N431 Care Plan # 1

Lakeview College of Nursing

Sarah Evans

Demographics (3 points)

Date of Admission 9/26/21	Patient Initials D.A.	Age 53	Gender Male
Race/Ethnicity **Caucasian**	**Occupation** **Disabled**	**Marital Status** **Divorced**	**Allergies** **lisinopril, penicillin, polytrim, valsartan**
Code Status **Full**	**Height** **182.4**	**Weight** **118.9kg**	

Medical History (5 Points)

Past Medical History: The patient has a past medical history of parkinson's, non-insulin dependent diabetes mellitus type two, hypertension, hypertensive cardiovascular disease, schizoaffective disorder, depression, anxiety, dilated aorta root, elevated troponin, first degree atrioventricular block, history of chronic grade one diastolic heart failure, anemia, hyperlipidemia, impair mobility, obesity, obstructive sleep apnea, and is a former smoker.

Past Surgical History: Femur fracture open reduction and internal fixation, tonsillectomy.

Family History: The patient stated he had an abusive childhood. He is no longer in contact with his family. To his knowledge his mother, father, sister, and two brothers are still living. The only family medical history the patient was aware of is his sister who is in remission from an unspecified form of cancer.

Social History (tobacco/alcohol/drugs): The patient claimed he stopped smoking on 9/25/21. The medical chart says he stopped smoking on 7/19/17. The patient is not a good historian and was unable to describe his amount of tobacco use. Therefore, the number of pack years is unknown. The patient denies the use of alcohol and elicit drugs.

Assistive Devices: The patient is using a gait belt when ambulating. He needs a stand by assist due to his fall risk score, but his gait is steady. He does not require any other assertive devices.

Living Situation: The patient lives at the Arcola Health Care Center in Arcola, IL. He is a ward of the state of Illinois.

Education Level: The patient stated he graduated from high school in 1987. The patient has an unspecified difficulty with communication. This could be due to his psychiatric history, his extensive psychiatric medications, or his present condition which includes high ammonia levels which could alter his ability to communicate clearly. Due to this deficit, he is unable to answer more complex questions. The patient's chart also noted in several places that he is a poor historian. The patient's chart notes he is a ward of the state of Illinois, but the student nurse was not able to find more information about why. All of these factors will influence patient education.

Admission Assessment

Chief Complaint (2 points): The patient originally complained of weakness in his lower extremities by stating, "My legs don't work".

History of present Illness (10 points):

On the morning of 9/26/21 (onset) the patient told a member of the healthcare team at the facility where he lives that his "legs (location) wouldn't work and I can't walk (severity)". Patient had sensation to his legs, but felt weak (characteristics). The patient stated this problem started today only (timing). The nurse at the facility noticed a change in mental status and upon assessment noted his oxygen saturation was 83% on room air (associated factors). The symptoms continued (duration) so they called emergency medical services.

Upon arrival the patient stated, "I took an Amish pill (possibly patient's perceived relieving factor) because my legs won't work". The first responders noted pin point pupils and administered 1mg of Naloxone. The patient did not articulate any aggravating factors. They transported the patient to Sarah Bush Lincoln Health Center in Mattoon, IL for further medical assessment and observation. In the emergency department the patient complained of shortness of breath, but denied coughing and sputum production. The patient takes a significant amount of time to respond appropriately to questions, but the facility staff say this is his base line. The patient's chest x-ray indicated pneumonia. At the time of admission the patient required 2 liters of oxygen via nasal cannula to maintain an oxygen saturation above 90%. The patient was admitted by the hospitalist on 9/26/21.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Community acquired pneumonia.

Secondary Diagnosis (if applicable): Rhabdomyolysis, acute kidney injury, and hypoxia.

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

Pneumonia is and infectious disease spread by contact or droplets. It can be caused by a bacterial, viral, or fungal infection. The infection causes inflammation in the lungs. Pneumonia is a common cause of death, but the patient is 53 years old so his prognosis is favorable.

The signs and symptoms of pneumonia are tachypnea, dyspnea, shortness of breath, a productive cough with purulent sputum, tachycardia, fever, elevated white blood cells, and a sputum culture showing a viral, bacterial, or fungal origin (Capriotti, 2020). Risk factors for pneumonia include other disease processes like asthma, chronic obstructive pulmonary disorder, heart disease, smoking, age greater than 65 years, infants, young children, a disorder that weakens the immune system, hospitalization, and the use of a ventilators (Capriotti,2020). Pneumonia is diagnosed by x-ray of the chest showing opacity in the lungs and sputum culture specifying if the pneumonia is of fungal, bacterial, or viral origin.

