N311 Care Plan # 1

Lakeview College of Nursing

Cheyenne Gardner

Demographics (5 points)

Date of Admission 2/25/2021	**Patient Initials** C.S.	**Age** 63	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Courthouse	**Marital Status** Married	**Allergies** Vancomycin, Hcl, Rituximab
Code Status Full code (has ACP doc)	**Height** 5'9" (175.25 cm)	**Weight** 79.4 kg (175 lb)	

Medical History (5 Points)

Past Medical History: Client has a history of Thrombocytopenia, Seasonal allergies, Pneumonia, Pancytopenia, Mediastinal Lymphadenopathy, Macrocytic Anemia, Hypoatremia, CLL, ARDS.

Past Surgical History: Client had a Bronchoscopy on 02/12/21.

Family History: Client's mother had congenital heart failure. Client's father had lung cancer.

Social History (tobacco/alcohol/drugs): No history of tobacco, or drug use. Alcohol use, 3.6 oz per week about 6 cans.

Admission Assessment

Chief Complaint (2 points): Shortness of breath and dry cough

History of present Illness (10 points): Client is a 63 year old Cauasian male and was first admitted to the hospital on 02/12/21 due to Covid-19. Client had been showing signs of cough and fever for 3 days prior. Once client was admitted he suffered from fluid in his lungs and was placed in a medically induced coma for 10 days. After sustaining muscle loss from the coma, the client was transferred to the Rehab floor on 02/25/21. Treatment of the stroke is working with physical and occupational therapy to perform ADLs by himself. The client's chief complaint was shortness of breath and a dry cough. Client has hypoxia from not having enough oxygen in his

blood. When asked about pain, Client stated “I have shortness of breath still during therapy, but other than that I have no pain”. The client has dysphagia, but is able to feed himself. The client is mobile with one assist with the use of a gait belt and walker. The client has a good support system at home with his wife and children that live in the area. The Client's wife is able to come and visit, but his children are not able to currently because of restrictions.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Acute hypoxemia

Secondary Diagnosis (if applicable): Covid-19

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

Acute hypoxia is the lack of oxygen in the blood that is able to meet the needs of tissues (Capricotti, 2020). The body cannot work properly if oxygen levels get too low. Some risk factors of hypoxemia include heart and lung conditions, if someone lives in an area of high altitude, taking strong pain medications, breathing difficulty at night, and inflammation or scarring of the lung tissue (Cleveland Clinic, 2021). My client has a history of lung conditions, including pneumonia which puts him at risk for hypoxia. Some of the signs and symptoms of hypoxia include headache, shortness of breath, tachycardia, coughing, wheezing, confusion, bluish discoloration in the skin, fingernails and lips (Cleveland Clinic, 2021). Upon admission my client had shortness of breath, coughing and wheezing. As of today my client has resolved these symptoms. The diagnostic tests that can be used to diagnose hypoxia are using pulse oximetry, arterial blood gas test, pulmonary breathing tests (Cleveland Clinic, 2021). When the client was first admitted, multiple breathing tests were done. Clients can use an incentive spirometer at the hospital and at home. Once my client is discharged, he will be able to take his

pulse oximetry at home and see how his oxygen levels are improving. Mitochondrial activity is diminished due to a lack of oxygen for glycolysis and the electron transport chain (Capricotti, 2020). Treatment is based around raising levels of oxygen in the blood. Clients can receive oxygen through a nasal cannula (Cleveland Clinic, 2021). Clients can improve their risk for hypoxemia by doing deep breathing exercises, exercise, eating a healthy diet and drinking plenty of water (Cleveland Clinic, 2021). By educating my client about the risk factors and healthier lifestyle choices my client can make, will help to keep improving his oxygen levels.

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis.

