N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2-22-2021	**J.W.**	**79**	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	**Retired- worked at quaker oats factors in Danville.**	**Married**	**Codeine, hydrocodone, tramadol, and naproxen. The patient experiences confusion and vomiting.**
Code Status	**Height**	**Weight**	
Full code	**4'8"**	**150 pounds**	

Medical History (5 Points)

Past Medical History: This patient's past medical history includes COPD, Left-sided carotid artery disease, CHF, stroke, arthritis, osteoporosis, hypertension, thyroid disease and hypercholesteremia.

Past Surgical History: This patient's past surgical history includes Carpal tunnel surgery, colonoscopy, kyphosis surgery, and left carotid endarterectomy.

Family History: The patient's mother had cancer, her father had a stroke, and her sister has diabetes.

Social History (tobacco/alcohol/drugs): The patient is an everyday smoker. She has been smoking for 60 years and smokes ½ a pack a day. This makes her a 30-year pack history smoker. The patient does not drink alcohol or do drugs.

Assistive Devices: The patient does not use assistive devices. She is completely independent at home.

Living Situation: The patient lives in a single-story with her husband.

Education Level: The patient has a GED.

Admission Assessment

Chief Complaint (2 points): The patient came into the emergency department with shortness of breath.

History of present Illness (10 points):Onset: The patient came into the emergency department on February 22nd complaining of shortness of breath. The patient stated that the shortness of breath had been going on since the night before. Location: The patient is experiencing shortness of breath in the chest. Duration: The client stated, "my shortness of breath is constant". Characteristics: The client stated, "the shortness of breath feels tight and like I can't catch my breath". Associated manifestations: The client stated, "When I am short of breath, I cough a lot more than usual, and when I cough more, I get a headache." Relieving factors: The patient takes acetaminophen when experiencing a headache. Upon coming into the emergency department, nothing was relieving the shortness of breath. Treatment: The patient has not sought out treatment before to coming into the emergency department.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): COPD exacerbation.

Secondary Diagnosis (if applicable): Hyponatremia.

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

COPD, also known as Chronic obstructive pulmonary disease, is characterized by a combination of chronic bronchitis, hyperactive airway disease, and emphysema (Capriotti and Frizzell, 2016). When a patient has COPD, they have excessive mucus in the bronchioles, narrowing, smooth muscle hypertrophy, and loss of alveolar recoil (Capriotti and Frizzell, 2016). The walls are thickened, and there is chronic inflammation. Signs and

symptoms of COPD include dyspnea, cough with sputum production, wheezing, cyanosis, and over time COPD can turn into right ventricular heart failure (Capriotti and Frizzell, 2016). Expected findings for a patient with COPD would include a lowered O2 saturation level, clubbing of the fingernails, frequent respiratory infections, and swelling (Mayo Clinic, 2020). To help diagnose COPD, the COPD assessment test (CAT) is done. This questionnaire asks the patient about their activity limitation and breathing pattern (Capriotti and Frizzell, 2016).

PFT's are also done (spirometry). PFT's measure the amount of air that can be exhaled with maximum effort (Capriotti and Frizzell, 2016). A CBC, ABG's, Chest X-ray, and electrocardiogram is monitored. When the COPD is severe, the X-ray will show fibrosis (damage) (Capriotti and Frizzell, 2016). The patient's vital signs could show hypertension or an elevated heart rate (Capriotti and Frizzell, 2016). 90% of patients who have COPD are smokers, and that is the primary cause. Treatment of COPD includes smoking cessation, oxygen therapy, bronchodilators, corticosteroids (for acute exacerbations), and preventative infection measures like vaccines (Capriotti and Frizzell, 2016). The patient presented with COPD symptoms (dyspnea, cough, wheezing, and elevated respiratory rate) upon admission. The patient also smokes (which is the leading risk factor of COPD). The patient had a chest X-ray was done, which confirmed fibrosis in the lungs. Inflammation was also present. To treat the patient, oxygen was administered as well as bronchodilators and corticosteroids. These treatments improved the patient's airway patency, and O2 saturation was up to 97%. Nonpharmacological interventions were also put in place (placing the patient in a chair and placing the bed in an upright position) and helped the patient breathe better, and she seemed comfortable. The patient was taught how to use an

incentive spirometer, and smoking cessation was suggested. The activity was increased and tolerated as well as lung sounds were clearing up. The patient also maintained a 95% oxygen saturation without oxygen, and the respiratory rate decreased to normal levels.

