

N321 Care Plan #1
Lakeview College of Nursing
Lindsay Cox

Demographics (3 points)

Date of Admission 5/18/21	Patient Initials DE	Age 80	Gender Male
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Married	Allergies Iodine; skin adhesive
Code Status FULL	Height 5'11"	Weight 76.8 kg (169 lbs 6 oz)	

Medical History (5 Points)

Past Medical History: Acute exacerbation of chronic obstructive pulmonary disease (COPD), ascites, arthritis, atrial fibrillation (A-fib), basal cell carcinoma (BCC), cholangitis, cirrhosis, gastroesophageal reflux disease (GERD) without esophagitis, hemochromatosis, herpes zoster, multiple myeloma/multiple myeloma in remission, osteoarthritis, hypothyroidism, plasmacytoma, pneumonia due to an infectious organism, shortness of breath (SOB).

Past Surgical History: Biliary endoscopy percutaneous, heart dilation and stent implantation (DIL + Stent), bone marrow biopsy, bilateral cataract removal (2017), cholecystectomy, colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), laparotomy, skin biopsy from the head, removal of rib(s) upper left (1994) and lower right (2007).

Family History: Mother (deceased)- heart attack, heart surgery. Father (deceased)- no known problems. 2 sons (alive)- no known issues.

Social History (tobacco/alcohol/drugs): The patient smoked an average of 0.5 packs of cigarettes a day for two years and quit on 1/1/1996. The patient denies ever vaping, using alcohol, or using drugs.

Assistive Devices: The patient utilizes glasses, a walker, a hearing aid, and a gait belt.

Living Situation: Lives with wife, no pets.

Education Level: Patient completed high school.

Admission Assessment

Chief Complaint (2 points): Patient complains of cough.

History of present Illness (10 points): The patient is an 80-year-old male who presented to the emergency department with complaints of cough. While eating at home earlier in the day on 5/18/21, the patient developed a cough. The patient's wife believed that the patient choked on his food. The patient developed a fever but denied any shortness of breath or difficulty breathing. The patient also denies any nausea, vomiting, or diarrhea. The patient denied finding any relief from his cough. The patient has sought treatment for COPD and GERD in the past.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia

Secondary Diagnosis (if applicable): N/A

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

According to Capriotti, pneumonia is when the alveolar spaces in the lungs fill with discharging pus from inflammatory cells and fibrin. (Capriotti, 2020). Bacterial or viral infections most commonly cause the inflammation of the lung tissue. (Capriotti, 2020). Although, the patient developed pneumonia from suspected inhalation of his food. Capriotti states that in the United States, pneumonia, when compared to other infections, causes the most deaths. (Capriotti, 2020). Pneumonia is categorized depending on which setting the infection occurred. The three types listed in *Introductory Concepts and Clinical Perspectives* are community-acquired, hospital-acquired, and ventilator-associated. (Capriotti, 2020). According to Capriotti, the risk of pneumonia is more significant for men than women, increasing with age. The possibility of contracting bacterial pneumonia is more likely in clients with comorbidities, a

weakened immune system, and a declining defense against aspiration, such as we have seen in my patient. (Capriotti, 2020). My patient has a history of GERD and COPD, which I believe predisposed him to pneumonia when he aspirated on his food that refluxed from his stomach.

According to Capriotti, most commonly, pneumonia is caused by inhaling bacteria contained droplets or other pathogens. (Capriotti, 2020). In the case of my patient, his food was the pathogen in question. The route that the pathogen takes once entering the upper airways of the lungs is to pass through the lung tissue and stick itself to the respiratory epithelium. (Capriotti, 2020). The adherence to the epithelium triggers an inflammatory response that travels to the lower respiratory tract, where vasodilation then ensues. (Capriotti, 2020). The widening of the blood vessels allows neutrophils to leave the capillaries and enter the air spaces to envelop and destroy the pathogens. (Capriotti, 2020). Mucous then accumulates in the alveoli from overactive goblets cells in the lungs. (Capriotti, 2020). The excess mucous causes the alveoli to have trouble opening and closing, impairing gas exchange, which is the crackling sound heard when auscultating the patient's lungs. (Capriotti, 2020).