Pneumonia can be treated by administration of antibiotics (if the pneumonia is of bacterial origin), the use of supportive therapies like oxygen supplementation, IV fluid to treat dehydration, smoking cessation, and respiratory therapy to regain pulmonary function.

My patient's pneumonia has an unknown etiology. During the shift the nurse and student nurse were able to collect a sputum culture. At the end of the clinical experience the results were still pending. Currently the patient is being treated with antibiotic therapy, IV fluids, and rest. The patient's chart did not explain these connections well but the student nurse believes it is possible the patient's pneumonia caused the rhabdomyolysis, acute kidney injury exacerbation (Zhao, 2019). This is supported by the patient's venous blood gas levels, creatinine level, and elevated total CK (Zhao, 2019). Therefore, he should be educated on the signs and symptoms of reduced oxygen perfusion so he can ask for assistance when he begins to feel these symptoms, the use of a humidifier, effective disease transmission prevention methods like hand washing and coughing into the bend in the arm instead of the hands. Before the patient education the nurse needs to assess the patient's level of understanding and mental status at the time of teaching. During this patient education the nurse must consider the patient's communication deficits to be most effective in her communication.

Pathophysiology References (2) (APA):

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

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

Zhao, B., Zheng, R. (2019). Community-acquired pneumonia complicated by rhabdomyolysis: A clinical analysis of 11 cases. *World Journal of Clinical Cases*, *7*(24). https://doi.org/10.12998/wjcc.v7.i24.4218

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	**3.57**	**3.24**	**The patient has a history of anemia, and chronic illness which can cause low red blood cell counts (Pagana et al, 2019).**
Hgb	12.0-15.8	**11.6**	**11.3**	**Low hemoglobin can be caused by anemia and kidney dysfunction (Pagana et al, 2019).**
Hct	36.0-47.0	**33.6**	**31.0**	**Low hematocrit can be caused by anemia (Pagana et al, 2019).**
Platelets	140-440	**268**	**246**	**n/a**
WBC	4.0-12.0	**18.4**	**12.6**	**This patient has pneumonia which can cause**
Neutrophils	40-60	**60**	**58.9**	**n/a**
Lymphocytes	19-49	**24.7**	**26.5**	**n/a**
Monocytes	3.0-13.0	**13.9**	**13.5**	**Monocytes are elevated due to viral infections (Pagana et al, 2019).**
Eosinophils	0-8.0	**0.4**	**0.8**	**n/a**
Bands	3-5	**3**	**3**	**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-	134-144	139	138	n/a
K+	3.5-5.1	4.6	4.6	n/a
Cl-	98-107	105	102	n/a
CO2	21-31	28	27	n/a
Glucose	70-99	98	104	Stress can cause elevated blood glucose levels. (Pagana et al, 2019).
BUN	7-25	23	15	n/a
Creatinine	0.50-1.20	1.36	0.80	Acute kidney injury causes elevated creatinine levels (Pagana et al, 2019).
Albumin	3.5-5.7	3.8	n/a	n/a
Calcium	8.6-10.3	9.1	8.6	n/a
Mag	1.6-2.6	2.4	n/a	n/a
Phosphate	2.5-4.5	n/a	n/a	n/a
Bilirubin	0.3-1.0	0.4	n/a	n/a
Alk Phos	30-120	35	n/a	n/a
AST	0-35	35	n/a	n/a
ALT	4-36	17	n/a	n/a
Amylase	60-120	n/a	n/a	n/a
Lipase	0-160	n/a	n/a	n/a
Lactic Acid	0.5-2.2	1.0	n/a	n/a
Troponin	<0.04	<0.01	n/a	n/a
CK-MB	3-5	4.30	n/a	n/a
Total CK	22-198	1087	816	Pneumonia with rhabdomyolysis can cause elevated cardiac enzymes (Zhao, 2019).