Cleveland Clinic. Hypoxemia: Symptoms, Causes, Treatments (n.d.). Retrieved March 09, 2021, from https://my.clevelandclinic.org/health/diseases/17727-hypoxemia

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.90-4.988= (mill/ cumm)**	**N/A**	**2.83**	**Clients low levels due to anemia (Saunders, 2012).**
Hgb	**12.0-15.5**	**N/A**	**10.8**	**Clients low levels due to anemia (Saunders, 2012).**
Hct	**35- 45%**	**N/A**	**31.4**	**Low levels due to anemia (Saunders, 2012).**
Platelets	**140-400 (1000/mm3)**	**N/A**	**78**	**Low levels due to infection from CLL (Saunders, 2012).**
WBC	**4.0-9.0 (10 x 3/uL)**	**N/A**	**3.10**	**Low levels due to infection from CLL (Saunders, 2012).**
Neutrophils	**40- 70%**	**N/A**	**69.0**	**N/A**

Lymphocytes	**10- 20%**	**N/A**	**19%**	**N/A**
Monocytes	**5%**	**N/A**	**N/A**	**N/A**
Eosinophils	**1-4%**	**N/A**	**N/A**	**N/A**
Bands	**0.0-10.0%**	**N/A**	**3.0**	**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 (mEq/L)**	**N/A**	**135**	**N/A**
K+	**3.5-5.1 (mEq/L)**	**N/A**	**4.3**	**N/A**
Cl-	**98-107 (mEq/L)**	**N/A**	**100**	**N/A**
CO2	**22-29 (mEq/L)**	**N/A**	**27**	**N/A**
Glucose	**60- 110 (mg/dL)**	**N/A**	**101**	**N/A**
BUN	**8-23 (mg/dL)**	**N/A**	**15**	**N/A**
Creatinine	**0.05-1.00 (mg/dL)**	**N/A**	**0.41**	**N/A**
Albumin	**3.5-5.2 (gm/ dL)**	**N/A**	**2.9**	**Low levels due to malnutrition (Saunders, 2012).**
Calcium	**8.4-10.0 (mg/dL)**	**N/A**	**8.6**	**N/A**
Mag	**1.6-2.4 (mg/ dL)**	**N/A**	**2.1**	**N/A**
Phosphate	**2.5-5 (mg/dL)**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.0-1.2 (mg/ dL)**	**N/A**	**0.8**	**N/A**
Alk Phos	**35-105 (U/L)**	**N/A**	**75**	**N/A**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow Clear**	**N/A**	**N/A**	**N/A**
pH	**5.0-8.0**	**N/A**	**N/A**	**N/A**
Specific Gravity	**1.005-1.034**	**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	**0-0.5**	**N/A**	**N/A**	**N/A**
RBC	**0-3**	**N/A**	**N/A**	**N/A**
Leukoesterase	**Negative**	**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**	**No growth**	**N/A**
Sputum Culture	**Negative**	**N/A**	**N/A**	**N/A**
Stool Culture	**Negative**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

Malarkey, M. Louise., & McMorrow, M. E. (2012). *Saunders Nursing guide to laboratory and diagnostic tests.* St. Louis, MO: Elvisier/Saunders.

