N441 Care Plan

Lakeview College of Nursing

Hannah Johnson

Demographics (3 points)

Date of Admission 02/06/2021	**Patient Initials** K.K.	**Age** 72 years old	**Gender** Male
Race/Ethnicity African American	**Occupation** Retired Welder	**Marital Status** Widowed	**Allergies** NKDA
Code Status DNI/DNR	**Height** 5'9"	**Weight** 146 lbs. (66.4 kg)	

Medical History (5 Points)

Past Medical History: Hypertension, Atrial Fibrillation, Hyperlipidemia, COPD

Past Surgical History: Appendectomy in 1995

Family History: Mother: Diabetes Mellitus, Brother: Diabetes Mellitus, Father: MI

Social History (tobacco/alcohol/drugs): Current smoker (1 pack per day for the past 50 years), Casual drinker (1-2 times per month), never uses drugs.

Assistive Devices: No assistive devices.

Living Situation: Patient lives at home alone.

Education Level: High school diploma.

Admission Assessment

Chief Complaint (2 points): Shortness of breath, cough

History of present Illness (10 points): Patient was admitted to the hospital on 02/06/2021 after he was experiencing shortness of breath and a cough for several days. He stated that his activity levels have declined over the last several days due to the shortness of breath. Patient states exertion aggravates the shortness of breath and rest periods alleviate the shortness of breath along with patients PRN oxygen at 2L/min. Patient is a current smoker of 1 ppd for the last 50 years. He has a history of Hypertension, Atrial Fibrillation, Hyperlipidemia and COPD.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): COPD exacerbation

Secondary Diagnosis (if applicable): Acute respiratory failure

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

"Chronic obstructive pulmonary disease (COPD) is a preventable and treatable slowly progressive respiratory disease of airflow obstruction involving the airways, pulmonary parenchyma, or both. The parenchyma includes any form of lung tissue, including bronchioles, bronchi, blood vessels, interstitium, and alveoli. The airflow limitation or obstruction in COPD is not fully reversible. Most patients with COPD present with overlapping signs and symptoms of emphysema and chronic bronchitis, which are two distinct disease processes" (Hinkle & Cheever, 2018, p. 634). "Airflow limitation is progressive and associated with abnormal inflammatory response of the lungs to noxious particles or gases and characterized by chronic inflammation throughout the airways, parenchyma, and pulmonary vasculature. The Chronic airflow limitation characteristic of COPD is caused by a mixture of small airway inflammation (bronchitis) and parenchymal destruction (emphysema), the relative contributions of each varying from person to person" (Swearingen, 2016, p. 111).

"Common symptoms associated with chronic COPD include dyspnea, chronic cough, and chronic sputum production. Dyspnea that interferes with daily activities is the main reason patients seek medical attention. Environmental exposure is the most common cause of COPD. Cigarette smoking, or passive exposure to cigarette smoke, is the most commonly encountered risk factor. Chronic occupational exposure to dust or volatile gases is an important risk factor.

Indoor air pollutants, especially from burning biomass fuels in confined spaces" (Swearingen, 2016, p. 111).

There are many diagnostic tests used to determine COPD. Spirometry is used when all of the common symptoms of chronic COPD are present. Pulse oximetry for normal COPD patients is about 88-92%. Chest x-ray could be used to determine if the patient has chronic bronchitis. Arterial blood gasses are drawn, and they use these to monitor a COPD exacerbation (Swearingen, 2016). Some labs you would see is a decreased pH, increased PaCO2 when arterial blood gases are drawn.

Treatment can vary from each patient we see. "Bronchodilators are key for symptom management in stable COPD. Inhaled therapy is preferred, and the vidual response in terms of symptom relief and side effects. Inhaled therapy may be prescribed on an as needed or regular basis to reduce symptoms. Although inhaled and systemic corticosteroids may improve the symptoms of COPD, they do not slow the decline in lung function. Their effects are less dramatic than in asthma. A short trial course of oral corticosteroids may be prescribed for patients to determine whether pulmonary function improves, and symptoms decrease" (Hinkle & Cheever, 2018, p.640). "Oxygen therapy can be given as long-term continuous therapy, during exercise, or to prevent acute dyspnea during an exacerbation. The goal of supplemental oxygen therapy is to increase the baseline resting partial pressure of arterial oxygen" (Hinkle & Cheever, 2018, p.643).