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	0.9-1.1	**n/a**	**n/a**	**n/a**
PT	10.1-13.1	**n/a**	**n/a**	**n/a**
PTT	25-36 seconds	**n/a**	**n/a**	**n/a**
D-Dimer	<0.05	**n/a**	**n/a**	**n/a**
BNP	>400	72	**n/a**	**Pneumonia with rhabdomyolysis can cause changes in the BNP level (Zhao, 2019).**
HDL	**>60**	**n/a**	**n/a**	**n/a**
LDL	**<130**	**n/a**	**n/a**	**n/a**
Cholesterol	**<200**	**n/a**	**n/a**	**n/a**
Triglycerides	**<150**	**n/a**	**n/a**	**n/a**
Hgb A1c	**<5.7**	**n/a**	**n/a**	**n/a**
TSH	**0.5-5.0**	**n/a**	**n/a**	**n/a**
Ammonia	**15-45**	**n/a**	124	**Acute kidney disease causes elevated ammonia levels (Capriotti, 2020).**

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, yellow**	**n/a**	**pending**	**n/a**

pH	5.0-9.0	**n/a**	**pending**	**n/a**
Specific Gravity	**1.003-1.013**	**n/a**	**pending**	**n/a**
Glucose	**negative**	**n/a**	**pending**	**n/a**
Protein	**negative**	**n/a**	**pending**	**n/a**
Ketones	**negative**	**n/a**	**pending**	**n/a**
WBC	**negative**	**n/a**	**pending**	**n/a**
RBC	**negative**	**n/a**	**pending**	**n/a**
Leukoesterase	**negative**	**n/a**	**pending**	**n/a**

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

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
pH	**7.35-7.45**	**7.39**	**n/a**	**n/a**
PaO2	**10.7-13.3**	**11.6**	**n/a**	**n/a**
PaCO2	**35-45**	**45.0**	**n/a**	**n/a**
HCO3	**22-26**	**25.9**	**n/a**	**n/a**
SaO2	**92-100**	**83**	**93**	**The patient was hypoxic due to his pneumonia which can cause low oxygen saturation (Pagana, 2019).**
pH venous	**7.31-7.41**	**n/a**	**7.43**	**The student nurse looked for several reasons this level could be**

				on the basic side but was unable to find a suitable answer for this patient.
CO2 venous	**41-51**	**n/a**	**44.6**	**n/a**
PO2 venous	**30-40**	**n/a**	**192.0**	**The patient could have high levels of oxygen in his blood due to the oxygen therapy he was receiving until it was discontinued (Pagana et al, 2019).**
HCO3 venous	**23-29**	**n/a**	**28.3**	**n/a**
O2 Sat venous	**75**	**n/a**	**100.2**	**n/a**
Carbon Monoxide	**< 2.3%**	**n/a**	**2.2**	**n/a**

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

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
Urine Culture	**negative**	**n/a**	**pending**	**n/a**
Blood Culture	**negative**	**n/a**	**n/a**	**n/a**
Sputum Culture	**negative**	**n/a**	**pending**	**n/a**
Stool Culture	**negative**	**n/a**	**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.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference (Fourteenth edition. ed.). Elsevier.

Zhao, B., Zheng, R. (2019). Community-acquired pneumonia complicated by rhabdomyolysis: A clinical analysis of 11 cases. *World Journal of Clinical Cases*, *7*(24). https://doi.org/10.12998/wjcc.v7.i24.4218

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Computed tomography with out contrast ordered on 9/26/21-

There were not signs of hemorrhage, no masses, no fracture. The white matter and sinuses were unremarkable. The results showed no acute intracranial abnormality.

X-ray chest ordered on 9/26/21-

This x-ray showed cardiomegaly and patches opacities indicating fluid in the lungs likely caused by pneumonia. The fluid was mostly seen in the base of the lungs.

Electrocardiogram ordered on 9/26/21-

This test revealed no abnormal findings. The report stated the patient has a normal sinus rhythm.

Respiratory identification panel ordered on 9/26/21-

The patient was negative for everything analyzed by this panel.

Urine Analysis ordered on 9/27/21-

The results were pending at the end of this clinical experience.

Sputum culture ordered on 9/27/21-

The results were pending at the end of this clinical experience.

Diagnostic Test Correlation (5 points):

Computed tomography of the head with out contrast ordered on 9/26/21-

This test was ordered because of the patient's mental status change and confusion. The doctor likely wanted to rule out stroke and trauma as causes for these changes. This test can visualize the anatomy in greater detail to show tissue damage and unexpected findings like masses or blood clots.