Lakeview College of Nursing Diagnostic Lab Value Sheet

Sarah Bush Lincoln Center Hospital System. Medical Values

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

2/11/21 - MRI C Spine without Contrast - N/A

2/11/21 - MRI Brain without contrast - N/A

2/9/21 - X-Ray Chest single view portable - N/A

2/9/21 - X-Ray Chest Single View - N/A

Current Medications (10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/Generic	Demeclocycline	Docusate Sodium	Famotidine (Pepcid)	Zinc Sulfate (Zincate)	Prednisone (Deltason)
Dose	Tablet 300 mg	Capsule 100 mg	Tablet 20 mg	Capsule 220 mg	Tablet 20 mg
Frequency	Daily	Daily	BID	Daily	BID
Route	Oral	Oral	Oral	Oral	Oral
Classification	tetracycline antibiotic (RxList)	Surfactant (Jones, 2021)	Histamine-2 Blocker (Jones, 2021)	Trace element, mineral (Jones, 2021)	Glucocorticoid (Jones, 2021)
Mechanism of Action	Stopping the growth of bacteria (Jones, 2021)	softens stool by decreasing surface tension (Jones, 2021)	Reduces HCL formation by preventing histamine from binding with H2 receptors (Jones, 2021)	Helps maintain cell growth, and wound healing. (Jones, 2021)	connects to intracellular glucocorticoid receptors and suppresses inflammatory and immune responses (Jones, 2021)
Reason Client Taking	Possibly due to acne or fighting a bacteria infection. (RxList)	Stool softener (Jones, 2021)	to treat GERD (Jones, 2021)	Possibly a deficiency in Zinc.	To suppress immune system and decrease inflammation (Jones, 2021)
Contraindications (2)	Hypersensitivity to any of the tetracyclines or any of the components to this product formula (RxList)	Acquired or congenital QT, severe renal impairment. (Jones, 2021)	Hypersensitivity to famotidine, other H2 receptor antagonists (Jones, 2021)	Hypersensitivity to zinc or its components (Jones, 2021)	hypersensitivity to prednisone or its components, systemic fungal infection (Jones, 2021)
Side Effects/Adverse Reactions (2)	Dysphagia, Nausea (RxList)	Headache and syncope (Jones, 2021)	Fatigue, dry skin (Jones, 2021)	Neurological deterioration and Nausea. (Jones, 2021)	Headache and restlessness (Jones, 2021)

Medications Reference (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett

Learning.

RxList. (2021). RxList. WebMD. Retrieved 8 March 2021 from

https://www.rxlist.com/declomycin-drug.htm#description

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client was alert and oriented to person, place, time, and situation (x4) He appeared to be calm. Client's overall appearance was well groomed.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N X** **Type:**	Client's skin was warm, pink, dry and intact with skin turgor less than three seconds. Skin was absent of rashes and wounds. Client had bruises on hands and arm from IV. No drains present. Client has a Braden score of 20. I deducted two for mobility because of limited ability to get out of bed without one person assist, but can move within the bed alone. I deducted one for activity, because client walks occasionally with assistance.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Client's head and heck appeared to be midline with no deviations or bruises. His ears were intact and symmetrical with no drainage. Client was able to hear well, being able to respond to questions. Client has no assistive devices and his eyes exhibited PERRLA and six cardinal fields. Eyes appeared to be symmetrical with no drainage. Clients nose was midline and absent of deviated septum. Client has dentures. Dentures have good hygiene. Tongue appeared to be pink in color and midline. Mucosa was pink and moist.

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N X** **Edema Y ☐ N X** **Location of Edema:**	S1 and S2 heard. Client had a regular heartbeat. Peripheral pulses were palpable at carotid (bilaterally), radial and left brachial at a 2+. Right brachial was weaker, a 1+. Capillary refill was less than three seconds. No edema upon assessment.
RESPIRATORY: **Accessory muscle use: Y☐ N X** **Breath Sounds: Location, character**	.No abnormal lung sounds heard upon assessment. Client had a respiratory rate of 18 breaths per minute. No chest deformities noted. Client's chest raised and lowered evenly and deeply with no accessory muscles used.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N X** **Nasogastric: Y ☐ N X** **Size: N/A** **Feeding tubes/PEG tube Y ☐ N X** **Type: N/A**	.Client eats a heart healthy diet in the hospital. Client states that he has no restrictions at home. Client weighs 79.4 kg (175 lbs) Client stands at 5'9" (175.25 cm) Client's bowel sounds were active. Last BM 2/28/21 (pm). No sign of pain or masses when palpating the abdomen. No sign of distention or incisions. No scars, drains, or wounds present. No ostomy, NG, or feeding tubes present.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N X** **Dialysis: Y ☐ N X** **Inspection of genitals:** **Catheter: Y ☐ N X** **Type:** **Size:**	Client stated "my urine was yellow to light brown." Not able to see client void during my time in the hospital. Client denied any pain while voiding. Client stated he had a normal amount of urine.
MUSCULOSKELETAL:	.Neurovascular status is normal. Client was able