My patient was intubated during his time at the hospital and upon discharge will need oxygen therapy all the time. He will go home on 2L/min via nasal cannula. He had a chest x-ray done these findings were indicative of chronic bronchitis. He also had his ABGs drawn which showed signs of respiratory acidosis. His admitting diagnosis was SOB and a cough. The patient

was put on IV antibiotics due to his COPD exacerbation; he was also given a potassium supplement due to his low potassium levels. Due to acute respiratory distress my patient was also intubated as well.

Pathophysiology References (2) (APA):

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing.* (14th ed.). Wolters Kluwer.

Swearingen, P.L. (2016). *All-in-one care planning resource: medical-surgical, pediatric, maternity & psychiatric nursing care plans.* Elsevier/Mosby.

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: 4.5-5 M: 4.5-6	N/A	N/A	N/A
Hgb	F: 12-15 M: 14-16	13.6	13.6	Could be related to patient's chronic COPD. Anemia is often associated with chronic disease. (Van & Mickey Lynn Bladh, 2017)
Hct	F: 42-52 M: 35-47	N/A	N/A	N/A
Platelets	150,000-400,00	N/A	N/A	N/A
WBC	4,500-11,000	9.4	9.4	N/A
Neutrophils	45-75%	N/A	N/A	N/A
Lymphocytes	20-40%	N/A	N/A	N/A
Monocytes	1-10%	N/A	N/A	N/A
Eosinophils	<7%	N/A	N/A	N/A
Bands	<1%	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	124	124	Hyponatremia could be related to an insufficient intake of salt in the patient's diet. (Van & Mickey Lynn Bladh, 2017)
K+	3.5-5.0	2.8	2.8	Hypokalemia could be related to patient's hypertension medications. Some hypertension medications may result in loss of potassium. (Van & Mickey Lynn Bladh, 2017)
Cl-	97-107	N/A	N/A	N/A
CO2	20-30	N/A	N/A	N/A
Glucose	70-110	94	94	N/A
BUN	10-20	24	24	High Bun levels could be related to an undiagnosed AKI which is related to the decreased renal excretion. (Van & Mickey Lynn Bladh, 2017)
Creatinine	0.7-1.4	2.8	2.8	High creatinine levels could happen due to if the patient is dehydrated or if there is an undiagnosed AKI (Van & Mickey Lynn Bladh, 2017)
Albumin	3.5-5	N/A	N/A	N/A
Calcium	8.6-10.2	N/A	N/A	N/A
Mag	1.3-2.1	N/A	N/A	N/A
Phosphate	2.5-4.5	N/A	N/A	N/A
Bilirubin	0.3-1	N/A	N/A	N/A
Alk Phos	30-120	N/A	N/A	N/A
AST	0-35	N/A	N/A	N/A

ALT	4-36	N/A	N/A	N/A
Amylase	30-220	N/A	N/A	N/A
Lipase	0-160	N/A	N/A	N/A
Lactic Acid	0.5-1	N/A	N/A	N/A
Troponin	0-0.04	N/A	N/A	N/A
CK-MB	5-25	N/A	N/A	N/A
Total CK	22-198	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.8-1.1	N/A	N/A	N/A
PT	11-12.5	N/A	N/A	N/A
PTT	30-40	N/A	N/A	N/A
D-Dimer	<0.4	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A
HDL	>60	N/A	N/A	N/A
LDL	<130	N/A	N/A	N/A
Cholesterol	<200	N/A	N/A	N/A
Triglycerides	<150	N/A	N/A	N/A
Hgb A1c	4-5.9%	N/A	N/A	N/A
TSH	0.4-4.0	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow and Clear	N/A	N/A	N/A
pH	5.0-8.0	N/A	N/A	N/A
Specific Gravity	1.005-1.035	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	<5	N/A	N/A	N/A
RBC	0-3	N/A	N/A	N/A
Leukoesterase	Negative	N/A	N/A	N/A

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	7.25	7.25	The patient's pH levels could be low due to his COPD exacerbation which is a result of respiratory acidosis. (Van & Mickey Lynn Bladh, 2017)
PaO2	80-100	91	91	N/A

	mmHg			
PaCO2	35-45 mmHg	84	84	The patient's $PaCO_2$ levels are elevated due to his COPD exacerbation. This is a result of respiratory acidosis. (Van & Mickey Bladh, 2017)
HCO3	22-26 mEq/ L	24	24	N/A
SaO2	95-100%	N/A	N/A	N/A

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (APA):

Van, A. M., & Mickey Lynn Bladh. (2017). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implications.* F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient's Chest x-ray shows findings consistent with chronic bronchitis. Patients EKG shows A. Fib at a rate of 88 bpm.

