N321 Care Plan #3

Lakeview College of Nursing

Kristy Geier

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
03/28/2021	K.H.	57 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Part-time cashier/stocker at Dollar General in Greenup, IL	Single	Caffeine, Codeine (rash), Latex, Penicillin (anaphylaxis, rash), clindamycin (rash).
Code Status	**Height**	**Weight**	
Full	183 cm	107.20 kg	

Medical History (5 Points)

Past Medical History: Chronic Obstructive Pulmonary Disease, Hypothyroidism, Stress urinary incontinence, Gastroesophageal reflux disease, Urinary incontinence

Past Surgical History: Colonoscopy, Polypectomy with snare (9/20/2019), Cystectomy (1/1/2001).

Family History: Mother: Colon cancer, stroke, brain aneurysm (pass away 6/1/2016); Father: Benign Prostatic Hyperplasia, Prostate Cancer (alive and well).

Social History (tobacco/alcohol/drugs): Patient states he has a history of tobacco use of 35 years. She started smoking at age 16 and quit at age 54 on September 6, 2019. She has a history of alcohol use but quit drinking March 8, 2018. The patient states she also has smoked recreational marijuana in the past but the last time she smoked was March 8, 2018.

Assistive Devices: Nebulizer

Living Situation: Patient currently lives in a one bedroom, one-bath apartment alone. She does not have any pets at home. She does live on a fixed income.

Education Level: Patient's highest level of education completed was tenth grade. She states she dropped out of school and completed her General Education Degree quite a few years later.

Admission Assessment

Chief Complaint (2 points): Rash, Vomiting, Trouble breathing

History of present Illness (10 points): A pleasant fifty-seven-year-old white female came to the emergency room via ambulance on 03/28/2021. The patient states she was eating an ice-cream bar on 3/26/2021. She states that she felt some pain in her upper left molar tooth number 15. She states that she bit down on something and realized it was her tooth. She also noticed blood during that time which she was able to stop. The patient states she had minimal pain that evening and the next day, she went to see her primary care provider who prescribed clindamycin. She does not recall ever taking this type of medication before. She did fill the prescription and took the first pill that evening before bed. The patient states she woke up the next morning with a rash and urticaria on her abdominal trunk and her bilateral extremities. She also complained of nausea and vomiting. She also noticed a slight trouble with breathing as well. She called her local 911 and was taken to the emergency room for evaluation at Sarah Bush Lincoln Health System in Mattoon, IL. Using the FACES scale, she was not having much pain. However, she did complain of slight breathing deficits as well as wanting to itch her urticaria and the nausea and vomiting which are both aggravating. She has not taken any steps for any relieving factors prior to calling 9-1-1.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):Allergic Reaction to Medication

Secondary Diagnosis (if applicable): N/A

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

A person can develop an immunity from medications or allergens. These types of immunity however can have consequences. There are different types of hypersensitivity reactions that

people can have, but systemic anaphylaxis is the most severe. Systemic anaphylaxis can be life-threatening if not immediately treated. Small doses of allergens can trigger an allergic reaction within minutes of exposure. Patients can sometimes identify the reason for exposure but can place themselves in immediate danger of an anaphylactic reaction at any time (Capriotti & Frizzell, 2016). Some people will react differently, yet others may notice itching, urticaria and skin erythema within minutes of exposure, which could be followed by bronchoconstriction which can be life threatening. Laryngeal edema, tongue swelling, and angioedema can also occur also placing the person at risk for death if not immediately treated which essentially leads to anaphylactic shock (Capriotti & Frizzell, 2016). This medical emergency requires rapid response from emergency medical personnel. The person will likely require IV or IM antihistamines, glucocorticoids, and epinephrine. Some people who know their allergies will carry an epi pen which is a prescription pen filled with epinephrine that can be self-administered if an allergic reaction occurs. Even with self-administration, the person will need to follow up at their local hospital and be placed on cardiac monitoring and have their vitals monitored for a period to make sure they are recovering properly. Patients should note with their healthcare provider which allergic reaction triggered the response so this can be noted on the patient's medical record. Patients should also think about wearing a medical alert bracelet or necklace as well so they can notify medical personnel in case they are unconscious during any event (Capriotti & Frizzell, 2016). In the case of my patient, she had a tooth which self-extracted one evening while eating food. She made an appointment with her primary care provider the following day to be checked out. The primary provider prescribed clindamycin which is a medication given in the case of an infection. Although the patient did not have an infection at the time, the provider was likely wanting to prevent an infection from occurring. The patient

took this medication and noticed urticaria and skin erythema as well as slight trouble with breathing which prompted her to call the ambulance to be transported to her local hospital. She does have other allergic reactions to caffeine, codeine, penicillin. She also had medical personnel place clindamycin on her list of allergic reactions as well.