Pneumonia clinically presents acute symptoms such as cough and fever, precisely like my patient presented when entering the emergency department on 5/18/21. Other symptoms include headache, nausea, vomiting, and diarrhea, all of which my patient denied. (Capriotti, 2020). When diagnosing pneumonia, chest x-rays are essential. (Sattar, 2021). A complete blood count can distinguish between bacterial or viral infection. Pulse oximetry verifies that the patient can breathe adequately. (Capriotti, 2020). Treatment for pneumonia consists of taking antibiotics and supplemental oxygen, pain relievers, fever reducers, or bronchodilators if needed. (Capriotti, 2020).

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Chapter 20 Respiratory Inflammation and Infection. *Introductory Concepts and Clinical Perspectives* (pp.483-485). Philadelphia: F.A. Davis.

Sattar, S. B. A. (2021, May 7). *Bacterial Pneumonia*. StatPearls [Internet]. <https://www.ncbi.nlm.nih.gov/books/NBK513321/>.

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	4.4-5.8 10(6)/ mCL	2.39	N/A	Low levels may be due to bone marrow damage from multiple myeloma.(CBC,2021).
Hgb	13-16.5 g/dL	9.3	N/A	Low levels may be due to bone marrow damage from multiple myeloma. (CBC,2021).
Hct	38-50%	26.6	N/A	Low levels may be due to bone marrow damage from multiple myeloma. (CBC,2021).
Platelets	140-440 10(3)/mCL	90	N/A	Low levels may be due to cirrhosis or pneumonia. (CBC,2021).
WBC	4-12 10(3)/mCL	6.7	7.5	These labs are within the normal range.
Neutrophils	40-68%	87	N/A	Elevated levels possibly due to infection of pneumonia. (CBC,2021).
Lymphocytes	19-49%	7.9	N/A	Low levels possibly due to infection of pneumonia. (CBC,2021).
Monocytes	3-13%	3.4	3.9	These labs are within the normal range.
Eosinophils	0.0-8.0 cells/ mCL	1.4	0.4	These labs are within the normal range.
Bands	N/A	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-	133-144 mmol/L	128	N/A	Low levels may be due to edema, ascites, or cirrhosis.(CMP,2021).
K+	3.5-5.1 mmol/L	3.7	N/A	These labs are within the normal range.
Cl-	98-107 mmol/L	95	N/A	Low levels may be due to not getting enough oxygen due to COPD or pneumonia. (CMP,2021).
CO2	21-31 mmol/L	25	N/A	These labs are within the normal range.
Glucose	70-99 mg/dL	120	N/A	Elevated levels may be due to the stress of being in the hospital. (CMP,2021).
BUN	7-25 mg/dL	14	N/A	These labs are within the normal range.
Creatinine	0.5-1.2 mg/dL	0.96	N/A	These labs are within the normal range.
Albumin	3.5-5.7 g/dL	2.2	N/A	Low levels may be due to cirrhosis and ascites. (CMP,2021).
Calcium	8.8-10.2 mg/dL	7.3	N/A	Low levels may be due to multiple myeloma. (CMP,2021).
Mag	N/A	N/A	N/A	N/A
Phosphate	N/A	N/A	N/A	N/A
Bilirubin	0.2-0.8 mg/dL	1.1	N/A	Elevated levels could be due to cirrhosis. (CMP,2021).
Alk Phos	34-104 U/L	113	N/A	Elevated levels may be due to cirrhosis. (CMP,2021).
AST	13-39 U/L	27	N/A	These labs are within the normal range.
ALT	7-52 U/L	16	N/A	These labs are within the normal range.
Amylase	N/A	N/A	N/A	N/A
Lipase	N/A	N/A	N/A	N/A

