

N321 Care Plan #2
Lakeview College of Nursing
Bailey Pierce

N321 CARE PLAN

Demographics (3 points)

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|-------------------------------------|---------------------------------------|----------------------------------|---|
| Date of Admission 6/24/21 | Patient Initials L.R. | Age 73 | Gender F |
| Race/Ethnicity Caucasian | Occupation Retired Nurse-VA | Marital Status Married | Allergies Erythromycin, lisinopril, orange juice, orange oil, Sulfa antibiotics, Tramadol |
| Code Status Full Code | Height 5'2" | Weight 205 | |

Medical History (5 Points)

Past Medical History: Hypertension, Hypothyroidism, Osteoporosis, Neurocardiogenic syncope, Gastroesophageal reflux disease, Cataract left eye, Histoplasmosis as a child.

Past Surgical History: Pacemaker, hysterectomy, shoulder arthroscopy, knee surgery, colonoscopy, cataract removal with implant.

Family History: Mother passed from congestive heart failure. Father passed away from liver cancer. Brother is diabetic.

Social History (tobacco/alcohol/drugs): Patient denies any alcohol or drug use. Patient reported she had previously smoked ½ packs of cigarettes a day for 40 years until 14 years ago when she quit.

Assistive Devices: Glasses, Walker

Living Situation: Lives at home with husband and chihuahua.

Education Level: Bachelor's in nursing-Lakeview Graduate '84

Admission Assessment

Chief Complaint (2 points): Patient complains of chest pain when breathing. She rates her pain between 5 on a scale of 1-10. The patient is being treated for pneumonia that has potentially led to bacterial sepsis.

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History of present Illness (10 points):

Patient came to the Emergency Room (ER) 06/24/20 with shortness of breath, hypertension, and chest pain. The patient had previously been diagnosed with bronchitis 06/22/2021 and was given prednisone. She reports telling the Physician's Assistant (PA) that she would need an antibiotic along with the prednisone and the PA refused. The patient states she has been experiencing shortness of breath for 2 weeks now. She is very easily fatigued and spends most of her time lying down. Patient stated, "I am too tired to even eat.". She states resting helps keep her comfortable as she is only in pain when she breathes in deeply. Pt is currently receiving 4 L/min oxygen with humidity.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute hypoxemic respiratory failure

Secondary Diagnosis (if applicable): Pneumonia

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

Respiratory failure occurs when the respiratory system is unable to efficiently oxygenate the blood or eliminate carbon dioxide. There are two categories of respiratory failure, Type 1 (hypoxemic) and Type 2 (hypercapnic) (Capriotti, 2020). My patient has acute hypoxemic respiratory failure meaning a sudden onset where pressure of oxygen in the arterial blood supply is less than 60 mmHg and is maintaining normal arterial carbon dioxide (Capriotti, 2020). Hypoxemic respiratory failure is commonly associated with pulmonary edema, pulmonary embolism, pneumonia, and pneumothorax (Capriotti, 2020). This is consistent with my patient's diagnosis of pneumonia and original diagnosis of suspected pulmonary embolism. Due to condensation within the lobes of the lungs the patient is experiencing atelectasis which is a

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complete or partial collapse of all or a lobe of the lung (Merck Manuals, 2020). When the alveoli are unable to inflate due to alveolar fluid, sufficient exchange of carbon dioxide and oxygen are not possible. Signs and symptoms of hypoxemic respiratory failure include dyspnea, chronic cough, fever, crackles, weight loss, pallor, weak pulse, low oxygen saturation, and fatigue (Capriotti, 2020). My patient is experiencing cough, crackles, low oxygen saturation, and fatigue. Diagnosis includes chest X ray and arterial blood gases. The patient's chest X Ray presented bibasilar opacities within the lower lungs consistent with atelectasis or fibrosis. This indicates partial collapse of the lungs (Capriotti, 2020). The patient was previously a smoker and had histoplasmosis as a child which could contribute to some of the fibrosis. A chest CT was also performed and areas of condensation within the right middle, upper, and lower lungs were observed, as well as a mucous plug in the right lower lobe bronchi. The chest CT also ruled out a pulmonary embolism. Treatment for acute hypoxemic respiratory failure includes high flow oxygen between 70-100% via nonrebreather mask (Merck Manuals, 2020). The patient is receiving 4L/min 100% oxygen via nasal cannula. Her oxygen saturations were between 93-95% during my rotation. If oxygen saturation drops below 90% mechanical ventilation may be necessary (Merck Manuals, 2020). The patient is also receiving nebulizer treatments of ipratropium-albuterol (Duo-NEB) 3mL 4 times daily to help dilate the bronchi (Jones and Bartlett Learning, 2019).