Nausea and vomiting are the uncomfortable sensation of sickness which may be a result triggered by food, medications, odors, activity. Nausea and vomiting may be caused by irritation, infections. Distention of the duodenum of the stomach may be an early warning sign of pathologic progress. Vomiting is a physiologic protective response that empties the stomach contents of noxious agents (Hinkle & Cheever, 2018). In her case, the patient did have nausea and vomiting which accompanied her rash and trouble breathing. This was likely a reaction from the medication that she was taking prophylactically for the tooth to ward away any infection that could possibly occur. The patient did not have an elevated white blood cell count with her lab work which was completed at the hospital. The only elevation of labs were her glucose and D-Dimer which indicates higher than normal fibrin degradation products in the body which could signify a blood clot. The patient is a former smoker, but states she quit smoking in September of 2019. She is at a higher risk for comorbidities related to clotting and breathing issues due to slight underlying COPD which has not been a problem for her in the past.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

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

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	3.80-5.41x10^6/mcL	5.18	N/a	
Hgb	11.3-15.2 g/dL	14.4	N/a	
Hct	33.2-45.3%	41.8%	N/a	
Platelets	149-393 K/mcL	257	N/a	
WBC	4.0-11.7 K/mcL	7.8	N/a	
Neutrophils	45.3-79.0%	84.5%	N/a	
Lymphocytes	11.8-45.9%	10.1%	N/a	
Monocytes	4.4-12.0%	N/a	N/a	
Eosinophils	0.0-6.3%	N/a	N/a	
Bands	0.0-10.0%	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-	136-145 mmol/L	141	N/a	
K+	3.5-5.1 mmol/L	4.2	N/a	
Cl-	98-107 mmol/L	100	N/a	
CO2	21-31 mmol/L	29	N/a	
Glucose	74-109 mg/dL	121	N/a	This test is used to determine diagnoses such as urinary tract infections among patients. It checks the color, clarity, appearance, concentration, and content of the

				urine (*Urinalysis - Mayo Clinic*, n.d.). The patient's urine has glucose which means she likely has a UTI due to colonization of the glucose.
BUN	7-25 mg/dL	14	N/a	
Creatinine	.70-1.30 mg/dL	0.73	N/a	
Albumin	3.5-5.2 g/dL	4.4	N/a	
Calcium	8.6-10.3 mg/dL	9.2	N/a	
Mag	1.5-2.5 mg/dL	N/a	N/a	
Phosphate	2.4-4.5 units/L	N/a	N/a	
Bilirubin	0.3-1.0 mg/dL	0.6	N/a	
Alk Phos	34-104 units/L	72	N/a	
AST	13-39 U/L	18	N/a	
ALT	7-52 U/L	16	N/a	
Amylase	60-100 U/dL	N/a	N/a	
Lipase	0-160 U/L	11	N/a	
Lactic Acid	0.5-1.5 mEq/L venous	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	1-2	N/a	N/a	
PT	10-12 seconds	N/a	N/a	

PTT	30-45 seconds	N/a	N/a	
D-Dimer	Negative, less than <250mg/mL	2.53	N/a	Fibrin has a protein fragment which is made when a blood clot is dissolved. When the D-Dimer test is completed, the result is higher than normal, this means that there is a clot somewhere in the body (*Dimer - Clinical: D-dimer*, *Plasma*, n.d.).
BNP	<100pq.mL	N/a	N/a	
HDL	>60md/dL	N/a	N/a	
LDL	<100 mg/dL	N/a	N/a	
Cholesterol	<200 mg/dL	N/a	N/a	
Triglycerides	<150 mg/dL	N/a	N/a	
Hgb A1c	<5.7%	N/a	N/a	
TSH	0.5-5.0	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, clear	Clear, yellow	N/a	
pH	5.0-8.0	6.0	N/a	
Specific Gravity	1.005-1.034	1.010	N/a	
Glucose	0-0.8 mmol/ L	0	N/a	
Protein	Negative	Negative	N/a	
Ketones	Negative	Negative	N/a	
WBC	0.0-5	0	N/a	
RBC	0-3	0	N/a	

