<b>INTEGUMENTARY (2 points):</b> <b>Skin color:</b> <b>Character:</b> <b>Temperature:</b> <b>Turgor:</b> <b>Rashes:</b>	The patient is pale and warm.  Skin turgor within normal limits.

<p><b>Bruises:</b>  <b>Wounds:</b> .  <b>Braden Score:</b> 20  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>Skin has no bruises, rashes or lesions,</p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>Head and Neck are symmetrical. Trachea is midline without deviation.                  Bilateral auricles pink and moist with no lesions noted.                  Bilateral PEERLA. Bilateral EOM's intact.                  Bilateral conjunctiva white, bilateral sclera pink.                  Septum is midline.                  Dentition good.                  Lips are very dry and cracked</p>
<p><b>CARDIOVASCULAR (2 points):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>Clear S1 and S2 sounds with no murmurs, gallops, or rubs noted. Normal rhythm. EKG revealed Sinus Tachycardia.</p> <p>Peripheral pulses 2+ throughout bilaterally.                  Capillary refill with in normal limits.</p>
<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>Breath sounds labored with accessory muscle use and wheezing heard in lower lobes. Cough producing green sputum. The patient complains of chest tightness and back pain.</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at home:</b>  <b>Current Diet</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>              <b>Distention:</b> NO              <b>Incisions:</b> NO              <b>Scars:</b> NO              <b>Drains:</b> NO              <b>Wounds:</b> NO  <b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>The patient stated she was recently diagnosed with diabetes but has been having a lot of trouble changing her diet to accommodate to her new diagnosis.                  Clear liquid diet                  5'3                  155lbs                  Bowel sounds normoactive upon auscultation of all 4 quadrants. No tenderness upon palpation of all 4 quadrants. Patient is complaining of nausea. The abdomen was not distended.</p>

<p><b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	
<p><b>GENITOURINARY (2 Points):</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>Size:</b></p>	<p>The patient has no urinary problems.   Urine is clear/yellow</p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>Neurovascular status:</b>  <b>ROM:</b>  <b>Supportive devices:</b>  <b>Strength:</b>  <b>ADL Assistance:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Risk:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Score:</b> 10  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>Full strength and range of motion in all extremities bilaterally.   No supportive devices. The patient did state that she feels weak.   The patient can get up independently.</p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> <b>if no -</b>  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b> Alert  <b>Mental Status:</b> A&amp;O X 3  <b>Speech:</b> Clear and intact, communicates appropriately for age.  <b>Sensory:</b> Intact  <b>LOC:</b> Alert</p>	<p>.</p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>The patient lives at home with her husband and 3 children.   The patient is a member of The First United Methodist Church.  The patient has made it very clear she a great</p>

	support system between her husband and members of the church. The patient stated, "her church family is very important to her."
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**Vital Signs, 2 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0100	110	150/98	28	101.1	90% 2L NC
1400	108	126/84	24	99.4	95% 3L NC

**Pain Assessment, 2 sets (2 points)**

Time	Scale	Location	Severity	Characteristics	Interventions
0100	0-10	Back	7	Nagging, aching, constant	Dilaudid 1.5mg IV push in ER
1400	0-10	Back	5	Nagging, aching, constant	Toradol 30 mg IV push

**IV Assessment (2 Points)**

IV Assessment	Fluid Type/Rate or Saline Lock
<b>Size of IV:</b> 18 gauge <b>Location of IV:</b> Left forearm <b>Date on IV:</b> 2-14-2021 <b>Patency of IV:</b> Patent <b>Signs of erythema, drainage, etc.:</b> No redness, tenderness, or drainage noted. <b>IV dressing assessment:</b> Dressing dry and intact	Infusing 0.9 NS with 20 KCL at 100mL/hr

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
N/A	N/A

## Nursing Care

### Summary of Care (2 points)

**Overview of care:** The patient is now sitting up in her bed, vitals stable while on 3L oxygen via nasal canula.

**Procedures/testing done:** Chest x-ray, EKG, labs

**Complaints/Issues:** The patient presented to the emergency room feeling very weak, with shortness of breath, productive cough, and chest and back pain rated at a 7/10.

**Vital signs (stable/unstable):** Stable

**Tolerating diet, activity, etc.:** The patient is very tired and anxious. She has not eaten much since being admitted.

**Physician notifications:** Increase oxygen from 2L via nasal cannula to 3L via nasal cannula.

**Future plans for patient:** The patient has been admitted for observation

### Discharge Planning (2 points)

**Discharge location:** The patient will return to her home with her husband and three children.

**Home health needs (if applicable):** N/A

**Equipment needs (if applicable):** N/A

**Follow up plan:** The patient will follow up with her primary care provider after being discharged from the hospital.

**Education needs:** The patient will need education on how to take at home medications, education on diet and lifestyle changes to help manage her newly diagnosed diabetes, and when she should return to the hospital if her condition worsens.