Lactic Acid	0.5-2 mmol/L	2.6	N/A	Elevated levels could be due to COPD or pneumonia. Especially since the increase of lactic acid suggests that there is not enough oxygen in the blood. (CMP,2021).
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Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	N/A	N/A	N/A	N/A
PT	N/A	N/A	N/A	N/A
PTT	N/A	N/A	N/A	N/A
D-Dimer	N/A	N/A	N/A	N/A
BNP	N/A	N/A	N/A	N/A
HDL	N/A	N/A	N/A	N/A
LDL	N/A	N/A	N/A	N/A
Cholesterol	N/A	N/A	N/A	N/A
Triglycerides	N/A	N/A	N/A	N/A
Hgb A1c	N/A	N/A	N/A	N/A
TSH	N/A	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/clear	Yellow/clear	N/A	These labs are within the normal range.
pH	5-9	6.0	N/A	These labs are within the normal range.
Specific Gravity	1.003-1.030	1.011	N/A	These labs are within the normal range.

Glucose	neg	neg	N/A	These labs are within the normal range.
Protein	neg	neg	N/A	These labs are within the normal range.
Ketones	neg	neg	N/A	These labs are within the normal range.
WBC	neg	neg	N/A	These labs are within the normal range.
RBC	neg	neg	N/A	These labs are within the normal range.
Leukoesterase	neg	neg	N/A	These labs are within the normal range.

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	N/A	N/A	N/A	N/A
Blood Culture	N/A	N/A	N/A	N/A
Sputum Culture	N/A	N/A	N/A	N/A
Stool Culture	N/A	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Complete Blood Count (CBC). Understand the Test & Your Results. (2021).
<https://labtestsonline.org/tests/complete-blood-count-cbc>.

Comprehensive Metabolic Panel (CMP). Understand the Test & Your Results. (2021).
<https://labtestsonline.org/tests/comprehensive-metabolic-panel-cmp>.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): A portable chest X-ray (XR) can visualize the chest and lungs. (Capriotti, 2020).

Diagnostic Test Correlation (5 points): The patient could only take shallow breaths. Lung auscultation posteriorly and anteriorly confirms wheezes in the lower lobes bilaterally. The physician ordered an XR to investigate. The XR reveals the patient's lungs to have scattered bilateral lower lobe infiltrates, possibly due to aspiration of food.

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). Chapter 20 Respiratory Inflammation and Infection. *Introductory Concepts and Clinical Perspectives* (pp.479). Philadelphia: F.A. Davis.

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

Home Medications (5 required)

Brand/Generic	Brovana	Budesonide (Pulmicort)	Calcium carbonate	CephALEXin (Keflex)	Omeprazole (PriLOSEC)
Dose	1 vial in nebulizer 15 mcg/2mL	1 vial in nebulizer 0.5 mg/2mL suspension	1 chewable tablet 1250(500 Ca)	1 capsule 500mg	1 delayed release capsule 20 mg
Frequency	Two times daily (BID)	BID	daily	daily	As needed (prn) for GERD
Route	Orally (PO)	PO	PO	PO	PO
Classification	Therapeutic : bronchodilator	Therapeutic : antiasthmatic	Therapeutic: Antacid	Therapeutic: antibiotic	Therapeutic: antiulcer
Mechanism of Action	Causes stimulation of the intracellular adenylyl cyclase, which initiates the relaxation of the bronchial smooth muscles.	It inhibits inflammatory cells and mediators, possibly by decreasing influx into nasal passages and inflammation.	It increases intracellular and extracellular calcium levels needed to maintain homeostasis. It can also buffer stomach acid and decrease discomfort caused by hyperacidity.	It interferes with bacterial wall synthesis and inhibits the final step in the cross-linking of peptidoglycan strands (which protects the cell membrane; without it, the	It interferes with gastric acid secretion by inhibiting the hydrogen potassium adenosine triphosphatase enzyme system. This prevents additional hydrochloric acid from forming.