Pathophysiology References (2) (APA):

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

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Jones & Bartlett Learning. (2019). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Merck Manuals. (2020, March). *Acute hypoxemic respiratory failure (AHRF, ARDS)*.

Merck Manuals Professional Edition.

<https://www.merckmanuals.com/professional/critical-care-medicine/respiratory-failure-and-mechanical-ventilation/acute-hypoxemic-respiratory-failure-ahrf.-ards?redirectid=8>

(^^should be hanging indent...will not let me for website)

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 | Male: 4.7-6.1 Female: 4.2-5.4 | 4.19 | 4.18 | Low RBC values could be related to dietary deficiency (Pagana et al., 2016). The patient stated she has felt too tired to eat. |
| Hgb | Male: 14-18g/dL Female: 12-16g/dL | 12.8 | 12.8 | Within Normal Limits (WNL) |
| Hct | Male: 40-52% Female: 36-47% | 37.7 | 38.3 | WNL |
| Platelets | 150-400 x 10 ⁹ /L | 228 | 199 | WNL |
| WBC | 5-10 x 10 ⁹ /L | 14.10 | 11.90 | Elevated WBCs correlate with infection (Pagana et al., 2016). The patient's blood work came back positive for Staphylococcus Aureus and Staphylococcus Hominis. |
| Neutrophils | 55-70 | 55.6 | 64.4 | WNL |
| Lymphocytes | 20-40 | 34.6 | 24.4 | WNL |

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|-------------|-------|-----|-----|---|
| Monocytes | 2-8 | 9.5 | 9.1 | Elevated monocytes can be correlated with osteoporosis (Ye et al., 2020). Elevated monocytes can also be associated with inflammation (Pagana et al., 2016). The patient was originally treated for bronchitis and is currently being treated for pneumonia which can lead to inflammation in the bases of the lungs (Capriotti, 2020). |
| Eosinophils | 1-4 | 0 | 1.0 | Low eosinophil counts can be related to increased cortisol production (Pagana et al., 2016). The patient has been ill for over a week. This could put stress on the body leading to increased cortisol levels. |
| Bands | 0.5-1 | ** | ** | ** |

**labs not completed

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 mEq/L | 138 | 137 | WNL |
| K+ | 3.5-5 mEq/L | 3.1 | 3.8 | Low potassium levels can be related to excess cortisol production (Pagana et al., 2016). The patient has been ill for over a week. This could put stress on the body leading to increased cortisol levels. The patient is also on hydrochlorothiazide. This is a diuretic and can lower potassium levels. |
| Cl- | 98-106 mEq/L | 100 | 98 | |
| CO2 | 23-30 mEq/L | 26 | 31 | Increased carbon dioxide can be related to poor gas exchange. The patient is currently being treated for pneumonia which leads to an accumulation of fluid in the bases of the lungs potentially decreasing |

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| | | | | gas exchange. |
| Glucose | 74-106 mg/dL | 247 | 183 | Elevated glucose levels can be related to acute stress response and corticosteroid use (Pagana et al., 2016). The patient's condition has put a great deal of stress on herself and her body. The patient is also on hydrochlorothiazide and levothyroxine which can elevate glucose levels. |
| BUN | 10-20 mg/dL | 23 | 18 | Elevated BUN levels can indicate dehydration (Pagana et al., 2016) |
| Creatinine | 0.5-1.1 mg/dL | 0.95 | 0.81 | WNL |
| Albumin | 3.5-5 mg/dL | 3.4 | ** | Acute infection and stress can cause decreased albumin levels (Pagana et al., 2016). The patient's blood work was positive for Staphylococcus Aureus and Staphylococcus Hominis. |
| Calcium | 9-10.5 mg/dL | 9.0 | 9.2 | WNL |
| Mag | 1.3-2.1 mEq/dL | 2.8 | ** | Increased magnesium levels can be related to hypothyroidism and uncontrolled diabetes (Pagana et al., 2016). The patient has hypothyroidism and blood sugar has been higher than normal since arrival peaking at 318. The patient has not been diagnosed with diabetes. |
| Phosphate | 3-4.5 mg/dL | ** | ** | ** |
| Bilirubin | 0.3-1 mg/dL | 0.6 | ** | WNL |
| Alk Phos | 30-120 U/L | 68 | ** | WNL |
| AST | 0-35 U/L | 28 | ** | WNL |
| ALT | 4-36 U/L | 29 | ** | WNL |
| Amylase | 60-120 U/L | ** | ** | ** |