Leukoesterase	Negative	Negative	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/no growth	N/a	N/a	*No cultures were performed during this admission.
Blood Culture	Negative/no growth	N/a	N/a	
Sputum Culture	Negative/no growth	N/a	N/a	
Stool Culture	Negative/no growth	N/a	N/a	

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

Dimer - clinical: D-dimer, plasma. (n.d.). https://www.mayocliniclabs.com/test-catalog/Clinical and Interpretive/602174

Lakeview College of Nursing Diagnostic Lab Value Sheet

Sarah Bush Lincoln Cerner Hospital System. Medical values.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

During this admission, the patient had the following diagnostic tests completed was a computed tomography coronary angiography scan, otherwise known as a CT Angio scan, of the chest and pulmonary cavity with contrast. She also had a computed tomography scan, also

known as a CT scan, of the abdomen and pelvis, chest x-ray as well as an echocardiogram of her chest also known as an ECHO with contrast. The Angio CT scan was performed on 3/29/2021 due to the patient complaining of chest pain with an elevated D-Dimer laboratory test. It showed that there was good contrast opacification of the pulmonary arteries with no evidence of embolus. The heart size appeared to be of normal shape and size. The thoracic artery was of normal shape, caliber, and size. There was a small amount of fluid adjacent to the distal esophagus which was noted as uncertain etiology. The CT Angio went on to note that there was no pneumothorax noted. There was no pleural effusion noted. There was, however, bibasilar atelectasis. The central airway is noted to be patent. The pulmonary vasculature is not engorged. The abdominal and pelvic CT scan which was completed due to her complaints of chest pain, abdominal pain and vomiting showed no acute intra-abdominal or intrapelvic abnormalities, however it did show a small amount of distal paraoesophageal fluid of doubtful clinical significance. The Chest X-Ray (CXR) was completed dur to chest pain from Gastroesophageal Reflux Disease (GERD). The heart size is normal. There were no atherosclerotic changes noted. There is left basilar atelectasis. Lungs are otherwise clear. No visual pneumothorax or pleural effusion. The osseous structures appeared intact. The patient's Echocardiogram with contrast (ECHO) was completed due to the patient complaining of chest pain with hypoxia. The ECHO results were that there was a normal size left ventricular chamber and systolic function. The ejection fraction was 60-70%. The left ventricular wall thickness was grade 1 with diastolic dysfunction. The right ventricular function was of normal size. The Trileaflet aortic valve had mild calcification and thickening. There was no evidence of stenosis or regurgitation. The mitral and tricuspid valves were both of normal structure and function. There was no evidenced pericardial effusion and the heart showed normal sinus rhythm.

Diagnostic Test Correlation (5 points):

The CT was used to determine why the patient was experiencing pain in the chest and the related chest pain in correlation with her gastrointestinal reflux disease, hypoxia, and elevated D-Dimer.

Diagnostic Test Reference (1) (APA):

Ct coronary angiogram - mayo clinic. (n.d.). https://www.mayoclinic.org/tests-procedures/ct-coronary-angiogram/about/pac-20385117

Ct scan - mayo clinic. (n.d.). https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675

Echocardiogram - mayo clinic. (n.d.). https://www.mayoclinic.org/tests-procedures/echocardiogram/about/pac-20393856

Chest x-rays - mayo clinic. (n.d.). https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Proair HFA / albuterol sulfate	Synthroid / levothyroxine	Zyrtec / cetirizine	Mucinex/ guaifenesin	Spiriva/ tiotropium bromide
Dose	90mcg/2 puffs	0.125mg	10mg	600mg	18mcg/1 puff
Frequency	PRN/ every 4 hours	Daily	Daily	Every 12 hours	Daily