Diagnostic Test Correlation (5 points): A chest x-ray was performed for the patient's initial complaint of SOB. Chest radiography, commonly called chest x-ray, is one of the most frequently performed diagnostic imaging studies. This study yields information about the pulmonary, cardiac, and skeletal systems. The lungs, filled with air, are easily penetrated by x-rays and appear black on chest images. A routine chest x-ray includes a posteroanterior projection, in which x-rays pass from the posterior to the anterior, and a left lateral projection. (Van & Mickey Lynn Bladh, 2017) The patient's chest x-ray showed findings consistent with chronic bronchitis. An EKG was performed due to the patients underlying atrial fibrillation. An EKG is used to evaluate the electrical impulses generated by the heart during the cardiac cycle to assist with diagnosis of cardiac dysrhythmias, blocks, damage, infection or enlargement. (Van & Mickey Lynn Bladh, 2017) The EKG shows the patient remains in atrial fibrillation and has a heart rate of 88 bpm.

Diagnostic Test Reference (APA):

Van, A. M., & Mickey Lynn Bladh. (2017). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implications.* 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	lisinopril (Zestril)	Amiodarone (Cordarone)	Aspirin (acetylsalicylic acid)	atorvastatin (Lipitor	metoprolol (Lopressor)
Dose	40 mg	200 mg	81 mg	40 mg	50 mg

Frequency	Daily	Daily	Daily	Daily at HS	BID
Route	PO	PO	PO	PO	PO
Classification	Antihypertensive, vasodilator	Class III antiarrhythmic	Anti-inflammatory, Antiplatelet	Antihyperlipidemic	Antihypertensive
Mechanism of Action	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II is a potent vasoconstrictor that also stimulated adrenal cortex to secrete aldosterone. Lisinopril may also inhibit renal and vascular production of angiotensin II. Decreased release of aldosterone reduces sodium and water reabsorption and increases their excretion, thereby reducing blood pressure.	Acts on cardiac cell membrane, prolonging repolarization and the refractory period and raising ventricular fibrillation threshold. Drug relaxes vascular smooth muscles, mainly in coronary circulation, and improves myocardial blood flow. It relaxes peripheral vascular smooth muscles, decreasing peripheral vascular resistance and myocardial oxygen consumption.	Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis. Prostaglandins, important mediators in the inflammatory response, cause local vasodilation with swelling and pain. With blocking of cyclooxygenase and inhibition of prostaglandins, inflammatory symptoms subside.	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown.	Inhibits stimulation of $beta_1$-receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand. These effects help relieve angina, minimize cardiac tissue damage from a myocardial infarction, and help relieve symptoms of heart failure. Metoprolol also helps reduce blood pressure by decreasing renal release of renin.

Reason Client Taking	Hypertension	Atrial Fibrillation	Prevent clotting, and to prevent MI.	Hyperlipidemia	Antihypertensive
Contraindications (2)	Patients with renal impairment, history of angioedema related to previous treatment	Bradycardia that causes syncope, hypomagnesemia	Asthma, bleeding problems.	Active hepatic disease, breastfeeding, and unexplained persistent rise in serum transaminase level	Acute heart failure, cardiogenic shock, and pulse less than 45 bpm
Side Effects/ Adverse Reactions (2)	Arrhythmias, confusion, acute renal failure.	Abnormal gait, acute renal failure, aplastic or hemolytic anemia.	Decreased blood iron level, bronchospasm, and diarrhea.	Arrythmias, anemia, and hyperglycemia.	Anxiety, confusion, constipation, and bronchospasm.
Nursing Considerations (2)	Use lisinopril cautiously in patients with fluid volume deficit, heart failure, impaired renal function, or sodium depletion. Be aware that lisinopril should not be given to a patient who is hemodynamically unstable after an acute MI.	Monitor vital signs and oxygen levels often. Check patient's implantable cardiac device (if present), as ordered, at the start of and during amiodarone therapy because drug may affect pacing or defibrillating threshold.	Don't crush timed-release or controlled-release aspirin tables unless directed. Ask about tinnitus. This reaction usually occurs when blood aspirin level reaches or exceeds maximum dosage for therapeutic effect.	Know that atorvastatin is used in patients with homozygous familial hypercholesterolemia as an adjunct to other lipid-lowering treatments or alone only if other treatments aren't available. Expect to measure lipid levels 2 to 4 weeks after therapy starts, to adjust dosage as directed, and to repeat periodically until lipid levels are within desired range.	Before starting therapy for heart failure, expect to give an ACE inhibitor, digoxin, and a diuretic to stabilize patient. If patient with heart failure develops symptomatic bradycardia, expect to decrease the metoprolol dosage.