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| Lipase | 0-160 U/L | ** | ** | ** |
| Lactic Acid | Venous blood: 5-20 mg/dL or 0.6-2.2 mmol/L Arterial blood: 3-7 mg/dL or 0.3-0.8mmol/L | 1.6 (venipuncture) | ** | WNL |

****labs not completed**

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 | 1.1 | ** | WNL |
| PT | 11-13.5 sec | 13.4 | ** | WNL |
| PTT | 25-36 sec | 27 | ** | WNL |
| D-Dimer | Greater than 0.4 mcg/mL or greater than 250 ng/mL | 961 | ** | An elevated D-Dimer is indicative of a clot in the body. The patient was originally believed to have a pulmonary embolism. |
| BNP | Less than 100 pg/mL | 97 | ** | WNL |
| HDL | Male: greater than 45 mg/dL Female: greater than 55 mg/dL | ** | ** | ** |
| LDL | Adult: less than 130 mg/dL Children: | ** | ** | ** |

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| | less than 110 mg/dL | | | |
| Cholesterol | Less than 200 mg/dL | ** | ** | ** |
| Triglycerides | 40-180 mg/dL | ** | ** | ** |
| Hgb A1c | Below 5.7% | 6.6 | ** | An elevated A1c can be related to diabetes. The patient's labs are elevated, but still within the non-diabetic range of 6-7% (Pagana et al., 2016) |
| TSH | 2-10 mU/L | ** | ** | ** |

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 | Clear, Amber/ Yellow | ** | ** | ** |
| pH | 4.6-8 Average: 6 | ** | ** | ** |
| Specific Gravity | 1.005-1.03 | ** | ** | ** |
| Glucose | 30-300 mg/day | ** | ** | ** |
| Protein | 0-8 mg/dL | ** | ** | ** |
| Ketones | Negative | ** | ** | ** |
| WBC | 0-4 per low- power field Negative for cast | ** | ** | ** |
| RBC | Less than or equal to 2, negative for cast | ** | ** | ** |
| Leukoesterase | Negative | ** | ** | ** |

**labs not completed

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

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| Test | Normal Range | Value on Admission | Today's Value | Explanation of Findings |
|----------------|--|--|---------------|--|
| Urine Culture | Negative: less than 10,000 per mm of U Positive: greater than 100,000 per mm of U | ** | ** | ** |
| Blood Culture | Negative | Positive for Staphylococcus Aureus, Staphylococcus Hominis | | The patient's blood work was positive for Staphylococcus aureus and Staphylococcus. This correlated with her high WBC count. There was talk that the patient had bacterial sepsis as I was completing my rotation. |
| Sputum Culture | Normal Upper RT | ** | ** | ** |
| Stool Culture | Normal intestinal flora | ** | ** | ** |

**labs not completed.

Lab Correlations Reference (1) (APA):

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

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2016). *Mosby's diagnostic and laboratory test reference* (13th ed.). Mosby.

Ye, X., Jiang, H., Wang, Y., Ji, Y., & Jiang, X. (2020). A correlative study between osteoporosis and blood cell composition. *Medicine*, 99(26).

<https://doi.org/10.1097/md.0000000000020864>

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

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CT-Chest w/ contrast-Pulmonary Embolism (PE) suspected. Diagnosed with bronchitis 06/22/2021) .