X-ray chest ordered on 9/26/21-

A chest x-ray was ordered due to hypoxia and shortness of breath. The provider can see fluid build up and masses using a chest x-ray. The provider can also see the size of the heart and lungs with this image.

Electrocardiogram ordered on 9/26/21-

This test was ordered to rule out cardiac problems as a cause of the patient's symptoms. The electrocardiogram gives a snap shot of the electrical activity of the heart. This test can show dysrhythmias and variations caused by heart attacks.

Respiratory identification panel ordered on 9/26/21-

This test was ordered to check the patient for several respiratory illnesses due to his hypoxia and trouble breathing. This test screens for 4 strains of COVID, Adenovirus, Coronavirus, Influenza A and B, mycoplasma pneumonia, respiratory syncytial virus, and a few other viruses and bacteria.

Urine Analysis ordered on 9/27/21-

This test was ordered due to a change in mental status. The client went from alert and oriented x 3-4. This deteriorated to alert and oriented x 2-3. This test screens the urine for things that are not normally present in urine like bacteria and protein among other things (Capriotti, 2020).

Sputum culture ordered on 9/27/21-

This test was ordered due to a change in mental status. The client went from alert and oriented x 3-4. This deteriorated to alert and oriented x 2-3. This test can tell the provider what type of infection is causing the patient's pneumonia.

Diagnostic Test Reference (1) (APA):

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

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference (Fourteenth edition. ed.). Elsevier.

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

Brand/Generic	**atenolol**	**sertraline Zoloft**	**haloperidol**	**benzotropine Cogentin**	**clonazepam**
Dose	**100mg**	**100mg**	**10 mg**	**1mg**	**1mg**
Frequency	**Daily**	**Daily**	**BID**	**BID**	**BID**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	Beta adrenergic blocker Antiangina, antihypertensive	Selective serotonin re-uptake inhibitor (SSRI) Anxiolytic, antidepressant	Butyrophenone derivative 1st generation antipsychotic	Anticholinergic Antiparkinsonian	Benzodiazepine Anticonvulsant

Mechanism of Action	Inhibits stimulation of beta 1 receptors decreasing cardiac contractility (Jones, 2021).	Stops the re-uptake of serotonin which increases the amount of serotonin in the nerve synaptic cleft which helps the mood. (Jones, 2021)	May block dopamine receptors (Jones, 2021).	Blocks acetylcholine at receptor sites (Jones, 2021).	Inhibits repute of norepinephrine and serotonin (Jones, 2021).
Reason Client Taking	To treat hypertension.	Client has a history of depression and other mental health disorders that can be exacerbated by depression	The client has schizoaffective disorder.	To treat Parkinson's disease.	The treat schizoaffective disorder.
Contraindications (2)	Anesthesia, cardiogenic shock (Jones, 2021).	Using disulfiram or an MAO in the last 14 days is a contraindication (Jones, 2021).	Dementia with lewy bodies, and hypersensitivity to haloperidol (Jones, 2021).	Children less than 3 years old should not take this, hypersensitivity to this medication (Jones, 2021).	Hepatic disease and acute narrow angle glaucoma (Jones, 2021).
Side Effects/Adverse Reactions (2)	Arrhythmias, bradycardia, mitral insufficiency (Jones, 2021).	atrial arrhythmia, bradycardia (Jones, 2021)	neuroleptic malignant syndrome, seizures (Jones, 2021).	Hypotension, diplopia, and blurred vision (Jones, 2021).	Suicidal ideation and leukopenia (Jones, 2021).