Key Nursing Assessment(s) Prior to Administration	Monitor serum creatinine, blood pressure, and potassium.	Monitor oxygen and vital signs, serum amiodarone, monitor liver enzymes and thyroid hormone levels.	Clotting factors	Lipid levels, and liver function tests.	ECG and blood pressure.
Client Teaching needs (2)	Explain that lisinopril helps to control but doesn't cure hypertension and that patient may need lifelong therapy. Advise patient to take at the same time every day.	Explain that the patient will need frequent monitoring and laboratory tests during treatment. Instruct patient to report abnormal bleeding or bruising.	Instruct patient to take aspirin with food or after meals because it may cause GI upset if taken on an empty stomach. Tell patient to consult prescriber before taking aspirin with any prescription drug for blood disorder, diabetes, gout, or arthritis.	Emphasize that atorvastatin is an adjunct to- not a substitute for-a low-cholesterol diet. Tell patient to take drug at the same time each day to maintain its effects.	Advise patient to notify prescriber if pulse rate falls below 60 beats/minute or is significantly lower than usual. Caution patient to not stop abruptly.

Hospital Medications (5 required)

Brand/Generic	azithromycin	Levaquin (levofloxacin)	Potassium Chloride (K-	acetaminophen (Tylenol)	Docusate (Colace)

	(Zithromax)		lyte)		
Dose	500 mg	750 mg	40 mEq	650 mg	100 mg
Frequency	Daily	Daily	Once	Q6H PRN	BID PRN
Route	PO	IV	IV	PO	PO
Classification	Antibiotic	Antibiotic	Electrolyte replacement	Nonopioid analgesic	Laxative; stool softener
Mechanism of Action	Binds to a ribosomal subunit of susceptible bacteria, blocking peptide translocation and inhibiting RNA-dependent protein synthesis. Drug concentrates in phagocytes, macrophages, and fibroblasts, which release it slowly and may help move it to infection sites.	Interferes with bacterial cell replication by inhibiting the bacterial enzyme DNA gyrase, which is essential for repair and replication of bacterial DNA.	Acts as the major cation in intracellular fluid, activating many enzymatic reactions essential for physiologic processes, including nerve impulse transmission and cardiac and skeletal muscle contraction. Potassium also helps maintain electroneutrality in cells by controlling exchange of intracellular and extracellular ions. It also helps maintain normal renal function and	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E_2.	Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces. This action lets more fluid penetrate stool, forming a softer fecal mass.

			acid-base balance.		
Reason Client Taking	COPD exacerbation	COPD exacerbation	Low potassium levels	Pain management/fever	Constipation
Contraindications (2)	History of cholestatic jaundice or hepatic dysfunction associated with prior use.	Hypersensitivity to levofloxacin, other fluoroquinolones, or their components and myasthenia gravis.	Acute dehydration, crush syndrome, and peptic ulcer disease.	Hypersensitivity to acetaminophen or its components, severe hepatic impairment, severe active liver disease	Fecal impaction, intestinal obstruction, and undiagnosed abdominal pain
Side Effects/Adverse Reactions (2)	Arrhythmias, allergic reaction, and aggressiveness.	Acute renal failure, arrhythmias, and CNS stimulation.	Confusion, arrhythmias, and dyspnea**.**	Abdominal pain, anaphylaxis, and hypoglycemic coma.	Dizziness, palpitations, and abdominal cramps
Nursing Considerations (2)	Monitor elderly patients closely for arrhythmias because they are more susceptible to drug effects on the QT interval. Assess patient for bacterial or fungal superinfection, which may occur with prolonged or repeated therapy. If it occurs,	Use levofloxacin cautiously in patients with renal insufficiency. Use drug cautiously in patients with CNS disorders, such as epilepsy, that may lower the seizure threshold. Also use cautiously in patients taking corticosteroids, especially elderly patients, because of	Regularly assess patient for signs of hypokalemia, such as arrhythmias, fatigue and weakness, and for signs of hyperkalemia, such as arrhythmias, confusion, dyspnea, and paresthesia. Infuse potassium slowly to avoid phlebitis and decrease risk of adverse cardiac	Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment. Monitor renal function in patient on long term therapy.	Asses for laxative abuse syndrome, especially in women with anorexia nervosa, depression, or personality disorders. Expect long-term or excessive use of docusate to cause dependence on laxatives for bowel