Route	Inhalation	PO	PO	PO	Inhalation
Classification	Bronchodilator	Thyroid hormone replacement	Antihistamine	Expectorant	Bronchodilator
Mechanism of Action	Albuterol attaches to beta 2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine triphosphate. This reaction decreases intracellular levels of cAMP, as shown. Together, these defects relax bronchial smooth-muscle cells and inhibit histamine release.	Replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis.	Used for the treatment of allergies, hay fever, angioedema, and hives. It is a second generation H1 receptor.	Increases fluids and mucus removal from the upper respiratory tract by increasing the volume of secretions and reducing their adhesiveness and surface tension.	Prevents acetylcholine from attaching to muscarinic receptors on membranes of smooth-muscle cells. By blocking acetylcholine's effects in the bronchi and bronchioles, tiotropium relaxes smooth muscles and causes bronchodilation
Reason Client Taking	Chronic obstructive pulmonary disease / hypoxia	Hypothyroidism	Hives, urticaria	Hypoxia	Hypoxia
Contraindications (2)	Hypersensitivity to albuterol or its components	Acute MI, hypersensitivity to levothyroxine or its components, uncorrected adrenal insufficiency, untreated	Contraindicated in patients with a known hypersensitivity to hydroxyzine or any of its ingredients. Narcotics/opiates	Hypersensitivity to guaifenesin or its components	Hypersensitivity to atropine or its derivatives, including ipratropiu

		thyrotoxicosis	. Will cause drowsiness.		m, tiotropium, or their components.
Side Effects/Adverse Reactions (2)	Angina, Bronchospasm	Seizures, MI	Dry mouth, kidney disease, liver disease	Dizziness, headache, nausea, vomiting	Chest pain, dry mouth, abdominal pain
Nursing Considerations (2)	Administer pressurized inhalations of albuterol during second half of inspiration, when airways are open wider and aerosol distribution is more effective. Use cautiously in patients with cardiac disorders, diabetes mellitus, digitalis intoxication, hypertension, hyperthyroidism, or history of seizures.	Be aware that levothyroxine therapy is not to be used for treatment of obesity or for weight loss. Monitor pt. of patient who is receiving anticoagulants; she may require dosage adjustments	Be careful operating machinery. For many patients, cetirizine does not cause drowsiness, however, every person could react to it differently.	Watch for evidence of more serious condition such as cough that lasts longer than 1 week. Advice patient not to take drug longer than 1 week and to notify prescriber about fever, persistent headache, or rash.	Use tiotropium cautiously in patients with angle-closure glaucoma, benign prostatic hyperplasia, or bladder neck obstruction. Monitor patient closely after giving first dose of tiotropium for immediate hypersensitivity reactions.

Hospital Medications (5 required)

Brand/ Generic	Lovenox/enoxaparin	Protonix/pantoprazole	Benadryl/ diphenhydramine	Tylenol/ acetaminophen	Norco/ hydrocodone-acetaminophen
Dose	40mg	40mg	25mg	650mg	5mg-325mg
Frequency	Daily	Daily	PRN every 6 hours	PRN every 6 hours	PRN every 4 hours
Route	Subcutaneous	PO	PO	PO	PO
Classification	Low-molecular-weight heparin/anticoagulant	Proton pump inhibitor/ antiulcer	Antihistamine	Non salicylate	Opioid analgesic/analgesic
Mechanism of Action	Inactivates clotting factors by binding with antithrombin III, resulting in fibrinogen not being able to convert to fibrin due to no thrombin.	Interferes with gastric acid secretions by inhibiting hydrogen-potassium-adenosine triphosphatase enzyme and blocks the exchange of hydrogen and extracellular potassium and prevent additional HCl from forming.	Binds to central and peripheral H1 receptors competing with histamine for these sites and preventing it from reaching its site of action.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Suppresses cough centers in medulla and reduces pain by binding to opiate receptors in the CNS.
Reason Client Taking	To prevent deep vein thrombosis	Gastroesophageal reflux disease	Hives/urticaria	Abdominal pain	Pain
Contraindications (2)	Active major bleeding, Hypersensitivity	Concurrent therapy with rilpivirine containing products, Hypersensitivity	Hypersensitivity to diphenhydramine, similar antihistamines, or	Hypersensitivity to acetaminophen or its	GI obstructions, status asthmaticus