Nursing Considerations (2)	Use cautiously in pt with heart failure. Use cautiously with diabetic patient (Jones, 2021)	Do not give this medication to a person with a low heart rate, monitor closely for serotonin syndrome. (Jones, 2021)	Do not use this medication to treat psychosis in the elderly because it can cause death. Use cautiously in patients with a longer QT interval (Jones, 2021).	Stop medication and contact provider if vision changes occur. Do not give to children less than three years old (Jones, 2021).	Use caution for the patient with renal failure. Monitor for suicidal thinking (Jones, 2021).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check the patients heart rate and blood pressure (Jones, 2021).	Check the patient's heart rate (Jones, 2021).	Check patient for signs of neuroleptic malignant syndrome (Jones, 2021).	Assess for vision changes (Jones, 2021).	Monitor plateltes, WBC, CBC, and blood drug level (Jones, 2021).
Client Teaching needs (2)	Teach the client to take their heart rate and blood pressure (Jones, 2021).	Teach the client to take their own heart rate. This drug can cause the pupils to be more dilated (Jones, 2021),	Take exactly as prescribed, take tablet with food (Jones, 2021).	This drug has a cumulative effect increasing the risks over time. Do not drive until the effects of this medication are known (Jones, 2021).	Do not stop abruptly and may cause drowsiness (Jones, 2021).

Home Medications (5 required)

Hospital Medications (5 required)

Brand/Generic	**azithromycin**	**ceftriazone**	**amlodipine**	**enoxaparin Lovenox**	**pantoprazole**
Dose	**500mg**	**2000mg**	**5mg**	**40mg**	**40mg**
Frequency	**every 24 hours**	**every 24 hours**	**daily**	**daily**	**daily**
Route	**IV piggyback**	**IV piggyback**	**PO**	**SQ**	**PO**
Classification	Macrolide Antibiotic	Third generation cephalosporin Antibiotic	Calcium channel blocker Antihypertensive, antianginal	Low molecular weight heparin Anticoagulant	Proton Pump Inhibitor Anti ulcer

Mechanism of Action	Blocks peptide translocation disturbing RNA synthesis in the bacteria (Jones, 2021).	Interferes with the production the the bacterial cell wall (Jones, 2021).	Inbits calcium ions from causing smooth muscle contractions (Jones, 2021).	This medication binds with clotting factors which inactivates them (Jones, 2021).	Proton pump inhibitors block the last step of gastric acid production which prevents more stomach acid from forming (Jones, 2021).
Reason Client Taking	The patient has pneumonia which is berth treated empirically with a broad spectrum antibiotic.	The source of the client's pneumonia is unknown. This medication treats streptococcus pneumonia (Jones, 2021).	To control hypertension.	To prevent blood clots during period of decreased mobility.	Used for prophylaxis for GI ulcer.
Contraindications (2)	A history of cholestatic jaundice and liver disfunction (Jones, 2021).	Hypersensitivity to cephtriaxone and other cephalosporins (Jones, 2021).	Hypersensitivity to amilodipine and its components (Jones, 2021).	Active bleeding, hypersensitivity to heparin (Jones, 2021)	Concurrent therapy with rilpivirine containing products, or hypersensitivity to pantoprazole. (Jones, 2021)
Side Effects/Adverse Reactions (2)	Arrhythmias, diarrhea	Seizures, and hepatic	Arrhythmias and	CVA, Atrial fibrillation	C-diff, hepatic

	(Jones, 2021).	failure (Jones, 2021).	hypotension (Jones, 2021).	(Jones, 2021)	failure (Jones, 2021)
Nursing Considerations (2)	Do not use in patients with a prolonged QT interval. No not use in patients with bradycardia (Jones, 2021)**.**	Do not give a calcium containing product to a neonatal patient within 48 hours of giving this medication. Use with caution for a patient allergic to penicillin (Jones, 2021).	Use caustiously in a patient with a heart block and assess the patient for chest pain (Jones, 2021).	Prevent falls while using this medication because of risk for bleeding. Do not use this medication if the client has had heparin induced thrombocyto penia. (Jones, 2021)	When giving IV over 2 minutes, reconstitute with 10ml of normal saline injection. Solution may be stored for up to two hours at room temperatur e. (Jones, 2021)
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check patient's heart rate before administratio n (Jones, 2021).	Check that the patient is not allergic to this drug or penicillin (Jones, 2021).	Monitor liver tests (Jones, 2021).	Check the patient's most recent coagulation studies (Jones, 2021).	Do not give this medication within 4 weeks of testing for H. pylori. Flush the IV line with D5W or lactated ringers after giving this IV (Jones, 2021).