				cells rupture and die).	
Reason Client Taking	To help control symptoms of COPD.	To provide maintenance therapy in COPD.	To provide antacid effects.	To treat pneumonia.	To treat symptoms of GERD.
Contraindications (2)	If a patient has hypokalemia, they should not use it. If a patient uses a rescue inhaler medicine, but it doesn't relieve breathing problems.	Recent septal ulcers. Status asthmaticus or other acute asthma episodes.	Presence of ventricular fibrillation. Concurrent use of calcium supplements.	Hypersensitivity to cephalexin. Hypersensitivity to cephalosporins.	Concurrent therapy with rilpivirine-containing products. Hypersensitivity to omeprazole.
Side Effects/Adverse Reactions (2)	Trouble breathing. Leg swelling.	Bad taste. Rectal bleeding.	Nausea/vomiting. Or the sensation of warmth.	Hearing loss. Edema.	Hypoglycemia. Clostridium difficile-associated diarrhea.
Nursing Considerations (2)	Educate the patient on adverse reactions. Have the patient monitor their legs for swelling. (Jones & Bartlett,	Rinse mouth after treatment. Educate the patient on the adverse effect of rectal bleeding so that he can be aware of what to look out for when discharged. (Jones & Bartlett,	Store at room temperature. Evaluate therapeutic response by checking for Chovstek's and Trousseau's signs. (Jones & Bartlett, 2020)	Get the patient to monitor themselves for allergic reactions. Educate patient to look out for diarrhea and notify the provider if it occurs (may indicate Clostridium difficile). (Jones &	Give omeprazole before meals, preferably in the morning. If given with an antibiotic, watch for diarrhea from Clostridium difficile. (Jones & Bartlett, 2020)

	2020)	2020)		Bartlett, 2020)	
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Hospital Medications (5 required)

Brand/ Generic	Ampicillin- sulbactam (Unasyn) 3g in NaCl 0.9% 100mL	Flecainide (Tamboco r)	Furosemide (LASIX)	Ondarsetro n (Zofran- ODT)	Potassium chloride (KLOR- CON)
Dose	3g 200mL/hr	1 tablet 100mg	40 mg injection	1 disintegratin g tablet 4mg	1 packet of 40 mEq dissolved into at least 120 mL of cold water.
Frequency	Every 6 hours	BID	BID	Every 6 hours as needed for nausea- 1 st line.	BID with meals
Route	Intravenous piggyback (IVPB)	PO	IV	PO	PO
Classification	Therapeutic: antibiotic	Therapeuti c: Class IC antiarrhyth mic	Therapeutic: antihypertensi ve, diuretic	Therapeutic: antiemetic	Therapeutic: electrolyte replacement
Mechanism of	It inhibits the	Achieves	It inhibits	By	Acts as the

Action	final step in the cross-linking of peptidoglycan strands in bacterial cell wall synthesis. Without this protection of the cell membrane, the cells rupture and die.	antiarrhythmic effect by inhibiting fast sodium channels of myocardial cell membranes, which increases myocardial recovery after repolarization and by depressing the upstroke of the action potential.	sodium and water reabsorption in the loop of Henle and increases urine formation	preventing serotonin release in the small intestine and blocking signals to the central nervous system, nausea and vomiting are reduced.	primary cation in intracellular fluid, activating many enzymatic reactions essential for physiological processes, including nerve impulse transmission and cardiac and skeletal muscle contraction.
Reason Client Taking	To treat pneumonia.	To prevent and suppress recurrent life-threatening ventricular tachycardia.	To reduce edema.	To prevent nausea and vomiting.	To prevent or treat hypokalemia.
Contraindications (2)	Hypersensitivity to ampicillin. Infection caused by the penicillinase-producing organism.	Cardiogenic shock. Recent myocardial infarction.	Anuria. Hypersensitivity to furosemide or its components.	Cocombinant use of apomorphine. Hypersensitivity to ondansetron.	Acute dehydration. Severe hemolytic anemia.
Side Effects/Adverse Reactions (2)	Laryngeal stridor. Thrombocytopenia.	Heart failure. Hepatic dysfunction.	CNS: dizziness CV: thromboembolism	Anaphylaxis. Intestinal obstruction.	Hyponatremic encephalopathy. Arrhythmias.
Nursing Considerations (2)	-Monitor for an anaphylactic reaction.	-Monitor urine pH beginning	-Use cautiously in patients with	-Monitor patient for hypersensitivity	-Dissolve packet in at least 120mL