Pathophysiology References (2) (APA):

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

Mayo Clinic. (2020, April 15). *COPD.* https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. *Normal lab values per OSF epic system*

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30	4.55	4.06	NA
Hgb	12.0-15.8	14.3	12.7	NA
Hct	36.0-47%	41.8%	37.1%	NA
Platelets	140-440	388	362	NA
WBC	4.00-12.0	9.60	12.30	The patients WBC was slightly elevated today. This could indicate infection/inflammation in the body (Capriotti and Frizzell, 2016).
Neutrophils	47-73	81.9	89.9	Neutrophils are the “first defense in line” when there is infection/inflammation. Elevation can indicate infection/inflammation in the body (Capriotti and Frizzell,

				2016).
Lymphocytes	**18-42%**	**11.1**	**6.0**	**Decreased lymphocytes can indicate presence of infection (Capriotti and Frizzell, 2016).**
Monocytes	**4-12%**	**5.1**	**4.0**	**NA**
Eosinophils	**0-5%**	**1.4**	**0**	**NA**
Bands	**0.0-1.0%**	**NA**	**NA**	**NA**

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-	**133-144**	**124**	**125**	**The patient's sodium level could be low for several reasons (the exact cause for this specific patient is unknown) but can be related to heart issues, certain medications (diuretics), and drinking too many fluids (Capriotti and Frizzell, 2016).**
K+	**3.5-5.1**	**3.7**	**4.1**	**NA**
Cl-	**98-107**	**88**	**90**	**The patient's chloride could be low due to congestive heart failure and COPD. The heart muscle is weakened which could be the cause (Capriotti and Frizzell, 2016).**
CO2	**21-31**	**23**	**27**	**NA**
Glucose	**70-99**	**137**	**122**	**The patient's glucose level is slightly elevated, and this could be from hypertension, smoking, or even a big meal (Capriotti and Frizzell, 2016).**
BUN	**6-20**	**29**	**12**	**Heart failure can cause BUN to be elevated (Capriotti and Frizzell, 2016).**
Creatinine	**0.50-1.00**	**0.65**	**0.59**	**NA**
Albumin	**3.5-5.7**	**4.5**	**NA**	**NA**

Calcium	**8.8-10.2**	**9.3**	**9.5**	**NA**
Mag	**1.6-2.6**	**1.4**	**NA**	**Older adults can have a decreased magnesium level because absorption and urinary output decrease (Capriotti and Frizzell, 2016).**
Phosphate	**3.4 – 4.5**	**NA**	**NA**	**NA**
Bilirubin	**0.2 – 1.3**	**NA**	**NA**	**NA**
Alk Phos	**38 – 126**	**84**	**NA**	**NA**
AST	**14 – 36**	**35**	**NA**	**NA**
ALT	**0 – 34**	**14**	**NA**	**NA**
Amylase	**30 - 110**	**NA**	**NA**	**NA**
Lipase	**0 - 160**	**NA**	**NA**	**NA**
Lactic Acid	**4.5 – 19.8**	**NA**	**NA**	**NA**
Troponin	**0 – 0.4**	**0.030**	**NA**	**NA**
CK-MB	**5 - 25**	**NA**	**NA**	**NA**
Total CK	**22- 128**	**NA**	**NA**	**NA**