			their components;	complements, severe hepatic impairment, severe active liver disease.	
Side Effects/ Adverse Reactions (2)	Thrombocytopenia, hyperkalemia	Abdominal pain, headache	Dizziness, nausea	Nausea, vomiting, fatigue	Constipation, Respiratory depression
Nursing Considerations (2)	Do no give medication as an intramuscular injection,	Monitor patients for bone fractures if using long term, advise patient to take on an empty stomach but can be taken with apple juice of gastric upset occurs.	Expect to give parenteral form of diphenhydramine only when oral ingestion is not possible. Keep elixir container tightly close. Protect from light.	Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, sever hypovolemia, or severe renal impairment.	Monitor for respiratory depression and hypotension, Have naloxone on hand in case of serious adverse effects

Medications Reference (1) (APA):

Jones and Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed). Jones and Bartlett Publishers.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and orientated to date, place, person, and current events for visit x4. She appears to be in no apparent/noticeable distress. She is appropriately dressed for the weather and is well-groomed.

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is warm, dry, intact, pink in all areas of her body with no rashes, bruises, or wounds present. Braden score is 23 which indicated the patient is not at risk for pressure sores or impaired skin integrity.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is round and bilaterally equal with no obvious contusions or abnormalities. No tracheal deviation. Thyroid rises and falls during swallowing. Ears are symmetrical and bilaterally placed on the side of the patients head. Tympanic membranes are a pearly, gray color. No cerumen or drainage noted or present within the ears. Eyes are placed in the center of the face, symmetrical without them being too far set or too close to each other. The patient sclera is white, and conjunctiva is pink. There is no drainage present from the eyes. Patient does have prescription glasses; however, they were on her bedside table. Patient's nares are bilaterally equal and has no deviated septum. There is no pain or discomfort noted from patient upon palpitation of sinuses. No drainage noted from the nares. Patients gums are a pale pink, firm, and moist. All the patient's adult teeth were intact except for all four wisdom teeth, and second molar which was extracted prior to the patient presenting to the hospital. There is no dental caries or discoloration to the teeth noted. Rise and fall of the soft pallet were observed and tonsils and uvula is pink and moist and is placed centrally in the patient's mouth with no deviation to one side or the other. .
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:**	The patient was not being monitored by telemetry. The patient's S1and S2 were heard. The peripheral pulses were assessed and were noted a 70 and 110. The capillary refill was less than three seconds. She did not have neck vein

Capillary refill: **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	distention. The patient did not present with edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient did not use accessory muscle to aid in breathing. Her trachea was midline and showed no deviations. She did not show signs of shortness of breath although she was on 2L oxygen stating at 90%. Anterior and posterior breath sounds were assessed and were transparent and diminished.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient is on a regular diet at the hospital as well as at home. 183 cm 107.20 kg The bowel sounds were heard in all four quadrants. Patient's last bowel movement was on 03/28/21. Using the FACES scale, the patient did not show signs of discomfort or pain when the abdomen was palpated. No masses were present. The patient did not have distention, incisions, scars, drains, or wounds on the stomach. The patient did not have an ostomy, nasogastric tube, or any feeding or PEG tubes present.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine was pale yellow and clear with no foul odor noted. Patient voided a total of 1200 mL of urine during my clinical duration. Using the FACES scale, the patient did not show discomfort or pain when he urinated. The patient is not on dialysis. She does not have a catheter and is not on dialysis. Her external genitalia are normal in appearance without lesions, swelling, masses or tenderness. I only inspected external genitalia during my rotation.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:**	The patient was A&Ox4. She presented with an active range of motion. She showed no signs of a neurovascular deficit. The patient is a moderate fall risk, with a score of 25 due to an IV access