	-Inject slowly over 10 to 15 minutes. (Jones & Bartlett, 2020)	at the start of the flecainide therapy. - Check blood pressure, fluid intake, and output, and regularly weigh during treatment. (Jones & Bartlett, 2020)	advanced hepatic cirrhosis. -Monitor patient for hypokalemia. (Jones & Bartlett, 2020)	vity reactions. -Assess for signs of secondary infections. (Jones & Bartlett, 2020)	of cold water. If GI upset occurs, increase the dilution. -Administer with or directly after meals. (Jones & Bartlett, 2020)
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Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>The patient was alert and oriented to person, place, and time. He was well-groomed with no acute distress.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin is normal for ethnicity. His skin was warm, dry to the touch, except for his peripheral upper extremities, which were cool upon palpation. Slight tenting of the skin. No rashes. Slight bruising on the right upper arm. Wound on the stomach from ascites paracentesis. Nails did not have any clubbing or cyanosis. The patient had a Braden Score of 21, which is considered low risk.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>The head and neck are symmetrical. His trachea is midline without deviation. His thyroid is non-palpable, and no nodules of note. Bilateral carotid pulses are palpable. Bilateral lids are moist and pink, with no lesions or discharge noted. Bilateral sclera white, the bilateral cornea appears cloudy, bilateral conjunctive pink, and no visible drainage from eyes. Pupils bilaterally 2 mm. Right eye shakes during PERRLA otherwise intact. Redlight reflex was unable to be performed. EOMs were intact bilaterally.</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema: lower extremities bilaterally.</p>	<p>S1 and S2 were present; my professor nor I detected any murmurs, gallops, or rubs. The patient's peripheral pulses were all 2+. The patient's capillary refill was greater than 3 seconds. The patient has edema of the lower extremities bilaterally. Pillows were placed under his legs, and swelling was monitored.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>The patient had a standard rate and pattern of respirations, although they were slightly labored when taking deep breaths. Lower left quadrant wheezing upon auscultation anteriorly and posteriorly.</p>
<p>GASTROINTESTINAL (2 points):</p>	<p>The patient has a regular diet at home. His wife</p>

<p>Diet at home: Current Diet: Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>cooks for him every day. While at the hospital, the patient is on a dysphagia diet. The patient has a height of 5'11" and a weight of 76.8 kg. Bowel sounds were unable to be auscultated due to ascites. The abdomen was firm to the touch, but the patient denied any pain upon palpitation. I was unable to perform deep palpation due to ascites. The patient's last bowel movement was at 1100 in his bedside toilet. The patient had distention of the stomach due to ascites. There was an incision on the right lower quadrant from the ascites paracentesis procedure, and the bandage was clean and dry. No scars or drains were present.</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Urine yellow/clear. 375mL of urine output. Genital inspection appeared normal for age. The patient denies any pain with urination.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 100 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input checked="" type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/></p>	<p>All extremities have a full range of motion except for the right upper extremity. The patient has an unsteady gait, and he utilizes a walker and a gait belt for mobility. With the assessment of a Morse Fall Risk, the patient has a fall risk of 100. The patient needs someone to assist him in ambulation. Bedside precautions are in use. Hand grips and pedal pushes and pulls demonstrate normal and equal strength except for the right upper extremity. Olfactory and Snellen were not performed. The patient's soft palate rises and falls evenly, uvula and tongue are both midlines.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p>	<p>The patient moves all extremities well except his right upper extremity (limited). Pupils are pinpoint, right eye twitch.</p>