Client Teaching needs (2)	This medication is best taken 1 hour before or 2-3 hours after food. Tell patient to contact provider if they experience severe diarrhea (Jones, 2021).	Tell patient to report signs of super infection to the provider immediately and assess bowel patterns daily (Jones, 2021).	Teach patient to take a missed dose as soon as possible and notify the doctor if they become dizzy (Jones, 2021).	Teach the client to prevent trauma which could cause excessive bleeding. Ensure patient's safety to reduce fall risk (Jones, 2021).	Teach the client not to chew PO form of this medication. Tell the patient to expect relief from symptoms in 2 weeks (Jones, 2021).

Medications Reference (1) (APA):

2020 Nurse's drug handbook (Nineteenth edition. ed.). (2020). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	At the time of this assessment the patient was alert and oriented x 3 to person, place, and time. He did not understand his situation well and was considerably confused. The patient was able to answer simple questions. When asked a more complex question he would state, "I don't know" or say a response that did not fit the question. The patient was not distressed and had a friendly demeanor. The patient's appearance was neat and clean.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient's skin color was appropriate for ethnicity. The patient's skin was warm and dry upon palpation. The patient's skin turgor did not show any signs of tenting. The patient did not have any rashes, wounds, or bruises. The patient's Braden score was 22 which indicates no risk of skin break down. The patient's nails showed no clubbing or cyanosis. His hair appeared to have normal quantity, distribution, and texture. The patient had no drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head and neck were symmetrical. His trachea was without deviation and midline. There was no lymphadenopathy inspected or palpated. His thyroid was non palpable. The patient's ears were without drainage and non tender. He denied hearing deficit and recent changes in visual acuity. His eyes had symmetrical extra ocular movements and his eyes PERRLA bilaterally. The patient's pupils were more constricted than usual to about 2mm. His sclera were white and his conjunctiva were pink. The patient denied nasal tenderness and drainage. The patient's dentition was good. He stated he has no missing teeth.

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	The stunned nurse clearly auscultated the S1 and S2 heart sounds. There were no audible murmurs, gallops, or rubs. Pulses were 2+ and were palpated at the carotid, radial, posterior popliteal, and dorsalis pedis pulse sites bilaterally. The patient's capillary refill was normal, less than 3 seconds. There was no JVD or edema noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient's breath sounds were even, vesicular and non-labored bilaterally. No crackles, wheezes, or rhonchi noted even though the patient has pneumonia. His lungs sounded clear. The client was allowed to return to room air after the physical therapist conducted two oxygen saturation trials during activity. The patient maintained adequate saturation and returned to room air at 1145.
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:**	The patient stated he always eats at the facility where he lives. They always have nutritional food. In the hospital the nurse quickly changed the patient's diet to a consistent carb 15-17 diet. The patient was observed to order multiple snacks in a short amount of time which precipitated this diet change. 182.4 cm 118.9 kg The patient's bowel sounds were normoactive. The patient's last bowel movement was on 9/27/21. The patient's abdomen was non-tender to light and deep palpation. There was no abdominal distention noted at time of assessment. There was a facial scar and a scar on the patient's thumb which he claims he got while being thrown through a glass window as a child. There were no incisions, drains, ostomy, or peg tubes.

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The student nurse observed the patient going to the bathroom once during this shift but otherwise used a urinal. He urinated at least four times during this shift. He denied pain with urination. The urine was light yellow, not cloudy, and contained no sediment or foul odor. The patient had no catheter or dialysis.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y ☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	The patient had no tingling and his capillary refill was less than three-seconds. There was not pallor, pain, or pulselessness. The patient was able to move all his extremities through their full ranges of motion without pain. The patient required very minimal assistance with ADLs like cues and setting up supplies. Fall score 45. The patient received this score due to his IV and state of confusion. The patient was not up at liberty due to being a fall risk, but only requireed a stand by assist of one. The patient did not need assistance with ambulation or equipment.
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 oriented to person, place, and time. He was not oriented to situation and was not able to answer complex questions. The patient's chart notes a verbal communication deficit. The patient has a normal sensory response in fingers and toes. The patient is alert, but confused.