Findings: No PE. Heart enlarged. Small hiatus hernia. Muroid plugging versus mass involving the Right lung base. Correlation w/ follow up advised. Consolidations within the Right upper, middle, and lower lobes. Suspicious of multilobular pneumonia.

Chest Xray-Single view. Frontal.

Findings: Heart size borderline. Interim level of bilateral interstitial opacities which may suggest early pulmonary congestion. Interim level of bibasal opacities most likely atelectasis and or fibrosis. Costophrenic angles are clear

Diagnostic Test Correlation (5 points):

Consolidations on the chest CT are related to mucous and exudative edema that accumulates between the capillaries and alveoli in the lower lung (Capriotti, 2020). Atelectasis is the inability of the alveoli to open leading to partial or entire lung collapse. This is due to fluid buildup in the lungs. The CT indicates this is multilobular pneumonia indicates that more than one lobe is affected. The CT showed consolidations in the right upper, middle, and lower lobes. This is consistent with crackles heard in the R lower and middle lobe. The chest x-ray also showed signs of atelectasis or fibrosis.

Diagnostic Test Reference (1) (APA):

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

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

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Home Medications (5 required)

| Brand/Generic | albuterol (Proventil/ Ventolin) | amlodipine (Norvasc) | hydrochlorothiazide (Microzide) | levothyroxine (Synthroid) | metoprolol tartrate (Lopressor) |
|------------------------------|---|---|---|---|---|
| Dose | 2.5mg | 10mg | 25mg | 50mcg | 50mg |
| Frequency | every 4 hrs PRN | Daily | every 4 hrs PRN | Daily | 2x Daily |
| Route | PO | PO | PO | PO | PO |
| Classification | Bronchodilator | Antihypertensive | Diuretic | Thyroid hormone replacement | Antihypertensive |
| Mechanism of Action | albuterol attaches to beta2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine triphosphate (ATP) into cyclic adenosine monophosphate (cAMP) decreasing calcium levels and relaxing bronchial smooth muscle cells and inhibiting histamine release. (Jones & Bartlett Learning, 2019) | Decreases intracellular calcium levels, inhibiting smooth muscle cell contraction and relaxing coronary and vascular smooth muscles, decreasing peripheral vascular resistance and reducing systolic and diastolic blood pressure. (Jones & Bartlett Learning, 2019) | Promotes movement of water sodium, and chloride from blood in peritubular capillaries into nephron's distal convoluted tubule. (Jones & Bartlett Learning, 2019) | Replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis. (Jones & Bartlett Learning, 2019) | Inhibits stimulation of beta1 receptor sites located mainly in the heart resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand. Also helps to lower blood pressure by decreasing renal release of renin. (Jones & Bartlett Learning, 2019) |
| Reason Client Taking | Difficulty breathing. | Hypertension | Hypertension | Hypothyroidism | Hypertension |
| Contraindications (2) | Hypokalemia, hypersensitivity to albuterol and its components. | hypersensitivity to amlodipine, Severe liver disease (Jones & | Anuria, hypersensitivity to hydrochlorothiazide | Acute MI, uncorrected adrenal insufficiency (Jones & Bartlett | acute heart failure, pheochromocytoma (Jones & Bartlett |

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| | (Jones & Bartlett Learning, 2019) | Bartlett, Learning 2019) | (Jones & Bartlett Learning, 2019) | Learning, 2019) | Learning, 2019) |
| Side Effects/Adverse Reactions (2) | Hyperglycemia, drowsiness (Jones & Bartlett Learning, 2019) | Arrhythmias, pancreatitis (Jones & Bartlett Learning, 2019) | pulmonary edema, pneumonitis (Jones & Bartlett Learning, 2019) | wheezing, dyspnea (Jones & Bartlett Learning, 2019) | bronchospasms, dyspnea (Jones & Bartlett Learning, 2019) |
| Nursing Considerations (2) | Monitor serum potassium levels because albuterol may cause hypokalemia. monitor blood glucose as albuterol may cause hyperglycemia. (Jones & Bartlett Learning, 2019) | Assess patients frequently for chest pain when starting or increasing dose, can lead to worsening angina or an acute myocardial infarction. Educate patient to take with food and water to avoid GI distress. (Jones & Bartlett Learning, 2019) | Give hydrochlorothiazide in the morning and early evening to prevent nocturia. check blood glucose levels in diabetic patients and expect to increase antidiabetic dosage. (Jones & Bartlett Learning, 2019) | Monitor blood glucose levels of diabetic patients because it may worsen glycemic control. Give oral levothyroxine at least 4 hrs before or after aluminum, magnesium containing antacids, bile sequestrants, calcium carbonate, cation exchange resins, kayexalate, or sucralfate to prevent decreased drug absorption. (Jones & Bartlett Learning, 2019) | Check for signs of poor glucose control in patients with diabetes mellitus. If patient with heart failure develops symptomatic bradycardia, expect to decrease the metoprolol dosage. (Jones & Bartlett Learning, 2019) |

