N321 Care Plan # 2

Lakeview College of Nursing

Name: Destiny Bell

Demographics (3 points)

Date of Admission 10-09-2021	**Patient Initials** R.S	**Age** 47 Years old	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** N/A	**Marital Status** Separated	**Allergies** N/A
Code Status Full code	**Height** 5’8 feet	**Weight** 186 lbs 9.6 oz	

Medical History (5 Points)

UNABLE TO ATTAIN SOME DUE TO AIRWAY COMPROMISE, NG TUBE PLACED

ANSWERS BY NODDING OR THUMBS UP

Past Medical History: N/A

Past Surgical History: N/A

Family History: N/A

Social History (tobacco/alcohol/drugs):

- Drinks daily, history of alcohol abuse
- Smokes tobacco (Cigarettes) a few a day
- No recreational drug use reported

Assistive Devices: N/A

Living Situation: Lives alone

Education Level: Highschool diploma

Admission Assessment

Chief Complaint (2 points): Throat Swelling

History of present Illness (10 points): Patient presented to the emergency room on October 9th after calling 911, with a chief complaint of throat swelling. Patient stated that he woke up in the morning and that he felt like his throat was closing so he called 911.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Epiglottis

Secondary Diagnosis (if applicable):.

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

Epiglottis is the infection and inflammation of the epiglottis also known as the flap of tissue that sits atop the trachea to keep food from going into the trachea during swallowing (Capriotti, 2020). It may be caused by a respiratory infection, exposure to chemical substances in the environment, trauma, and various organisms, including bacteria, viruses, and fungi (Capriotti, 2020). Common organisms that cause epiglottitis include *Streptococcus pneumoniae*, *Haemophilus influenza*, parainfluenza, varicella-zoster virus, herpes simplex virus type 1, and *Staphylococcus aureus* (Capriotti, 2020). Blood tests for epiglottis will show signs of infection or inflammation, which we can see based off the patient's labs listed below, and ABGs will confirm lack of gas exchange (Capriotti, 2020). *H. influenzae*, and other infections of the epiglottis can lead to edema and swelling of the epiglottis of patients of any age and can rapidly spread to adjacent structures leading to a airway obstruction (Guerra, 2021) . While *H. infulenzae* remains the most common pathogen in both adults and children, other organisms such as *S. Pneumoniae*, *S. aureus*, and beta-hemolytic *Streptococcus sp*. are important pathogens also

in both adults and children (Guerra, 2021). In immunocompromised patients, the list of potential causes is much longer and must include *Mycobacterium tuberculosis,* as well as a litany of others, though the relative frequencies remain the same (Guerra, 2021). Symptoms may be mild for hours or days until they dramatically worsen and will result in the patient appearing very uncomfortable and possibly toxic (Guerra, 2021). Adults may be be reluctant to lie flat or be uncomfortable when doing so and drooling, dysphagia, and distress, or anxiety may be present, which we seen in our patient as he was drooling and appeared restless (Guerra, 2021). Swelling of the upper airway results in turbulent airflow during inspiration or stridor, which we observed in the patient and he had a stridor (Guerra, 2021). Signs of severe upper airway obstruction such as intercostal or suprasternal retractions, tachypnea, and cyanosis are concerning for impending respiratory failure and should signal the provider to act quickly (Guerra, 2021). The most important aspect of treatment is to secure the patient's airway, which likely results in the patient being intubated or a tracheostomy performed, which we observed in our patient as he had a trach placed and a NG tube (Guerra, 2021). Some common complications of epiglottis are hypoxia, respiratory failure, septic shock, prolonged ventilation, and even death (Guerra, 2021). For most patients the prognosis is good when the diagnosis and treatment of the disorder are prompt (Guerra, 2021).

Pathophysiology References (2) (APA):

Capriotti, Theresa M. "Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives" 2nd ed. (2020). *F.A Davis Company.*

Guerra, A. M. (2021, August 11). *Epiglottitis*. StatPearls [Internet]. Retrieved October 28, 2021, from https://www.ncbi.nlm.nih.gov/books/NBK430960/.