Neurovascular status: **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment X** **Needs support to stand and walk☐**	to perform ROM, although right side was slightly weaker. Client is a one assist with a gait belt and uses walker to ambulate. Strength is equal in upper extremities bilaterally. Client is stronger on left side, than right. Needs assistance standing up and getting in the shower. Client states "working on brushing teeth alone" Fall risk is a 55. High fall risk. Client needs a walker and gait belt when doing activities.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	.Strength is equal in upper extremities bilaterally. Lower left leg is stronger than the left leg. Client is alert and oriented to time, place, person and situation. Mental status is normal for his age. Normal cognitive speech. Fingers and toes had normal responsiveness. Client had no sign of LOC.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	.Client lives at home with his wife. Client has 4 children, 2 of which live in the area. The client has a good support system. Client states he is "catholic, born and raised". Client states that he copes by spending his time watching the news, reading the newspaper and his wife comes to visit him in the hospital. Client states "my son got me an ipad that I am learning to use". His developmental level is normal and has a high school diploma.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0745	**70 bpm** **RLA**	**119/76** **mmHg**	**18 rpm**	**36.1 C** **(97.1 F)** **Temporal**	**95%** **(RA)**

Pain Assessment, 1 set (5 points)

Time N/A	Scale N/A	Location N/A	Severity N/A	Characteristics N/A	Interventions N/A
	Numeric scale	**N/A**	**0**	**N/A**	**N/A**

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
840 mL oral intake- 840 mL	0701 - 275 mL

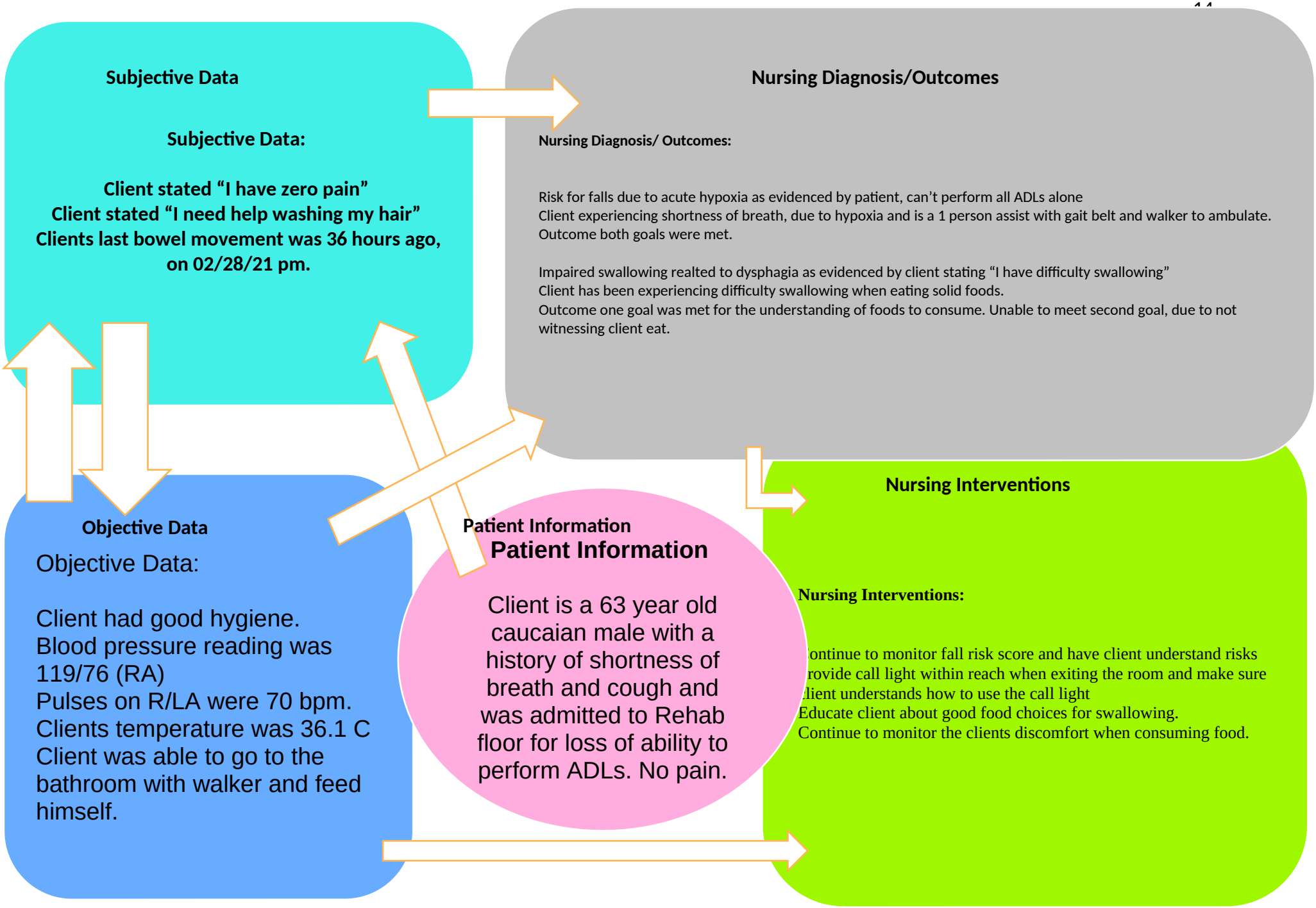
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