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 stated that he gets through difficult situations by "doing his best". The patient's developmental level is lower than expected. The student nurse was not able to fully determine a developmental level due to the limited communication of the patient. Guessing, I would say about 5th grade level. The patient is Lutheran but stated that religion is "not a big part" of his life. The patient lives in a skilled care facility called Arcola Health Care Center in Arcola, IL. He has lived there for 23 years. The patient is a ward of the state of Illinois likely because of his mental health status. The patient stated he does not keep in touch with his family members even though his mother father, sister, and two brothers are all still living nearby.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1120	73	102/53	20	36.1	93%
1500	71	131/75	14	36.6	93%

Vital Sign Trends: The patients heart rate, temperature, and oxygen saturation remained relatively unchanged during the clinical shift. The patient's blood pressure trended higher as the shift went on. This could be because his medication from the morning was beginning to lose its effectiveness. The patient's respiratory rate improved from the morning to the afternoon. This could be because his antibiotics started to work and his lungs became more clear.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1120	**Numeric**	**n/a**	**0/10**	**n/a**	**n/a**
1500	**Numeric**	**n/a**	**0/10**	**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:**	The patient had an 18 gauge IV in his right accessory cephalic (AC) vein. The anterior bend in his right arm at the elbow. (09/26/21) The patient's IV is patent There are no signs of erythema or drainage. The student nurse checked the IV site at 1120 and 1500. There were no signs of infiltration, erythema, or drainage. The IV dressing was dry and intact. The patient is receiving lactated ringers at 100mL/hr.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
The patient had two cups of coffee (480), and a cup of water (240) adding up to about 720mL oral intake and 600 mL IV intake of fluid in during this shift. The total intake is	Patient voided at least 6 times during this shift. The patient had two bowel movements.

1,320.	

Nursing Care

Summary of Care (2 points)

Overview of care: During this shift the nursing care centered on monitoring the patient's mental status changes and changes in his labs- specifically the level of ammonia. The patient was noted to have communication deficits and presumed severe mental illness in the medical chart. Determining what the patient's base line mental status is was difficult. During this shift the patient's respirations and oxygen saturation improved to 93% on room air and his lung sounds were clear in all lobes. This was a remarkable improvement, but his venous blood gas levels revealed some abnormalities that the student nurse does not yet understand well. The patient's ammonia levels are 124 which can cause a change in mental status. If levels exceed 200 the ammonia can cause a coma (Capriotti, 2020). The patient was prescribed lactulose to help lower these levels. The student nurse assisted the patient with going to the bathroom and setting up for lunch.

Procedures/testing done: The only tests done during this shift were the lab draw for the venous blood gas and ammonia level tests.

Complaints/Issues: The patient did not verbalize any complaints or issues during this shift. Instead, he had a pleasant and cooperative demeanor.

Vital signs (stable/unstable): The patient's vital signs were style during the shift.

Tolerating diet, activity, etc.: The patient used the bathroom once, and the urinal several times. The nurse requested a diet change to help with the patient's diabetes after noticing excessive snacking. The patient ambulated with ease and agility to the bathroom and did not show any balance deficit.

Physician notifications: The physician was notified about the patient's mental status change, ammonia level, and venous blood gas levels.

Future plans for patient: In 1-2 days the patient will likely be discharged back to the facility where he resides. He will have skilled nursing care in this location.

Discharge Planning (2 points)

Discharge location: Arcola Health Care Center Arcola, IL.

Home health needs (if applicable): The patient does not have current home health needs at this time because the nursing staff at the facility where he lives will take care of these needs.

Equipment needs (if applicable): Patient did not require any equipment prior to admission and is not expected to need any equipment post admission.

Follow up plan: The patient should follow up with his primary care physician one week after discharge. A neurology follow up is also anticipated.

Education needs: The patients needs to be taught how to recognize signs and symptoms of respiratory illness and decreased oxygenation. The patient should also be educated about ways to stop the transmission of pneumonia.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	**Rational**	**Intervention (2 per dx)**	**Evaluation**
• Include full nursing diagnosis with “related to” and “as evidenced by” components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.