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	4.10 – 5.70	3.95	3.40	**Anemia**
Hgb	12.0 – 18.0	15.7	13.6	
Hct	37.0 – 51.0	44.3	39.3	
Platelets	140-400	263	492	**Possible infection**
WBC	4.0 - 11.0	25.91	25.30	**Possible infection?**
Neutrophils	1.60 – 7.70	25.47	19.38	**Possible infection?**
Lymphocytes	1.0 – 4.90	0.21	3.17	**Infection, malnutrition or stress**
Monocytes	0.0 – 1.10	0.26	1.87	**Possible infection?**
Eosinophils	0.0 – 0.50	0.0	0.49	
Bands	0.0 – 10.0	9.5	NA	

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	136	128	
K+	3.5 – 5.1	4.4	3.7	
Cl-	98 - 107	100	104	
CO2	22 - 29	19	24	**Hyperventilation and medications**
Glucose	74 - 100	129	119	**Could be due to taking hydrochlorothiazide**
BUN	9 -21	10	39	**Dehydration, kidney's not working well**
Creatinine	0.55 – 1.30	1.20	1.09	

Albumin	3.5 – 5.0	3.4	NA	
Calcium	8.8- 10.0	9.1	10.5	**Patient is taking a vitamin supplement**
Mag	1.6 – 2.6	1.1	1.9	
Phosphate	NA	NA	NA	
Bilirubin	0.2 – 1.2	2.6	NA	**Liver problems possibly due to history of alcohol abuse**
Alk Phos	40 – 150	116	NA	
AST	5 - 34	34	NA	
ALT	0 - 55	16	NA	
Amylase	NA	NA	NA	
Lipase	NA	NA	NA	
Lactic Acid				

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	1.1	NA	
PT	11.7 – 13.8	13.7	NA	
PTT	NA	NA	NA	
D-Dimer	NA	NA	NA	
BNP	NA	NA	NA	
HDL	NA	NA	NA	

LDL	NA	NA	NA	
Cholesterol	NA	NA	NA	
Triglycerides	NA	NA	NA	
Hgb A1c	NA	NA	NA	
TSH	NA	NA	NA	

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

NO URINALYSIS LABS COLLECTED

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity				
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				
Leukoesterase				

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

NO CULTURES COLLECTED

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture				
Blood Culture				

Sputum Culture				
Stool Culture				

Lab Correlations Reference (1) (APA):

PhD Rn, P. K. D., & Facs, M. T. P. J. (2012). *Mosby's Diagnostic and Laboratory Test Reference (Mosby's Diagnostic & Laboratory Test Reference)* (11th ed.). Mosby.

All other information was gathered from PowerPoints presented in class or information received last semester in Pathophysiology

Diagnostic Imaging

All Other Diagnostic Tests (5 points): NA

Diagnostic Test Correlation (5 points): NA

Diagnostic Test Reference (1) (APA):

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

Home Medications (5 required)- NO HOME MEDS

Brand/Generic					
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Reason Client					

Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					

Hospital Medications (5 required)

Brand/ Generic	**Clonazepam (Klonopin)**	**Ferrous sulfate (Folic Acid)**	**Hydrochlorothiazide**	**Miralax (Polyethylene glycol (PEG) syrup)**	**Thiamine (Vit b-1)**
Dose	**0.5mg**	**1 mg**	**12.5 mg**	**5ml**	**100mg**
Frequency	**Every 12 hours**	**Daily**	**Daily**	**Twice a day**	**Daily**
Route	**Oral**	**Tube- Gastric**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacologic class: Benzodiazepine Therapeutic class: Anticonvulsant, antipanic Pregnancy: NA Controlled substance schedule: IV**	**Pharmacologic class: Hematinic Therapeutic class: antianemic, nutritional supplement Pregnancy: NA**	**Pharmacologic class: thiazide diuretic Therapeutic class: diuretic Pregnancy: B**	**osmotic laxatives.**	**Calcium supplement Pregnancy: A**