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☐**	according to the Morse fall risk score. The patient does not need any assistive devices to move about her room. She had equal strength bilaterally in both hands and feet.
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 patient was sitting up in bed. She is A&Ox4. The patient moves all extremities well, and PERLA is present. The patient's strength was equal bilaterally. Her speech is clear, and concise. Her sensation is intact bilaterally.
PSYCHOSOCIAL/CULTURAL (2 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):**	The patient has appropriate mood and affect. She is appropriately developmental level for her age. She received her General Education Degree after dropping out of high school in the tenth grade. Patient does attend church regularly and belongs to the Lutheran religion. Patient currently lives in a one-bedroom, one-bath apartment alone. She is not married and has no children. Her mother is deceased, but her father is still alive, and she often visits him. Her father, despite his age is her main support system along with her friends.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	68 BPM	145/81	18 breaths per minute	36.8 deg C	90% RA
1200	86 BPM	144/88	18 breaths per minute	37.2 deg C	92% 2L NC

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1200	FACES	None	0	N/a	N/a
1500	FACES	Abdominal	3/10	Dull	Protonix given for gastrointestinal reflux disease.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** Right forearm **Date on IV:** 03/28/21 **Patency of IV:** The IV line is easily flushed and is patent. **Signs of erythema, drainage, etc.:** No signs of erythema, drainage, or other abnormalities. **IV dressing assessment:** The IV dressing is clean, dry, and intact.	The patient's IV is saline lock.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
0.9% Sodium Chloride = 150 ml/hour (7 hours of clinical) = 1050mL Water= 5oz(30/oz) = 150mL Total: 1200mL Food: 100% of breakfast ate. The patient is awaiting her lunch tray.	Voided 125mL of urine at 0810 Voided 225mL of urine at 1030 Voided 150mL of urine at 1200 Total: 325mL of urine voided

Nursing Care

Summary of Care (2 points)

Overview of care: The patient sat in her bed during my whole clinical shift except when she got up to use the restroom. Her full body assessment and pain assessment were done at 12:00pm. She states she ate 100% of her breakfast around 8:30am and was awaiting her lunch tray during my clinical rotation.

Procedures/testing done: The patient did not leave the floor the day of clinical for any tests or procedures.

Complaints/Issues: The patient did not have any complaints or issues during the shift. She did have some slight pain around 3:00pm and I was able to

Vital signs (stable/unstable): All the patient's vital signs were stable, but her blood pressure was on the higher side of normal. The patient's nurse was notified of her blood pressure. There were no interventions done during the shift.

Tolerating diet, activity, etc.: During the shift, the patient sat in her bed except when she needed to use the restroom. She was planning on taking a bed bath, later in the day, closer to 6:00pm. She drank water the entire shift and did eat 100% of her breakfast. She did finally receive her lunch tray around 1300, which consisted of a salad, and sandwich which was 100% consumed.

Physician notifications: The patient's physician is reviewed the patient's diagnostic scans and labs. No other notes were made.

Future for patient: The patient will continue her current medications and will be sent home with pantoprazole (Protonix) to help with her gastrointestinal reflux disease.

Discharge Planning (2 points)

Discharge location: The patient will be discharged later this evening around 7:00pm as this is when her friend can come pick her up and take her home.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: The patient will follow up with her primary care provider within two-weeks of being discharged from the hospital.

Education needs: pantoprazole education. She will be educated that she may experience abdominal pain or cramps, upset stomach, nausea & vomiting. She also will be educated that she should take an over-the-counter calcium supplement because pantoprazole may increase her risk of osteoporosis. She will also be educated on having her provider order routine labs. She will notify her provider if she notices any abnormal issues such as not having the urge to urinate or noticing black or tarry stools. She will notify her dentist, and any other healthcare professional that she is taking this medication.

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. Impaired Gas Exchange as evidenced by low oxygen saturation.	This diagnosis was chosen because the patient had a tooth extracted and was given antibiotics for the possible infection.	**1.**Place patient on 2L oxygen maintain saturation at 90% or greater. **2.**Place patient in high-fowler position in her bed so she can	**Goal:** Patient will be able to breathe easier with repositioning and supplemental oxygen. Patient responded well to oxygen saturation. She states she felt better with