	expect to give another antibiotic or antifungal.	increased risk of tendon rupture.	reactions.		movements, electrolyte imbalances, osteomalacia, steatorrhea, and vitamin and mineral deficiencies.
Key Nursing Assessment(s) Prior to Administration	Renal function, culture and sensitivity, liver enzymes, and cardiac function.	Renal function, culture and sensitivity, cardiac function, and glucose levels.	Potassium levels, and renal function	Renal and liver function	Fecal impaction
Client Teaching needs (2)	Tell patient to take azithromycin capsules 1 hour before or 2 to 3 hours after food. Instruct patient to take tablets or suspension without regard to food. Teach patient to watch for and immediately report signs	Tell patient to tell prescriber about severe diarrhea, even if it's more than 2 months after drug therapy ends. Additional treatment may be needed. Advise patient to notify prescriber about heart palpitations or loss of consciousness.	Inform patient that potassium is part of a normal diet and that most meats, seafoods, fruits and vegetables contain sufficient potassium to meet recommended daily intake. Advise patient to watch stools for changes in color and	Tell patient that tablets may be crushed or swallowed whole. Teach patients to recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic overdose.	Tell patient not to use docusate when she has abdominal pain, nausea, and vomiting. Advise patient to take docusate with a full glass of water or milk.

	of superinfection, such as white patches in mouth.		consistency and to notify prescriber if they become black, tarry, or red.		

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2018 Nurse's drug handbook* (17th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Unable to assess patient is intubated/sedated.
INTEGUMENTARY (2 points): **Skin color:** Pink **Character:** Dry, warm **Temperature:** 36.8 degrees Celsius **Turgor:** Elastic **Rashes:** None present **Bruises:** None present **Wounds:** None present **Braden Score:** 16 **Drains present: Y☐ N ☒** **Type:** N/A	Skin is pink, dry and warm. Patient has a temperature of 36.8 degrees Celsius. Patients skin turgor is elastic. Patient has no sign of rashes, bruises or wounds. Patient has a Braden score of 16 and has no drains present.

HEENT (1 point): **Head/Neck:** Normophiliac, Trachea is midline **Ears:** Pearly gray tympanic membrane **Eyes:** Equal, round, reactive and accommodating to light. **Nose:** Midline **Teeth:** Patient has all teeth and they are clean.	Head is normophiliac. Trachea is midline. Ears have a pearly gray tympanic membrane. Patients eyes are equal, round, reactive and accommodate to light. Nose is midline, shows no signs of polyps. Oral mucosa is pink and moist. Patient has all teeth and they are clean. .
CARDIOVASCULAR (2 points): **Heart sounds:** S1, S2 noted. **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Atrial Fibrillation **Peripheral Pulses:** Pedal pulses 2+ **Capillary refill:** Less than 3 seconds. **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** N/A	Patient's heart sounds are normal. S1 and S2 noted. Patient has atrial fibrillation with a heart rate of 88 bpm. Pedal pulses were 2+ bilaterally. Capillary refill less than 3 seconds. Patient shows no signs of Neck Vein Distention or Edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** 8 **Placement (cm to lip):** 25 **Respiration rate:** 20 **FiO2:** 50% **Total volume (TV):** 400 **PEEP:** 10 **VAP prevention measures:** Oral care done Q2H, and frequent hand washing.	Patient has bilateral wheezes and diminished breath sounds that were auscultated anteriorly and posteriorly. Middle lobe auscultated; diminished breath sounds present. Patient has a size 8 ET tube. Placement is at 25 cm. RR is set at 20, FiO2 is 50%, TV is 400, and PEEP is 10.
GASTROINTESTINAL (2 points): **Diet at home:** Heart-Healthy **Current Diet:** NPO **Height:** 5' 9" **Weight:** 146 lbs. **Auscultation Bowel sounds:** Present **Last BM:** 2/05/2021 @ 2100 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** N/A **Incisions:** N/A	Patient's current diet is NPO due to intubation. Patient's diet at home is heart healthy. Patient is 5' 9" and weighs 146 lbs. Bowel sounds were active and present in all 4 quadrants. Patients last bowel movement was on 2/05/2021 at 2100. There are no signs of distention, incisions, scars, drains, or wounds. Patient has no ostomy or feeding tubes. Patient has a 16F NG tube hooked up to LIS.