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	**1 second**	**1.0**	**NA**	**NA**
PT	**9.5 – 11.3 seconds**	**12.7**	**NA**	**Heparin and other medications can cause PT to increase (Capriotti and Frizzell, 2016).**
PTT	**30 – 40 seconds**	**36 Seconds**	**NA**	**NA**

D-Dimer	**0-622 ng/ml**	**417**	**NA**	
BNP	**0-100**	**106**	**NA**	**Elevated BNP can be a result of poor or diminished cardiac output. The patient has congestive heart failure (Capriotti and Frizzell, 2016).**
HDL	**More than 60**	**NA**	**NA**	**NA**
LDL	**Less than 130**	**NA**	**NA**	**NA**
Cholesterol	**Less than 200**	**NA**	**NA**	**NA**
Triglycerides	**Less than 150**	**NA**	**NA**	**NA**
Hgb A1c	**Less than 7%**	**NA**	**NA**	**NA**
TSH	**0.4 – 4.0**	**NA**	**NA**	**NA**

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	**Colorless, clear, and no odor present.**	**NA**	**NA**	**NA**
pH	**4.5 - 8**	**NA**	**NA**	**NA**
Specific Gravity	**1.005 – 1.035**	**NA**	**NA**	**NA**
Glucose	**Negative**	**NA**	**NA**	**NA**
Protein	**Negative**	**NA**	**NA**	**NA**
Ketones	**Negative**	**NA**	**NA**	**NA**
WBC	**Negative**	**NA**	**NA**	**NA**
RBC	**Negative**	**NA**	**NA**	**NA**
Leukoesterase	**Negative**	**NA**	**NA**	**NA**

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	NA	NA	NA
PaO2	75 - 100	NA	NA	NA
PaCO2	38 - 42	NA	NA	NA
HCO3	22 - 28	NA	NA	NA
SaO2	95% - 100%	NA	NA	NA

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	Clean catch, no growth	NA	NA	NA
Blood Culture	No growth after 3 days	NA	NA	NA
Sputum Culture	Negative	Pending	Pending	The patient's sputum culture is pending.
Stool Culture	The stool should appear brown, soft, and well-formed in consistency with no blood, mucus, bacteria, or fungi.	NA	NA	NA

Lab Correlations Reference (1) (APA):

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

Normal lab ranges per OSF epic system.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient had a Chest X-ray, a Covid-19 test, a CT scan, and ejection fraction was measured.

Diagnostic Test Correlation (5 points): The chest X-ray indicated normal findings with "mild bibasal opacities most likely from fibrosis". Fibrosis is scarring and damage to the lungs. The patient has COPD, so this finding is normal and expected. The Covid-19 test was negative. The CT scan was done because the patient complained of a headache and has chronic hypertension. The results indicated no hemorrhage or mass with slight atrophy (from the patients stroke in 2015).

Diagnostic Test Reference (1) (APA):

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

Current Medications (10 points, 1 point per completed med)

10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Bayer / Aspirin**	**Ventolin HFA / Albuterol sulfate**	**Acetaminophen/ Tylenol**	**Guaifenesin / Mucinex**	**Cozaar / Losartan**
Dose	**81 mg**	**2 puffs (about 180 mcg)**	**650 mg**	**600 mg**	**50 mg**
Frequency	**2X daily**	**4X daily**	**Every 6 hours PRN**	**2 X daily**	**1 X daily**
Route	**orally**	**orally**	**orally**	**orally**	**orally**
Classification	**Salicylate, antiplatelet.**	**Adrenergic, bronchodilator.**	**Antipyretic, nonopioid analgesic.**	**Glyceryl guaiacolate, expectorant.**	**Angiotensin II receptor blocker (ARB), antihypertensive.**
Mechanism of Action	**Aspirin blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis.**	**Albuterol attaches to beta2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert ATP to Camp. (Cyclic adenosine monophosphate.**	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.**	**Increases fluid and mucus removal from the upper respiratory tract by increasing the volume of secretions and reducing their adhesiveness and surface tension.**	**Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle.**
Reason Client Taking	**The patient is taking aspirin to reduce the risk of a stroke and**	**The patient takes her albuterol daily to treat and prevent bronchospas**	**The client is taking to treat mild to moderate pain.**	**The patient is taking Mucinex to relieve cough.**	**The client is taking to manage high blood pressure.**