	She presented with low oxygen saturation (which could have been linked either to her COPD diagnosis or the allergic reaction from the medication)	breathe easier.	the oxygen nasal cannula and never noticed how much better she breathes with oxygen. Patient is in high flower's position and feels much better to be sitting upright while in bed. She states she breathes much better as well.
2. Ineffective protection as evidenced by itching related to hives/urticaria from medication allergy.	This diagnosis was chosen because she had an extracted tooth which was the underlying reason for coming to the hospital. She was placed on an antibiotic, which caused her to have an allergic reaction.	**1.** Administer an intravenous infusion of 0.9% sodium chloride as ordered at 150mL an hour for 7 hours to help flush out the antibiotic which caused the allergic reaction. **2.**Patient should be prescribed diphenhydramine 25mg every 6 hours/PRN for her rash/urticaria.	**Goal:** Patient will be free of rash/urticaria before she leaves the hospital. Patient was placed on intravenous infusion of 0.9% sodium chloride at 150mL per hour for 7 hours to help flush antibiotic out of her body. Patient was given diphenhydramine 25mg every 6 hours/PRN for the rash/urticaria to help elevate any itching or irritation to the skin on her abdominal area and legs that she was experiencing.
3. Risk for deficient knowledge as evidenced by new medication prescription.	This diagnosis was chosen because she had an extracted tooth which was the underlying reason for coming to the hospital. This was chosen because the patient was	**1.** Explain the medication Pantoprazole and side effects to the patient so she can be knowledgeable about the medication. **2.** Explain that patient should take Pantoprazole (Protonix) as a	**Goal:** Patient will be able to explain the medication and the need for the medication within her lifestyle. Patient was able to explain why she needed to take this medication. She was able to explain that nausea and vomiting may be a side effect that that if she notices dark,

	started on a new medication at the hospital that she has not taken before, and she needed education on the new medication.	prophylaxis for her Gastrointestinal Reflux Disease. Explain she should not crush or chew this medication.	tarry or diarrhea type stools, she should contact her primary care provider. Patient was able to link this medication back to her reflux disease which causes heartburn for her daily. She was able to explain that she needed to take this medication whole, and not to crush it. She also explains that she could take it either with or without food.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient described the breathing as slightly labored but did not bother her much. She did mention that the rash on her abdomen and legs was very red and excoriated and she did want to scratch it. She rated the pain as a 3/10 on the numeric 1-10 scale on the day of her admission, and has had intermittent pain since, but states her pain is well controlled with Tylenol which is prescribed at the hospital.

Nursing Diagnosis/Outcomes

1. Impaired Gas Exchange as evidenced by low oxygen saturation.
   a. **Goal:** Patient will be able to breathe easier with the positioning and supplemental oxygen.
2. Ineffective protection as evidenced by itching related to hives/urticaria from medication allergy.
   a. **Goal:** Patient will be free of rash/urticaria before she leaves the hospital.
3. Risk for deficient knowledge as evidenced by new medication prescription.
   a. **Goal:** Patient will be able to explain the medication and the need for the medication within her lifestyle.

Objective Data

Vitals:

BP: 145/81 144/88
Pulse: 68 86
RR: 18 18
O2: 90% RA 92% 2L NC
Temp: 36.8deg C 37.2deg C

Patient did have labs drawn and the only abnormal labs were her glucose and her slightly elevated D-Dimer. She also had some diagnostic testing completed due to chest pain after being admitted, but all tests were unremarkable.

Patient Information

Patient is a 57-year-old Caucasian female who presents with a chief complaint of nausea/vomiting, trouble breathing and a rash on her abdomen that started on 3/28/21. Patient has a past medical history of Hypothyroidism, Chronic Obstructive Pulmonary Disease, Gastroesophageal reflux disease, Stress Urinary Incontinence, Stress Incontinence. Her past surgical history includes polypectomy with snare, cystectomy, and a colonoscopy. The patient currently lives in a one-bedroom, one-bath apartment in Greenville, IL and lives on fixed income.

Nursing Interventions

1. Place patient on 2L oxygen maintain saturation at 90% or greater. **2.** Place patient in high-fowler position in her bed so she can breathe easier.
1. Administer an intravenous infusion of 0.9% sodium chloride as ordered at 150mL an hour for 7 hours to help flush out the antibiotic which caused the allergic reaction. **2.** Patient should be prescribed diphenhydramine 25mg every 6 hours PRN for hives/urticaria.
1. Explain the medication Pantoprazole and side effects to the patient so she can be knowledgeable about the medication. **2** Explain that patient should take Pantoprazole (Protonix) as a prophylaxis for her, Gastrointestinal Reflux Disease. Explain she should not crush or chew this medication.