Scars: N/A **Drains:** N/A **Wounds:** N/A **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☒ N ☐** **Size:** 16 F, hooked to LIS **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** N/A	
GENITOURINARY (2 Points): **Color:** Clear/yellow **Character:** Odorless **Quantity of urine:** 1750 mL in 4 hours **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** N/A **Size:** N/A **CAUTI prevention measures:** Proper perineal care needs to be done.	Patients urine is clear and yellow with no odor. Patient has voided 1750 mL in four hours. There is no pain upon urination. The patient is no on dialysis and does not have a catheter inserted. Patients genitals show no signs of irritation.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 50 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☒ **Needs support to stand and walk**☒	Unable to assess patient is intubated/sedated.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Unable to assess patient is intubated/sedated.
PSYCHOSOCIAL/CULTURAL (2 points):	Patients daughter is at bedside, she is asking questions. Patient is unable to ask questions due

Coping method(s): **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	to intubation.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	88	152/68	24	36.5	98% on mechanical ventilator – FiO2 50%
1100	68	136/62	24	36.8	97% on mechanical ventilator – FiO2 50%

Vital Sign Trends/Correlation: Patient's pulses were within normal limits. Patient's blood pressure which could be due to his hypertension, once patient's lisinopril and metoprolol the blood pressure decreased. Patients respirations are high which could be related to patients SOB upon admission. Patients temperature is within normal limits. Patients oxygen saturation is within normal limits, he is on PRN oxygen at 2L/min.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	FLACC	Generalized pain	6/10	Dull pain	Tylenol Administered
1100	FLACC	Generalized pain	2/10	Dull pain	No intervention

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20G/18G **Location of IV:** Left AC, right hand **Date on IV:** 2/26/2021, 2/27/2021 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No signs of erythema or drainage. **IV dressing assessment:** Patent, clean, and dry.	Fluid type/rate
Other Lines (PICC, Port, central line, etc.)	
Type: N/A **Size:** N/A **Location:** N/A **Date of insertion:** N/A **Patency:** N/A **Signs of erythema, drainage, etc.:** N/A **Dressing assessment:** N/A **Date on dressing:** N/A **CUROS caps in place: Y ☐ N ☒** **CLABSI prevention measures:** Perform hand hygiene and your appropriate skin antiseptics.	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600 mL 2 mcg/kg/min of Levophed	1750 mL Stool x2 NG output 200 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was originally admitted due to SOB. He was brought to the CCU and was then later intubated. He was put on an NPO diet.

Procedures/testing done: Patient had labs drawn, a chest x-ray, and an EKG. He also had an ET tube inserted.

Complaints/Issues: Patient had no complaints or issues during this clinical time.

Vital signs (stable/unstable): Oxygen, pulse, and temperature all within normal limits. Patients respiratory rate and blood pressure are a little high.

Tolerating diet, activity, etc.: Patient is on NPO diet due to intubation.

Physician notifications: Physician monitored the patient during this time.

Future plans for patient: Patient to follow up with PCP upon discharge and contact home health agencies.

Discharge Planning (2 points)

Discharge location: Patient denied a rehab facility, patient will be going back to living at home alone.

Home health needs (if applicable): Patient requested visiting nurses and bath aid prior to intubation.

Equipment needs (if applicable): Patient will need oxygen equipment.

Follow up plan: Patient to follow up with primary care provider 1 week following their discharge, and to also follow up with a home health agency who provides visiting nurses and bath aids.

Education needs: Education needed for this patient includes smoking cessation, reteaching them a heart-healthy diet, and at home oxygen use protocols.