Hospital Medications (5 required)

| Brand/Generic | Acetaminophen (Tylenol) | cefazolin (Ancef) | enoxaparin (Lovenox) | glucagon inject SOLR (GlucaGen) | insulin lispro (Humalog) |
|-----------------------|--------------------------------|--------------------------|-----------------------------|--|---------------------------------|
| Dose | 650mg | 2g/20mL | 40mg | 1mg | Sliding scale |
| Frequency | every 6 hr PRN | every 8 hrs | Daily | PRN | before meals 4x daily |
| Route | PO | IV | SubQ | IM | SubQ |
| Classification | Antipyretic | Antibiotic | Anticoagulant | Antihypoglycemic | Fast acting |

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| | Nonopioid analgesic | | | | insulin. (Islam et al., 2020) |
| Mechanism of Action | Inhibits the enzyme (Jones & Bartlett Learning, 2019)cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. (Jones & Bartlett Learning, 2019) | Interferes with bacterial cell wall synthesis by inhibiting the final step in the cross linking of peptidoglycan strands. Peptidoglycan makes cell membranes rigid and protective. Without it, bacterial cells rupture and die. (Jones & Bartlett Learning, 2019) | Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors. (Jones & Bartlett Learning, 2019) | Increases production of adenylate cyclase, which catalyzes conversion of adenosine triphosphate to cAMP, a process that in turn activates phosphorylase. (Jones & Bartlett Learning, 2019) | Lowers blood glucose by stimulating peripheral glucose uptake by skeletal muscle and fat. Also inhibits hepatic glucose production. (Islam et al., 2020) |
| Reason Client Taking | Pain PRN | Pneumonia | Prevent pulmonary embolism | PRN if blood sugar is too low. | High blood glucose (Pt is not diabetic) |
| Contraindications (2) | severe hepatic impairment, severe active liver disease (Jones & Bartlett Learning, 2019) | hypersensitivity to cefazolin, Kidney disease (Jones & Bartlett Learning, 2019) | Major bleeding, hypersensitivity to pork products (Jones & Bartlett Learning, 2019) | Hypersensitivity to glucagon or its components, pheochromocytoma (Jones & Bartlett Learning, 2019) | Hypoglycemia, hypersensitivity to insulin lispro or one of its ingredients. (Islam et al., 2020) |
| Side Effects/Adverse Reactions (2) | atelectasis, pulmonary edema (Jones & | dyspnea, fever (Jones & Bartlett | Hematuria, pneumonia (Jones & Bartlett | Hypotension, Hypertension | hypoglycemia hypokalemia |

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| | Bartlett Learning, 2019) | Learning, 2019) | Learning, 2019) | (Jones & Bartlett Learning, 2019) | (Islam et al., 2020) |
| Nursing Considerations (2) | <p>Use cautiously in patients with hepatic impairment.</p> <p>Monitor renal function in patients on long term therapy.</p> <p>(Jones & Bartlett Learning, 2019)</p> | <p>Monitor IV site for irritation, phlebitis, and extravasation. Assess bowel pattern daily, severe diarrhea may indicate pseudomembranous colitis.</p> <p>(Jones & Bartlett Learning, 2019)</p> | <p>Use cautiously in those with bleeding diathesis, diabetic retinopathy, hepatic or renal impairment, recent GI hemorrhage, or ulceration, or uncontrolled hypertension.</p> <p>Don't give drug by IM injection.</p> <p>(Jones & Bartlett Learning, 2019)</p> | <p>Administer by slow I.V. injection to decrease risk of tachycardia and vomiting. Place the unconscious patient on their side before injecting glucagon to prevent aspiration of vomitus when he regains consciousness.</p> <p>(Jones & Bartlett Learning, 2019)</p> | <p>Closely monitor glucose levels. may become hypoglycemic.</p> <p>Monitor injection site for signs of lipodystrophy.</p> <p>(Islam et al., 2020)</p> |

Medications Reference (1) (APA):

Islam, N., Khanna, N. R., & Zito, P. M. (2020, September 20). *Insulin lispro*. NCBI.