	helps to treat arthritis pain.	**m. The patient has COPD, so albuterol helps open her airway.**			
Contraindications (2)	**Active bleeding or coagulation disorders, current or recurrent GI bleed or ulcers.**	**Hypersensitivity to albuterol or its components. *The drug book only has one contraindication listed***	**Hypersensitivity to acetaminophen or its components, or severe hepatic impairment.**	**Hypersensitivity to guaifenesin or its components. *The drug book only has one contraindication listed***	**Concurrent aliskiren therapy (in patients with diabetes or renal impairment), hypersensitivity to losartan or its components.**
Side Effects/Adverse Reactions (2)	**CNS depression, GI bleeding.**	**Angina, pulmonary edema.**	**Hypotension, hepatoxicity.**	**Dizziness, headache.**	**Hypotension, angioedema.**
Nursing Considerations (2)	**Don't crush time released or controlled release aspirin unless directed, ask about tinnitus.**	**Be aware that drug tolerance can develop with prolonged use, administer pressurized inhalations of albuterol during second half of inspiration, when airways are open wider and aerosol distribution is more effective.**	**Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, ensure that the daily dose of acetaminophen from all sources does not exceed maximum daily limits.**	**Watch for evidence of more serious condition, such as cough that lasts longer than 1 week, fever, persistent headache, and rash. Instruct patient to take each dose with a full glass of water.**	**Know that in some patients, losartan is more effective when given in 2 divided doses daily, monitor patient for muscle pain.**
Key Nursing Assessment(s)/L	**Assess for pregnancy,**	**Monitor serum**	**Monitor liver**	**Assess the patients**	**Monitor blood**

ab(s) Prior to Administration	**bleeding disorders, or hypersensitivity to aspirin.**	**potassium levels because albuterol can cause transient hypokalemia. Monitor cardiac disorders or hypertension because albuterol can worsen these conditions.**	**function tests (AST, ALT, bilirubin, and creatinine). These must be monitored to ensure liver hepatoxicity has not occurred. Monitoring renal function is also important.**	**cough, amount of secretions, adverse reactions, and evidence of a more severe condition.**	**pressure and renal function studies to monitor effectiveness. Take blood pressure before to get a baseline. Monitor potassium level to detect hyperkalemia.**
Client Teaching needs (2)	**Tell patient not to take aspirin if it has a strong vinegar like odor, instruct patient to take aspirin with food or after meals because it may cause GI upset if taken on an empty stomach.**	**Advise patient to wait at least 1 minute between inhalations if dosage requires more than one inhalation, tell the patient to check with his/her prescriber before using other inhaled drugs.**	**Tell patient that tablets may be crushed or swallowed whole, teach patient to recognize signs of hepatoxicity such as bleeding, easy bruising, and malaise.**	**Advise patient not to break, chew, or crush tablets. Swallow whole. advise patient not to take drug longer than 1 week and to notify prescriber about fever, headache, or rash.**	**Warn patient to tell all prescribers of losartan therapy, instruct patient to avoid potassium-containing salt substitutes because they may increase the risk of hyperkalemia.**

Hospital Medications (5 required)