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 increased mucosal edema as evidenced by suctioning	The patient had increased mucus production.	**1.** Assess respiratory status, LOC, and breath sounds. **2.** Assess RR, HR, and O2 saturation.	Patient responded well. Patient was intubated. Patients O2 saturation and HR were within normal limits. Patients RR was a little high. Patients breath sounds were diminished

secretions.			bilaterally.
2. Impaired gas exchange related to altered oxygen supply as evidenced by supplemental oxygen administration.	This was chosen because the patients SOB and the needing of supplemental O2.	**1.** Monitor pulse oximetry readings to maintain a level above 92%. **2.**Assess for signs and symptoms of hypoxia and report significant findings.	The goal is for this patient's oxygen saturation to remain above 92% and to report signs of hypoxia. The patient responded well to the interventions.
3. Activity intolerance related to imbalanced oxygen supply as evidenced by the decline is his activity levels.	This was chosen upon admission, because the patient stated before intubation, he was having difficulty completing activities.	**1.** Assist with ROM exercises. **2.** Request consultation from pulmonary rehabilitation.	Patient responded well when PROM exercises were performed. Upon discharge we will notify the client that he may benefit from pulmonary rehabilitation.
4. Fluid volume deficit related to insensible loss as evidenced by patient's NPO diet.	Patient is on an NPO diet after intubation. No intake after intubation was established.	**1.** Assess temperature Q4H. **2.** Assess intake and output Q2-Q4H.	Patients temperature was within normal limits. Patients output was 1750 mL during the clinical time, and a 200 mL output from his NG. He also had a BM twice.
5. At risk for aspiration related to intubation as evidenced by Endotracheal tube insertion.	Patient had endotracheal tube inserted upon admission to the CCU.	**1.** Elevate head of bed. **2.** Suction and perform oral care on the patient frequently.	Patients head of the bed is elevated 30 degrees. Patient is suctioned and oral care is performed every 2 hours.

Other References (APA):

Swearingen, P. L. (2016). *All-in-one care planning resource: Medical-surgical, pediatric, maternity & psychiatric nursing care plans.* Elsevier/Mosby.

Concept Map (20 Points):

Subjective Data

Patient came into the hospital for SOB and a cough. He states he is a smoker of 1 pack per day for the last 50 years. He is a casual drinker of 1-2 drinks per month, he denies other drug use.

Nursing Diagnosis/Outcomes

Ineffective airway clearance related to increased mucosal edema as evidenced by suctioning secretions. Outcome: Patient responded well. Patient was intubated. Patients O2 saturation and HR were within normal limits. Patients RR was a little high. Patients breath sounds were diminished bilaterally.
Impaired gas exchange related to altered oxygen supply as evidenced by supplemental oxygen administration. Outcome: The goal is for this patient's oxygen saturation to remain above 92% and to report signs of hypoxia. The patient responded well to the interventions.
Activity intolerance related to imbalanced oxygen supply as evidenced by the decline is his activity levels. Outcome: Patient responded well when PROM exercises were performed. Upon discharge we will notify the client that he may benefit from pulmonary rehabilitation.
Fluid volume deficit related to insensible loss as evidenced by patient's NPO diet. Outcome: Patients temperature was within normal limits. Patients output was 1750 mL during the clinical time, and a 200 mL output from his NG. He also had a BM twice.
At risk for aspiration related to intubation as evidenced by Endotracheal tube insertion. Outcome: Patients head of the bed is elevated 30 degrees. Patient is suctioned and oral care is performed every 2 hours.

Objective Data

Patient has wheezes and diminished breath sounds anteriorly and posteriorly. Patient has been using his PRN O2 2L/min via nasal cannula to help reelevate his symptoms. His labs show he has a decreased potassium, Hgb, and sodium levels. He has an increased creatinine and BUN level. His ABG also showed a decreased pH and an increased PaCO2 level. He has a history of hypertension, hyperlipidemia, atrial fibrillation and COPD. Patient is also intubated on physical examination, he is on a Propofol drip of 2 mcg/kg/min.

Patient Information

K.K is a 72-year-old male who came into the hospital complaining of SOB and a cough. He states his activity slowly started to decrease over several days. He has PRN oxygen at 2L/min via nasal cannula. He has a history of Hypertension, Hyperlipidemia, Atrial Fibrillation, and COPD. He is a current smoker of 1 ppd for the last 50 years. He was intubated upon admission to the hospital.

Nursing Interventions

Assess respiratory status, LOC, and breath sounds.
Assess RR, HR, and O2 saturation.

Monitor pulse oximetry readings to maintain a level above 92%.
ssess for signs and symptoms of hypoxia and report significant findings.

ssist with ROM exercises
equest consultation from pulmonary rehabilitation.

Assess temperature Q4H.
Assess intake and output Q2-Q4H.

Elevate head of bed.
Suction and perform oral care on the patient frequently