<https://www.ncbi.nlm.nih.gov/books/NBK507840/>

Jones & Bartlett Learning. (2019). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

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|---------------------------|--|
| GENERAL (1 point): | |
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| Alertness: Orientation: Distress: Overall appearance: | AxO x4 (Person, place, time, situation) Patient is anxious about having a peripheral catheter (picc line) placed. She is worried that the nurse who places the picc line will leave for the day before coming to place hers. Well groomed and dressed appropriately. |
| 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: | Ivory Lentigo generalized, dry. Warm to touch Normal skin turgor (2+) No rashes present. Bruising on abdomen consistent with Lovenox and insulin injections. Bruise around IV site on the R antecubital space. No wounds present. 18 |
| HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth: | Symmetric, free of lesions Symmetric, dry around auricles w/ no drainage. No break down around the ears in conjunction with oxygen tubing. Symmetric. Sclera white, cornea clear, conjunctiva pink. No drainage or lesions observed. Septum is midline with no deviation. Pt is receiving oxygen via nasal cannula. No signs of skin breakdown present. Dentition intact. Oral mucosa pink, moist, with no lesions. |
| 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 type="checkbox"/> N <input checked="" type="checkbox"/> | . Clear s1 and s2 sounds without gallops, murmurs, or rubs. N/A Bilateral radial pulses 2+. Bilateral dorsalis pedis 1+. Capillary refill fingers and toes bilaterally 3+. No edema present. |

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| Location of Edema: | |
| RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character | <p>.</p> <p>Coarse crackles heard in the right middle and lower lobes. Pt also had a slight wheeze on the right and left bronchi. Respirations are slightly labored and shallow.</p> |
| 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 <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> <p>Regular Regular (Pt put herself on a low carb diet due to high blood glucose readings.) 5'2" 205 Normoactive bowel sounds in all 4 quadrants. 06/27/2021 No Pain upon light and deep palpation. Patient was easily fatigued and was dressed in pajama pants and a gown. I was able to observe the arms, legs below the knee, back, abdomen, and chest. No distention present. No incisions present. Scar on the R knee consistent with knee surgery. Scar on upper left chest consistent with pacemaker. No drains present. No wounds present.</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>Yellow amber. Clear. Pt toileted 2x.</p> <p>Not observed.</p> |
| MUSCULOSKELETAL (2 points): Neurovascular status: ROM: | <p>.</p> <p>Full range of motion in all extremities.</p> |

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| <p>Supportive devices:</p> <p>Strength:</p> <p>ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score:</p> <p>Activity/Mobility Status:</p> <p>Independent (up ad lib)</p> <p>Needs assistance with equipment <input checked="" type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p> | <p>Pt is able to ambulate with walker. I stayed close behind just in case. Pt is easily fatigued. Patient has generalized weakness but is able to ambulate and change position. Pt stated she was too weak to even eat.</p> <p>60</p> <p>No</p> <p>Pt is ambulating with a walker.</p> <p>Pt does not need support to walk.</p> |
| <p>NEUROLOGICAL (2 points):</p> <p>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -</p> <p>Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p> <p>Sensory:</p> <p>LOC:</p> | <p>.</p> <p>Pupils are equal, round, reactive to light, and able to accommodate.</p> <p>Equal strength of the hands and feet when performing hand grips and pedal pushes pulls.</p> <p>AxO x4- Person, Place, Time, and Situation.</p> <p>Alert. No signs of distress.</p> <p>Comprehensible</p> <p>No sensory deficits</p> <p>No</p> |
| <p>PSYCHOSOCIAL/CULTURAL (2 points):</p> <p>Coping method(s):</p> <p>Developmental level:</p> <p>Religion & what it means to pt.:</p> <p>Personal/Family Data (Think about home environment, family structure, and available family support):</p> | <p>.</p> <p>Patient likes to talk with her girlfriend and husband about what she is going through.</p> <p>Appropriate for age.</p> <p>Christian. Attend church every Sunday with her husband. Likes to think there is a higher power and everything happens for a reason.</p> <p>Pt has a close friend who was at the hospital with her. They accompany each other to doctor's visits and stay with each other when they are hospitalized. Friend is a 9-year colon cancer survivor. Pt went to every chemo appointment with her.</p> |