Brand/Generic	**Zithromax / Azithromycin**	**Hepalean / Heparin**	**0.9 % sodium chloride**	**Euthyrox / Levothyroxine**	**Medrol / Methylprednisolone**
Dose	**250 mg**	**5,000 units**	**75 ml/hr.**	**75mg**	**60mg**
Frequency	**1 X daily**	**3 X daily**	**Continuous**	**1X daily**	**4X daily (every 6 hours).**
Route	**orally**	**Subcutaneous**	**IV fluids.**	**orally**	**IV push.**
Classification	**Macrolide, antibiotic.**	**Anticoagulant.**	**IV fluids replacement.**	**Thyroid hormone replacement.**	**Glucocorticoid, Corticosteroid.**
Mechanism of action	**Binds to ribosomal subunit o susceptible bacteria, blocking peptide translocation and inhibiting RNA-dependent protein synthesis.**	**Binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin and factors Xa and Xia.**	**Extracellular fluid volume and pressure is controlled.**	**Replaces endogenous thyroid hormone, which may exert its physiological effects by controlling DNA transcription and protein synthesis.**	**Binds to intracellular glucocorticoid receptors and suppresses inflammatory and immune responses by inhibiting accumulation of monocytes and neutrophils at inflammation sites, stabilizing lysosomal membranes, suppressing the antigen response of macrophages and helper T cells, and inhibiting the synthesis of inflammatory response**

					mediators, such as cytokines, interleukins, and prostaglandins.
Reason Client Taking	**The patient is taking azithromycin for acute bacterial exacerbation of COPD.**	**The patient is taking heparin to decrease the risk of embolism and to prevent clots.**	**The patient is receiving IV fluids to try and raise the sodium level.**	**The patient is taking to treat hypothyroidism.**	**The patient is taking this steroid to treat the inflammation in the lungs to help her breathe better.**
Contraindications (2)	**History of cholestatic jaundice or hepatic dysfunction associated with prior use of azithromycin, Hypersensitivity to azithromycin or its components.**	**Severe thrombocytopenia, and uncontrolled active bleeding.**	**Fluid overload, can increase sodium levels too high (Hypernatremia).**	**Acute MI, hypersensitivity to levothyroxine or its components.**	**Fungal infection, idiopathic thrombocytopenic purpura.**
Side Effects/Adverse Reactions (2)	**Seizures, arrythmias.**	**Thrombosis, Asthma.**	**Nausea, vomiting, and diarrhea.**	**Seizures, angioedema.**	**Increased intracranial pressure, adrenal insufficiency.**
Nursing Considerations (2)	**monitor elderly patients closely for arrhythmias because they are more susceptible**	**Avoid injecting any drugs by I.M. route during heparin therapy, to decrease the risk of bleeding.**	**Do not administer fluid that is cloudy (make sure it is clear), monitor the patient's IV site to make**	**Be aware that Levothyroxine is not to be used for treatment of obesity or for weight loss.**	**Administer with extreme caution in patients with recent myocardial infarction because the steroid can**

	to drug effects on the QT interval. Give 1 hour before or 2-3 hours after food.	**Alternate injection sites and watch for signs of bleeding and hematoma.**	**sure it has not blown or become infiltrated.**	**Use Levothyroxine cautiously in the elderly and patients with underlying cardiovascular disease.**	**increase the risk of left ventricle free wall rupture. Discard parenteral products that are discolored or contain particles.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Assess the patient for bacterial or fungal superinfection which can occur with prolonged or repeated therapy. Monitor bowel elimination and be aware that laboratory abnormalities can occur.**	**Check hematocrit and platelet count before and during heparin therapy.**	**Assess labs before administering fluids to achieve a baseline. Assess labs during fluid replacement therapy to make sure a therapeutic level is being achieved.**	**Monitor blood glucose levels, PT time if the patient is taking anticoagulant (which the patient is taking) and monitor thyroid function tests.**	**Assess sodium and potassium levels because the patient needs to be on a low-sodium diet with added potassium. Monitor blood glucose levels and assess for infection.**
Client Teaching needs (2)	**Tell the patient to report signs and symptoms of an allergic reaction (rash, itching, hives, trouble breathing) immediately. Warn**	**Explain that heparin can't be taken orally. Advise patient to wear or carry appropriate medical identification.**	**Teach the client how to recognize symptoms of fluid overload (crackles, edema), teach the client how to recognize that the IV site is infiltrated.**	**Teach the patient that Levothyroxine is replacing a hormone so this will be a lifelong treatment. Instruct the patient to take this drug at least 30 minutes**	**Tell the patient to take a missed dose as soon as they remember unless its nearly time for the next dose. Caution the patient to avoid people with an infectious disease.**