Mechanism of Action	**Although unknown, the drug is thought to prevent panic and seizures by potentiating the effects of gamma-aminobutyric acid (GABA), which is an inhibitory neurotransmitter. This action is also though to suppress the spread of seizure activity caused by seizure-producing foci in the cortex, limbic, and thalamus structures.**	**Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, and spleen. Iron is an essential component of hemoglobin, myoglobin, and several enzymes, including catalase, cytochromes, and peroxidase. Iron is needed for catecholamine metabolism in normal neutrophil function**	**A thiazide diuretic, hydrochlorothiazide promotes movement of sodium chloride in water from blood in peritubular capillaries into nephrons distal covulated tubule. Initially, it may decreased cardiac output, extracellular fluid volume, or plasma volume, which helps explain Blood pressure reduction. It may also reduce blood pressure by direct artillery all dilation. After several weeks, cardiac output, extracellular fluid volume, and plasma volume return to normal, and peripheral vascular resistance remains decreased.**	**PEGs have a variety of molecular weights and are composed of multiple ethylene glycol monomer units that undergo catalysis.[1]** **As a medication, PEG is soluble in water and is not reabsorbed in the gastrointestinal tract. PEG forms hydrogen bonds with water molecules. For this reason, it can prevent the reabsorption of water, which causes water retention in the stool and increases the osmotic pressure. As a result, the stool softens, and bowel movements**	**Thiamine combines with adenosine triphosphate (ATP) in the liver, kidneys, and leukocytes to produce thiamine diphosphate. Thiamine diphosphate acts as a coenzyme in carbohydrate metabolism, in transketolation reactions, and in the utilization of hexose in the hexose-monophosphate shunt. Without adequate thiamine, pyruvic acid does not undergo conversion to acetyl-CoA and cannot enter the Krebs cycle. Pyruvic acid accumulates in the blood and is subsequently converted to lactic acid, with the potential**

				occur more frequently	**development of lactic acidosis. Diminished production of NADH in the Krebs cycle also results in lactic acid production through facilitation of anaerobic glycolysis. Thiamine deficiency appears as a nonspecific syndrome: headache, nausea, malaise, myalgias. Severe thiamine deficiency causes beriberi. Beriberi can affect the cardiovascular system (wet beriberi) and the nervous system (dry beriberi and the Wernicke-Korsakoff syndrome). Cardiovascular manifestations include peripheral**

					vasodilation, biventricular failure, and edema. Neurologic symptoms include neuropathy, ataxia, retrograde amnesia, impaired ability to learn, and confabulation. Once Korsakoff's syndrome appears, thiamine supplementation is successful in only half of the patients.
Reason Client Taking	**To reduce anxiety/panic**	**Possible anemia PREVENT iron deficiency**	**To manage blood pressure**	**constipation**	**To increase calcium**
Contraindications (2)	**Acute- narrow-angle glaucoma; Hepatic disease; hypersensitivity to clonazepam, other benzodiazepines, or their components**	**Hemochromatosis, hemolytic anemia's, hemosiderosis, hypersensitivity to iron salts or their components, other anemic conditions unless accompanied by iron deficiency**	**Anuria; hypersensitivity to hydrochlorothiazide, other thiazides, sulfonamide derivatives, or their components**	**contraindicated in patients with known or suspected bowel obstruction, appendicitis, inflamed bowel disease, perforated bowel, and hypersensitivity to**	**Encephalopathy Wernicke's encephalopathy may be precipitated or worsened if intravenous glucose is administered to a thiamine-deficient patient. Thiamine**

				polyethylene glycol any component of the formulation. **Precautionary measures are necessary for patients with electrolyte imbalances and patients with renal impairment**	**(vitamin B1) should be administered prior to glucose. Clinicians should note that parenteral glucose should never be administered to a comatose patient without the prior administration of thiamine. Pregnancy Thiamine is classified as FDA pregnancy risk category A. Appropriate maternal thiamine (vitamin B1) intake is encouraged during pregnancy, and no maternal or fetal complications associated with maternal dietary intake or supplementation to achieve adequate intake goals have been**