<p>Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input checked="" type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>The right upper extremity is weaker. The wife states, "he needs a shoulder replacement but is not eligible." The patient is A & O x 4, with no mental delays, speech is clear, his sensory perception was apparent, and the patient denies LOC.</p>
<p>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):</p>	<p>When angry or upset, the patient states that he "just lets it go and forgets it," or sometimes he will "complain to wife." No developmental delays. The patient claims to be Baptist. He "used to go to church every Sunday before the pandemic." States that he has "a great support system." His sons live nearby.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	77	102/51 Normal for patient.	20	98.1 degrees Fahrenheit	95% room air
1130	67	105/56 Normal for patient.	20	97.9 degrees Fahrenheit	98% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	0-10	N/A	denies	N/A	N/A
1100	0-10	N/A	denies	N/A	N/A

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:	Size 22g IV saline lock in the left hand. The nurse did not know the date on the IV, and the patient was discharged before I was able to check. Patency was efficient, and fluids passed through quickly without obstruction—no signs of erythema or drainage of note. The IV dressing was clean and dry.

Intake and output (2 points)

Intake (in mL)	Output (in mL)
240 mL	375 mL

Nursing Care**Summary of Care (2 points)**

Overview of care: Supportive care was provided while the patient's symptoms were treated.

Procedures/testing done: Non-alcoholic steatohepatitis ascites paracentesis gastrointestinal procedure was completed, removing 2.5 L of fluids.

Complaints/Issues: Patient denies.

Vital signs (stable/unstable): Vital signs were stable.

Tolerating diet, activity, etc.: Yes, the patient is on a dysphagia diet.

Physician notifications: There was no notification to the physician during the shift.

Future plans for patient: Patient advised to take medications as indicated and to follow up with primary care provider in 1-2 weeks.

Discharge Planning (2 points)

Discharge location: The patient is discharging to home health.

Home health needs (if applicable): The patient will need PT/OT rehabilitation.

Equipment needs (if applicable): Walker and gait belt needed for safe ambulation and one person to assist the client.

Follow up plan: Follow up with primary care provider.

Education needs: The patient needs to learn how to implement safer eating habits such as smaller bites. The patient needs education on GERD and techniques to prevent symptoms after meals, such as not lying down immediately after.

Nursing Diagnosis (15 points)

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

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with "related to" and "as evidenced by" components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Ineffective airway clearance related to aspiration as evidenced by cough.</p>	<p>Inflammation and increased secretions in pneumonia make it challenging to maintain a patent airway.</p>	<p>1. Auscultate lung fields, noting areas of decreased or absent airflow and adventitious breath sounds; crackles, wheezes.</p> <p>2. Assess cough effectiveness and productivity.</p>	<p>The patient will demonstrate behaviors to achieve airway clearance. The patient responded positively, and his wife was very supportive.</p>
<p>2. Activity intolerance</p>	<p>Energy reserves can become</p>	<p>1. Determine the patient's</p>	<p>Demonstrate a measurable increase in</p>

<p>related to imbalance between oxygen supply and demand as evidenced by exertional dyspnea.</p>	<p>depleted due to decreased oxygen levels for metabolic demands.</p>	<p>response to activity. Note reports of dyspnea increased weakness and fatigue. 2. Pace activity for the patient with reduced activity.</p>	<p>tolerance to activity with an absence of dyspnea and excessive fatigue. The patient was very motivated to increase his activity intolerance. His wife was very encouraging.</p>
<p>3. Risk for deficient fluid volume related to decreased oral intake as evidenced by decreased skin turgor.</p>	<p>Patients with pneumonia who have a fever have insensible fluid losses from the lungs and skin that may lead to deficient fluid volume.</p>	<p>1. Monitor intake and output accurately. Observe urine color. Watch out for urine output less than 30 mL/hr. 2. Weigh the patient daily at the same time of day and in the same clothes, using the same scale. Monitor for weight changes of 1-1.5 kg/day.</p>	<p>Fluid intake will approximate fluid output. The patient was not interested in drinking fluids provided for him. His wife tried to encourage him to no avail.</p>