	patient that abdominal pain and loose, watery stools can occur.			**before breakfast because drug absorption is increased on an empty stomach and evening doses may cause insomnia.**	

Medications Reference (1) (APA):

Jones & Bartless Learning. (2020). 2020 Nurse's drug handbook (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient is alert and oriented X4.** **The patient does not appear to be in distress.** **The patient's appearance is normal (well groomed, hair combed, and looks well).**
INTEGUMENTARY (2 points):	**The patient's skin is dry and intact.**

Skin color: **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**The skin is white and warm.** **Normal turgor: 2+** **The patient does not have any rashes, bruises, or wounds.** **Braden score: 21** **No drains present.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**The patients head is symmetrical (midline with no deviations).** **The patient's hair is white with no patches or balding.** **The patient's ears are clear and pink with no drainage.** **The tympanic membrane is visible and is pearly grey.** **PEERLA is present.** **The patient does not have nasal deviation.** **The oral mucosa is pink and moist.** **The patient has dentures and they are at home.** .
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: None.**	**The patient was in normal sinus rhythm.** **S1 and S2 present.** **The patients radial and pedal pulses are palpable.** **There is no peripheral edema.** **Normal capillary refill: less than 3 seconds.** **The patient has no neck vein distension.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The patient's breath sounds are diminished, coarse, and rhonchi/wheezes are heard bilaterally. The patient's breath sounds are also accompanied by a rough cough.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:**	**The patient is on a regular diet at home and a cardiac diet here at the hospital.** **Height: 4'8"** **Weight: 150 pounds** **Normoactive bowel sounds heard in all four quadrants.** **Last BM: last night (2-23-21) around 5:00pm.** **There is no distension, incisions, scars, drains,**

Inspection: **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**or wounds.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**The patient's urine is clear and yellow.** **The patient is voiding regularly.** **The patient reports no pain or trouble with urination.** **The patient's genitals are clean and intact.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**The patient has active ROM bilaterally.** **The patient ambulates to the bathroom and around the room independently without the use of assistive devices.** **The patient was weak upon admission due to the COPD exacerbation, but her strength is increasing.** **The patient is at a slight fall risk because of the decreased strength (it is improving).** **Fall score: 4.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The patients grip strength is equal bilaterally in the upper and lower extremities.** **PERLA is present.** **The patient is oriented and mental status is normal.** **The patient's speech is clear and normal (makes sense).** **No LOC.**
PSYCHOSOCIAL/CULTURAL (2	**The patient is Christian and has a wonderful**

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):**	**support system. She lives with her husband and her sister lives next door. The patient copes with walking, being with her husband, and reading the paper. The patient's developmental level is normal and developed.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:30	**83**	**115/63**	**22**	**98.0**	**95% nasal cannula 2.5 L**
11:20	**66**	**121/66**	**20**	**97.9**	**97% Nasal cannula 2.5 L**

Vital Sign Trends: The patients vital signs are improving! In the morning, her O2 level was 95% and respirations were 22 but later that morning her O2 went up and respirations lowered. Her overall condition seemed to be improving and her vitals supported this.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
08:00	**0-10**	**NA**	**NA**	**NA**	**NA**
10:00	**0-10**	**The back of the head.**	**3**	**Aching.**	**Tylenol was given.**