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. Risk for falls due to acute hypoxia as evidenced by patient, can't perform all ADLs alone	The client is experiencing shortness of breath due to hypoxia and is a 1 person assist with gait belt and walker to ambulate.	**1.** Assess the fall risk score and educate the patient about risks. **2.** Have the client demonstrate the use of call light and keeping the call light within reach.	Goal Met. Able to assess the environment and clients fall risk and make changes for clients safety. Goal Met. Client was able to demonstrate the use of the call light.
2. Impaired swallowing related to dysphagia as	Clients has been experiencing difficulty swallowing when	**1.** Educate clients on different types of food that will go down easily.	Goal Met. Client was able to comprehend foods that are available to him to not cause discomfort.

evidenced by client stating “I have difficulty swallowing”	eating solid foods.	**2.** Continue to monitor the clients discomfort when consuming food.	Goal not. Did not observe client eating.

Overall APA format (5 points):

Concept Map (20 Points):


Subjective Data
Subjective Data:
Client stated “I have zero pain”
Client stated “I need help washing my hair”
Clients last bowel movement was 36 hours ago, on 02/28/21 pm.
Nursing Diagnosis/Outcomes
Nursing Diagnosis/ Outcomes:
Risk for falls due to acute hypoxia as evidenced by patient, can’t perform all ADLs alone
Client experiencing shortness of breath, due to hypoxia and is a 1 person assist with gait belt and walker to ambulate.
Outcome both goals were met.
Impaired swallowing realted to dysphagia as evidenced by client stating “I have difficulty swallowing”
Client has been experiencing difficulty swallowing when eating solid foods.
Outcome one goal was met for the understanding of foods to consume. Unable to meet second goal, due to not witnessing client eat.
Objective Data
Objective Data:
Client had good hygiene.
Blood pressure reading was 119/76 (RA)
Pulses on R/LA were 70 bpm.
Clients temperature was 36.1 C
Client was able to go to the bathroom with walker and feed himself.
Patient Information
Patient Information
Client is a 63 year old caucaian male with a history of shortness of breath and cough and was admitted to Rehab floor for loss of ability to perform ADLs. No pain.
Nursing Interventions
Nursing Interventions:
ontinue to monitor fall risk score and have client understand risks
rovide call light within reach when exiting the room and make sure
lient understands how to use the call light
Educate client about good food choices for swallowing.
Continue to monitor the clients discomfort when consuming food.