Vital Signs, 2 sets (5 points)

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|------|-------|--------|-----------|------|--------|
| 0737 | 88 | 116/56 | 19 | 97.2 | 93 |

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| | | Supine, head of bed elevated | | | |
| 1117 | 87 | 109/60 Supine, head of bed elevated | 20 | 97.6 | 95 |

Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|-------------|------------------|-----------------|-----------------|----------------------------|--|
| 1045 | 1-10, numeric | Chest | 5/10 | “Painful, stabbing” | Sat patient up in bed to help with breathing. Patient was administered Tylenol and received a nebulizer treatment shortly after. |
| 1345 | 1-10, numeric | Chest | 2/10 | Sharp only with breathing. | Pt did not feel she needed anything for pain at the moment, but requested additional pillows for support. |

IV Assessment (2 Points)

| IV Assessment | Fluid Type/Rate or Saline Lock |
|--|---------------------------------------|
| Size of IV: Location of IV: | 22 gauge Right Antecubital |

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| | |
|---|--|
| Date on IV: | 06/26/2021 |
| Patency of IV: | Flushes without difficulty. |
| Signs of erythema, drainage, etc.: | No signs of erythema or drainage. Pt does have a "quarter "size bruise at IV insertion site. |
| IV dressing assessment: | Clean, dry, and intact. |
| | |

Intake and Output (2 points)

| Intake (in mL) | Output (in mL) |
|---|-----------------------|
| 120mL coffee 360mL water 240mL Boost Glucose Control 235mL milk <hr/> 835mL | Toileted 2x |

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

Overview of care: I assisted the patient in ordering lunch and administered medications as prescribed. The patient needed assistance several times with repositioning to get comfortable in bed. I oversaw the patient using her spirometer, monitored I/O's, and vitals. Patient was very concerned with not being able to get her PICC line placed today. I reassured her the nurse was doing everything in her power to make sure the procedure was going to get done. The patient is a hard stick and was having blood drawn several times a day, as well as receiving medications that were painful when administered through the IV.

Procedures/testing done: Patient had blood drawn at least 2 times during my rotation. Her physician ordered her to speak with infection control before she would be eligible to

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have her PICC line placed. She was finishing up the call with infection control as we were leaving our rotation.

Complaints/Issues: Pt was very adamant about having a PICC line placed. She was in tears when the nurse was administering her Ancef. She mentioned that she was a hard stick and was having to be poked 2 and 3 times each time someone came to draw blood.

Vital signs (stable/unstable): Stable. Her blood sugar has been elevated over the last few days. The latest reading was 183. Her O2 sats were between 93-95% w/ 4L/min O2 via nasal cannula.

Tolerating diet, activity, etc.: Pt is easily fatigued and spends most of her time lying in bed. She was able to ambulate to and from the restroom. Pt put herself on a low carb diet due to increased blood glucose readings.

Physician notifications: Physician was notified of patient's request for a PICC line.

Future plans for patients: Pt will have a PICC line placed soon. She was waiting on approval from the physician. The nurse was discussing with another nurse that the patient may have bacteria sepsis. I would assume they will begin treatment to get her sepsis under control.

Discharge Planning (2 points)

Discharge location: Pt will be discharged home with her husband.

Home health needs (if applicable)

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Equipment needs (if applicable): Pt is receiving nebulizer treatments now. Will probably continue from home depending on how her condition progresses.

Follow up plan: Follow up pending discharge date. No plans have been made yet.

Education needs: Pt is a retired nurse of 47 years. She was on top of everything the doctors and nurses were saying. I believe she will need very little education when discharged.