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:**	22 gauge IV. Located in the right peripheral. Dated 2-23-21 Patency: IV is patent and there is no signs of erythema or drainage. IV dressing is intact and no sign of infiltration. IV fluid rate: 75ml/hr. The patient is receiving 0.9% sodium chloride for fluid replacement.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
100% of breakfast was consumed. **240ml- beverages from breakfast (coffee and water).** **440ml- (water and orange juice).** **180 ml- ice chips** **150ml IV fluids (from the time I was there)** **Total: 1,010 ml**	**250 ml- urine (08:00)** **300ml- urine (09:30)** **200 ml-urine (11:00)** **Total: 750 ml**

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was admitted to the medical-surgical floor for exacerbation of COPD. Upon admission, the patient's breath sounds were diminished, coarse, and rhonchi/wheezes were heard oxygen at 2.5 liters was placed on the patient. Oxygen improved breathing ability and increased the patient's O2 level (Today, 95 and 97%). The patient has been getting Tylenol every 6 hours as needed for pain. The only pain that the patient has been complaining of is a slight headache (3 on a scale from 0-10) in the

back of the head. The patient is on a cardiac diet. Since the patient's status is improving, discharge is to be expected by tomorrow (2-25-21).

Procedures/testing done: The patient had a Covid-19 test which was negative. The patient had a chest X-ray which confirmed fibrosis from COPD. The patient had an MRI of the brain which indicated no masses.

Complaints/Issues: The patient's complaint was shortness of breath and a slight headache.

Vital signs (stable/unstable): The patients vital signs were stable and within normal limits.

Tolerating diet, activity, etc.: The patient is tolerating a cardiac diet and is independent.

Physician notifications: There were no specific physician notifications. The physician came into the patient's room hoping to be able to plan discharge within 24 hours.

Future plans for patient: The patients lung status/function will continue to be monitored with the plan for the patient to go home.

Discharge Planning (2 points)

Discharge location: The patient will be going home with her husband after discharge.

Home health needs (if applicable): The patient does not need any home health.

Equipment needs (if applicable): The patient does not need any assistive equipment. An incentive spirometer will be sent home to exercise her lungs.

Follow up plan: The patient will need to follow up with her primary care provider to discuss her COPD and interventions.

Education needs: The patient needs to be educated on smoking cessation. Smoking can increase the risk of COPD exacerbation. The patient also needs to be educated on how to use the incentive spirometer.

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. Ineffective airway clearance related to COPD exacerbation as evidence by statement of trouble breathing.	**The patient came into the emergency department complaining of shortness of breath.**	**1.Position the patient in a semi-fowlers or high fowlers position to facilitate breathing.** **2.Administer bronchodilators as prescribed.**	**1.The goal of this nursing intervention was to facilitate breathing to make breathing easier for the patient. The patient was willing to follow this intervention and the outcome was positive. She was able to breath easier and was more comfortable.** **2.The goal of this nursing intervention was to open the patient's airway. The patient was willing to follow this intervention and felt relief after using the inhaler.**
2. Impaired gas exchange related to COPD as evidence by altered oxygen supply (O2 stat).	**The patients O2 was low on admission and is short of breath.**	**1. Encourage exportation of secretions.** **2.Provide oxygen as ordered.**	**1.The goal of this intervention was to clear out the lungs of blockage (from sputum). The patient was willing to try and cough the sputum up and out. The patient did follow through with this intervention and it helped facilitate breathing.**