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

<p><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<p><b>Rational</b></p> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<p><b>Intervention (2 per dx)</b></p>	<p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• How did the patient/family respond to the nurse’s actions?</li> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<p><b>1.</b> Impaired gas exchange related to pneumonia as evidenced by Sinus Tachycardia.</p>	<p>The patient had a heart rate of 110 beats per minute and the EKG showed Sinus Tachycardia.</p>	<p>1.Raise the head of the bed to help the patient breathe easier.</p> <p>2. Take measures to reduce fever and chills</p>	<p>The patient was very compliant about having the head of the bed raised because she just wanted to feel better. The patient also took Tylenol to help with her fever.</p>
<p><b>2.</b> Acute pain related to productive cough as evidenced by the patient stated having chest and back pain at 7/10.</p>	<p>The patient had been coughing up green sputum and complaining of chest and back pain at 7/10.</p>	<p><b>1.</b> Provide comfort measures such as back rubs, position changes, quiet music, massage.</p> <p><b>2.</b>Instruct and assist patient in chest splinting techniques during coughing episodes.</p>	<p>The patient was as happy as a sick person can be when she got her back massage. She stated it was very therapeutic.</p> <p>The patient also stated that when she put a pillow against her stomach while coughing that it did not hurt as much.</p>
<p><b>3.</b> Risk for unstable blood glucose</p>	<p>The patient had a blood glucose level of 405 in the emergency room</p>	<p>1.Assess the patient’s current knowledge and understanding about the prescribed diet.</p>	<p>The patient stated that she had received education on diet when she was diagnosed with</p>

<p>level related to diabetes as evidenced by elevated blood glucose levels.</p>	<p>and 225 after being admitted.</p>	<p>2 Assess the pattern of physical activity and address history of smoking.</p>	<p>diabetes, but she just did not follow it. She does not like to exercise either but stated that after this whole experience that she would try harder. She knows she needs to quit smoking, but she needed to work on diet and exercise before she could even tackle that hurdle. She has been given more education on diet, exercise, and how to manage diabetes.</p>
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**Other References (APA):**

11 Pneumonia Nursing Care Plans. (2020, December 5). *Nurseslabs*. Retrieved from <https://nurseslabs.com/pneumonia-nursing-care-plans/5/>

Risk for Unstable Blood Glucose Levels Care Plan. (2017, September 24). *Nurseslabs*. Retrieved from <https://nurseslabs.com/risk-unstable-blood-glucose-level/>

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**Concept Map (20 Points):**

**Subjective Data**

Pt reports chest pain and feels like she is suffocating.

Very anxious, weak, says she has never felt like this before.

Husband had to help her get into car and walk into the Emergency Room.

**Nursing Diagnosis/Outcomes**

1. Impaired gas exchange related to pneumonia as evidenced by Sinus Tachycardia.  
Outcome: The patient was very compliant about having the head of the bed raised because she just wanted to feel better. The patient also took Tylenol to help with her fever.
2. Acute pain related to productive cough as evidenced by the patient stated having chest and back pain at 7/10.  
Outcome: The patient was as happy as a sick person can be when she got her back massage. She stated it was very therapeutic. The patient also stated that when she put a pillow against her stomach while coughing that it did not hurt as much.
3. Risk for unstable blood glucose level related to diabetes as evidenced by elevated blood glucose levels.  
Outcome: The patient stated that she had received education on diet when she was diagnosed with diabetes, but she just did not follow it. She does not like to exercise either but stated that after this whole experience that she would try harder. She knows she needs to quit smoking, but she needed to work on diet and exercise before she could even tackle that hurdle. She has been given more education on diet, exercise, and how to manage diabetes.

**Objective Data**

Pt coughing up yellowish green sputum  
Fever 101.1 F  
P 110  
BP 150/98  
RR 28  
O2 90% on 2L NC  
Pain 7/10

Using accessory muscles to breathe

**Patient Information**

Janis Joplin  
48 years old  
Female  
Diabetes, Hypertension,  
psoriasis, hypothyroidism,  
GERD  
Smokes Cigarettes 1 pack per  
day

**Nursing Interventions**

1. Raise the head of the bed to help the patient breathe easier.
2. Take measures to reduce fever and chills
3. Provide comfort measures such as back rubs, position changes, quiet music, massage.
4. Instruct and assist patient in chest splinting techniques during coughing episodes.
5. Assess the patient's current knowledge and understanding about the prescribed diet.
6. Assess the pattern of physical activity and address history of smoking.