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. Risk for infection related to pneumonia as evidence by Staphylococcus Aureus and Staphylococcus Hominis present in blood work. | The patient was believed to have bacterial sepsis after blood work was positive for | 1. Monitor for signs and symptoms of infection such as chills, pallor, and fever 2. Ensure adequate nutrition intake. | Pt was free of fever, chills, and pallor at the end of my rotation. I placed an order for the patient lunch. She ate half a serving of mashed potatoes and meatloaf with gravy. The patient also drank a Boost glucose control. |
| 2. Ineffective gas exchange related to pneumonia as evidence by coarse crackles heard in the right middle and lower lobes during respiration and O2 stat at 95% with 4L/ min of oxygen via | I chose this because the patient is on 4 L/ min of oxygen and oxygen was at 95% with receiving oxygen via nasal cannula. Coarse crackles were also heard in the R middle and lower lobe. | 1. Head of the bed was elevated to 45 degrees to help the patient breathe more easily. Additional pillows were also placed on the side to keep the patient from sliding off to the side of the bed. 2. Encouraged the | The patient was more comfortable sitting up. The patient’s O2 sats did improve from 93 to 95 over the course of 4 hrs. The patient was able to successfully use the spirometer. |

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| | | | |
|---|---|--|--|
| nasal cannula. | Crackles are indicative of fluid in the lungs which decreases the ability of the alveoli to efficiently exchange carbon dioxide and oxygen. | patient to use the incentive spirometer. | As a prior nurse, she was aware of the importance of using the spirometer to help open the alveoli. |
| 3. Acute pain related to medication regimen as evidence by patient grimacing and crying during medication administration. | The patient screamed out and cried when the nurse was administering Ancef. She cried and stated how much she dreaded her IV medications. She also mentioned she was tired of having to be stuck multiple times to have her blood drawn. The patient repeatedly requested a PICC line. | 1. Push IV meds very slowly to decrease discomfort. 2. Ensure IV site is intact and flushes without resistance. | Patient complimented the nurse on how much more comfortable receiving her Ancef was when slowed down her push rate. IV lines were flushed with no resistance before each medication administration. |

Other References (APA):**Concept Map (20 Points):**

Subjective Data

"I'm too tired to even eat."
"It only hurts when I breathe."
"Stop! Stop! Stop!"-when Ancef was administered.

Nursing Diagnosis/Outcomes

1. Risk for infection related to pneumonia as evidence by Staphylococcus Aureus and Staphylococcus Hominis present in blood work.
Goal: The patient will repeat understanding of proper handwashing technique and incentive spirometer care to decrease additional risk for infection.
2. Ineffective gas exchange related to pneumonia as evidence by coarse crackles heard in the right middle and lower lobes during respiration and O2 sat at 95% with 4L/min of oxygen via nasal cannula.
Goal: The patient will use the incentive spirometer 1x per hour while awake.
3. Acute pain related to medication regimen as evidence by patient grimacing and crying during medication administration.
Goal: The patient will report no or minimal discomfort when medications are given slowly via IV push.

Objective Data

Pulse 88,87
BP 116/56, 109/60
Resp 19, 20
Temp 97.2, 97.6
O2 93, 95
4L/min oxygen via nasal cannula
Chest CT- No PE, mucus plugs Right lower bronchi, consolidations Right upper, middle, and lower lobes. Subsequent atelectasis.
Chest X ray- bibasal opacities indicative of atelectasis or fibrosis.
Blood work positive for Staphylococcus Aureus and Staphylococcus Hominis.
Pain 5/10

Patient Information

73 year old, caucasian, female, married, retired VA nurse, previous smoker of 40 years (1/2 pack a day).

Nursing Interventions

1. Monitor for signs and symptoms of infection such as chills, pallor, and fever
 2. Ensure adequate nutrition intake.
-
1. Head of the bed was elevated to 45 degrees to help the patient breathe more easily. Additional pillows were also placed on the side to keep the patient from sliding off to the side of the bed.
 2. Encouraged the patient to use the incentive spirometer.
-
1. Push IV meds very slowly to decrease discomfort.
 2. Ensure IV site is intact and flushes without resistance.

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