			2. The goal of this intervention was to increase the patients O2 saturation level. The patient was willing to use oxygen via nasal cannula. The patients O2 saturation was improving (97% at 11:00am).
3. Risk for infection related to COPD exacerbation as evidence by weakened immune system and chronic disease.	**The patient has COPD which is a chronic disease that causes the patients immune system and lungs to be impaired. This increases the risk of infection.**	**1.Encourage a balance between activity and rest.** **2Discuss the need for adequate nutrition.**	**1.The goal of this intervention is for the patient to exercise and improve lung function while promoting healing. The patient was willing to ambulate around the room and wanted to go back to her daily activities. The outcome of this was positive. The patient was feeling stronger and breathing was improving.** **2. Adequate nutrition and fluid intake can decrease the patient's risk for infection. Fluids can also help mucus to loosen and make it easier for the patient to expel. The patient was willing to maintain nutrition and drink fluids. The outcome of increasing fluids and following a healthy diet was positive considering the patients condition is improving.**
4. Risk of activity intolerance related to COPD as evidence by COPD exacerbation	**The patient is experiencing shortness of breath and this may increase activity intolerance now**	**1.Encourage activity with rest.** **2. Encourage smoking cessation and adhering to the medication**	**1.The goal of this intervention is to continue activity and rest in between to increase strength and decrease the risk of activity intolerance. The**

causing shortness of breath.	**and in the future.**	**regimen.**	**patient was willing to exercise at home (walking around her neighborhood). The outcome was achieved. The patient started ambulating in the room and was feeling stronger. 2. The goal of taking medication and smoking cessation is to improve overall lung function and manage the patient's condition. The patient was willing to try and stop smoking. The patient is also willing to take all medications as prescribed. The outcome is yet to be determined on the smoking cessation portion, but the patient does take all medications as prescribed.**

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2020). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*****. St. Louis, MO: Elsevier.**

Concept Map (20 Points):

Subjective Data

The patient stated, "I came into the emergency department Sunday afternoon because I could hardly catch my breath".
The patient also stated, "Since I've been here, my breathing has improved, and I feel much better".
The patient rated her pain a 3 on a 0-10 scale.
The patient stated, "I am willing to try and stop smoking to improve my lung function".

Objective Data

Vital signs: Temperature: 98.0. RR: 22 BP: 115/63 O2: 95% Pulse: 83.
The patient looks well. She is up, eating breakfast, and walking around the room (independently). The patient's lung sounds are still coarse, and wheezes/rhonchi is heard, but they sound better since admission. The patient is talkative and ready to go home.

Patient Information

The patient is a 79-year-old female who came into the emergency department with shortness of breath. On 2-22-21 the patient was admitted to OSF in Danville. The patient has COPD and was diagnosed with COPD exacerbation. The patient is on 2.5 L of oxygen.

Nursing Diagnosis/Outcomes

1. **Ineffective airway clearance related to COPD exacerbation as evidence by statement of trouble breathing. Outcome: The goal of this nursing intervention was to open the patient's airway. The patient was willing to follow this intervention and felt relief after using the inhaler. the outcome was positive. She was able to breathe easier and was more comfortable.**
2. **Impaired gas exchange related to COPD as evidence by altered oxygen supply (O2 stat). Outcome: The patient did follow through with this intervention and it helped facilitate breathing. The patient was willing to use oxygen via nasal cannula. The patients O2 saturation was improving (97% at 11:00am).**
3. **Risk for infection related to COPD exacerbation as evidence by weakened immune system and chronic disease. Outcome: The patient was willing to ambulate around the room and wanted to go back to her daily activities. The outcome of this was positive. The patient was feeling stronger and breathing was improving. The outcome of increasing fluids and following a healthy diet was positive considering the patient's condition is improving.**
4. **Risk of activity intolerance related to COPD as evidence by COPD exacerbation causing shortness of breath. Outcome: The outcome was achieved. The patient started ambulating in the room and was feeling stronger. The outcome is yet to be determined on the smoking cessation portion, but the patient does take all medications as prescribed.**

Nursing Interventions

1. **Position the patient in a semi-fowlers or high fowlers position to facilitate breathing. 2.Administer bronchodilators as prescribed.**
2. **Encourage exportation of secretions.**
   2. Provide oxygen as ordered.
   3. Encourage a balance between activity and rest.2. Discuss the need for adequate nutrition.
   4. Encourage activity with rest.

   2. Encourage smoking cessation and adhering to the medication regimen.