1. Risk for ineffective peripheral tissue perfusion related to pneumonia as evidenced by O2 saturation 83% upon admission and opacity observed on chest x-ray.	**The patient's current O2 saturation is 93% on room air. This is on the lower end of what is considered normal. The patient needs close monitoring to ensure his oxygen perfusion remains sufficient without oxygen support.**	**1. Closely monitor the patient's respirations including rate, rhythm, depth, use of accessory muscles, and work of breathing. 2. Closely monitor the patient's lung sounds for signs of a decline in respiratory status.**	**1. Goal met: The client responded well to this intervention and was cooperative during each assessment. 2. Goal met: The client cooperated during auscultation and the student nurse heard no adventitious lung sounds.**
2. Acute confusion related to high ammonia level as evidenced by impaired verbal communication ability and severe fatigue.	**The patient's mental status change was apparent and worrisome. In the morning he was able to answer questions with a higher degree of clarity, but by the afternoon this had deteriorated significantly.**	**1. When speaking to the patient speak in a way he understands in an optimal way. 2. Prioritize the patient's safety during altered mental status by lowering the bed to lowest position, using alarm, placing the call light within reach, and frequently checking on the patient.**	**1. Goal met- the student nurse was able to effectively communicate simple ideas with the patient throughout the day. The student nurse also asked questions to check for understanding. The patient seemed to understand. 2. Goal met- all safety protocols were observed during the shift.**

3. Risk for impaired kidney function related to rhabdomyolysis acute kidney injury as evidenced by elevated creatinine and ammonia level.	**The patient's laboratory findings indicate elevated creatinine and ammonia. These finding can quickly deteriorate if not monitored closely leading to further kidney injury and failure.**	**1. The nurse will monitor the patient's basic metabolic panel closely for electrolyte imbalances. The nurse will also monitor the ammonia level.** **2. Ensure adequate oral fluid intake while also ensuring the patient does not become hypervolemic which can cause an exacerbation of the patient's chronic heart failure.**	**1. Goal met- the nurse completed these tests as quickly as possible and promptly notified the provider when abnormal findings were reported.** **2. The patient consumed an adequate amount of fluids during the 6 hours the student nurse was present and is also receiving maintenance fluids.**

4. Risk for imbalanced nutrition more than body requirements related to obesity as evidenced by BMI of 36.5.	**The patient ate breakfast at 0800 and then ordered a snack at 1000. The nurse expected him to have a late lunch due to the mid morning snack. When the patient ordered lunch at 1100 she asked the provider to change his dietary orders to consistent carb 15-17 to help the patient maintain a diet appropriate for a diabetic individual.**	**1. Explain the new diet change to the patient and the reasons why observing this type of diet are in his best interest.** **2. Assess the patient's attitude towards weight loss to establish if referral for nutritional counseling or weight loss management are appropriate.**	**1. Goal met- the patient was understanding and cooperative regarding the diet change. He stated he observes this type of diet at the facility where he lives.** **2. Goal partially met- the student nurse was able to establish a few insights into how the patient feels about weight loss, but due to the communication deficit meeting this goal was difficult.**

Other References (APA):

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

Concept Map (20 Points):

Subjective Data The patient complained of shortness of breath and stated, "my legs don't work".

Nursing Diagnosis/Outcomes

1. Risk for ineffective peripheral tissue perfusion related to pneumonia as evidenced by O2 saturation 83% upon admission and opacity observed on chest x-ray.

Outcome: the patient will maintain O2 saturation above 92% or greater on room air and have not further decline in LOC during admission.

2. Acute confusion related to high ammonia level as evidenced by impaired verbal communication ability and severe fatigue.

Outcome: The patient's laboratory values will be improved upon next lab draw at roughly 0500 on 9/28/21.

3. Risk for impaired kidney function related to rhabdomyolysis acute kidney injury as evidenced by elevated creatinine and ammonia level.

Outcome: The patient's laboratory values will be improved upon next lab draw at roughly 0500 on 9/28/21.

4. Risk for imbalanced nutrition more than body requirements related to obesity as evidenced by BMI of 36.5.

Outcome: The client will observe the 15-17 carb diet during the admission and express understanding of nutritional teaching to the degree to which he is able.

Objective Data The patient has opacities noted in the lower lobes of his lungs, had low O2 saturation upon arriving at the emergency department, and has an ammonia level of 124. His mental status changed during this shift.

Patient Information The patient is a 53 year old man with a history of DM type 2, Parkinsons, AKI, CHF, and schizoaffective disorder.

Nursing Interventions Closely monitor the patient's respirations including rate, rhythm, depth, use of accessory muscles, and work of breathing. Closely monitor the patient's lung sounds for signs of a decline in respiratory status. When speaking to the patient speak in a way he understands in an optimal way. Prioritize the patient's safety during altered mental status by lowering the bed to lowest position, using alarm, placing the call light within reach, and frequently checking on the patient.