Other References (APA):

Concept Map (20 Points):

Subjective Data

- The patient complains of a cough.
- The patient's wife believed that the patient choked on his food.
- The patient denied any shortness of breath or difficulty breathing.
- The patient also denies any nausea, vomiting, or diarrhea.
- The patient denied finding any relief from his cough.
- The patient has sought treatment for COPD and GERD in the past.

Nursing Diagnosis/Outcomes

1. Ineffective airway clearance related to aspiration as evidenced by cough.
 - The patient will demonstrate behaviors to achieve airway clearance.
 - The patient responded positively, and his wife was very supportive.
2. Activity intolerance related to imbalance between oxygen supply and demand as evidenced by exertional dyspnea.
 - Demonstrate a measurable increase in tolerance to activity with an absence of dyspnea and excessive fatigue.
 - The patient was very motivated to increase his activity intolerance. His wife was very encouraging.
3. Risk for deficient fluid volume related to decreased oral intake as evidenced by decreased skin turgor.
 - Fluid intake will approximate fluid output.
 - The patient was not interested in drinking fluids provided for him. His wife tried to encourage him to no avail.

Objective Data

- Low levels of platelets
- Elevated levels of neutrophils
- Low levels of lymphocytes
- Low levels of sodium
- Low levels of chloride
- Elevated levels of glucose
- Elevated levels of lactic acid
- A portable chest XR revealed the patient's lungs to have scattered bilateral lower lobe infiltrates, possibly due to aspiration of food.
- The patient has edema of the lower extremities bilaterally.
- There was an incision on the right lower quadrant from the ascites paracentesis procedure.

Patient Information

- The patient is an 80-year-old married Caucasian male with a history of COPD, ascites, arthritis, A-fib, BCC, cholangitis, cirrhosis, GERD without esophagitis, hemochromatosis, herpes zoster, multiple myeloma/multiple myeloma in remission, osteoarthritis, hypothyroidism, plasmacytoma, pneumonia due to an infectious organism, and SOB.
- Past surgical history: Biliary endoscopy percutaneous, DIL + Stent, bone marrow biopsy, bilateral cataract removal (2017), cholecystectomy, colonoscopy, ERCP, laparotomy, skin biopsy from the head, removal of rib(s) upper left (1994) and lower right (2007).
- The patient utilizes glasses, a walker, a hearing aid, and a gait belt.
- Fall risk score: 100
- Braden score: 21

Nursing Interventions

1. Auscultate lung fields, noting areas of decreased or absent airflow and adventitious breath sounds; crackles, wheezes.
2. Assess cough effectiveness and productivity.
3. Determine the patient's response to activity. Note reports of dyspnea increased weakness and fatigue.
4. Pace activity for the patient with reduced activity.
5. Monitor intake and output accurately. Observe urine color. Watch out for urine output less than 30 mL/hr.
6. Weigh the patient daily at the same time of day and in the same clothes, using the same scale. Monitor for weight changes of 1-1.5 kg/day.
7. Initiate and maintain compression.
8. Encourage active and passive leg exercises.
9. Assess readiness for transition care.
10. Educate on swallowing precautions. Get patient to demonstrate small bites and sips.
11. Encourage patient to continue taking medications after discharge.
12. Encourage patient to participate in physical therapy and occupational therapy after discharge.
13. Educate wife on the need for diet modifications and help with activities of daily living.