					reported. As with other water-soluble vitamins, the pregnancy risk factor increases to FDA risk category C if the vitamin is used in dosages exceeding the Recommended Dietary Allowance (RDA) during pregnancy. Breast-feeding According to the manufacturer, caution should be exercised when thiamine is administered during breast-feeding. However, while thiamine is excreted in human milk, appropriate maternal intake of thiamine (vitamin B1) is important during lactation, and no maternal or fetal complications have been

					identified with maternal supplementation to achieve adequate intake goals during breast-feeding. Seizures have occurred in nursing infants of mothers with thiamine deficiency, although causality has not been established. Supplementation with thiamine is recommended in lactating women whose diets do not provide adequate amounts of thiamine. The American Academy of Pediatrics classifies thiamine as compatible with breast-feeding. Consider the benefits of breast-feeding, the risk of potential infant drug exposure,

					and the risk of an untreated or inadequately treated condition. If a breast-feeding infant experiences an adverse effect related to a maternally administered drug, healthcare providers are encouraged to report the adverse effect to the FDA.
Side Effects/Adverse Reactions (2)	**CNS: Abnormal dreams, aggression, agitation, amnesia, anxiety, Patty, ataxia, attention disturbance, confusion, depersonalization, depression, dizziness, drowsiness, emotional liability, excessive dreaming, fatigue, hallucinations, headache, hostility, hysteria, insomnia, irritability, memory loss, nervousness, nightmares, organic disinhibition, psychosis, reduced intellectual ability, sleep disturbances, suicidal ideation**	**CNS: dizziness, fever, headache, paresthesia, syncope CV: chest pain, hypertension, hypotension, tachycardia EENT: metallic taste, tooth discoloration GI: abdominal cramps, constipation, epigastric pain, nausea, stool discoloration, vomiting HEME: Hemachromatosis, hemolysis, Hemosiderosis RESP: dyspnea, wheezing**	**CNS: Asthenia, dizziness, fever, headache, insomnia, paresthesia, restlessness, vertigo, weakness CV: elevated cholesterol and triglyceride levels, hypotension, orthostatic hypotension, vasculitis EENT: acute myopia, acute angle-closure glaucoma, blurred vision, dry mouth ENDO: hyperglycemia GI: A domino cramps, anorexia, constipation, diarrhea, indigestion,**	**flatulence, nausea, stomach cramps, diarrhea, swollen abdomen, and rectal hemorrhage**	**Severe angioedema / Rapid / Incidence not known anaphylactoid reactions / Rapid / Incidence not known pulmonary edema / Early / Incidence not known GI bleeding / Delayed / Incidence not known cyanosis / Early / Incidence not known**

	CV: palpations EENT: blurred vision, spasms, increase salvation, loss of taste, pharyngitis, rhinitis, sinusitis, yawning GI: abdominal pain, anorexia, constipation, increased appetite GU: altered libido, difficult ejaculation, dysmenorrhea, dysuria, enuresis, impotence, Nocturia, urine retention, UTI HEME: anemia, eosinophilia, leukopenia, thrombocytopenia MS: dysarthria, myalgia RESP: bronchitis, cough, respiratory depression Other: allergic reaction	**SKIN: Diaphoresis, flushing, pure writers, rash, urticaria Other: anaphylaxis (with IV administration), angioedema, injection site discoloration**	**notice, nausea, pancreatitis, vomiting GU: decreased libido, impotence, interstitial nephritis, Nocturia, polyuria, renal failure HEME: Agranulocytosis, aplastic anemia, bone marrow failure, hemolytic anemia, leukopenia, neutropenia, thrombocytopenia MS: muscle spasms and weakness RESP: pneumonitis, pulmonary edema SKIN: alopecia, cutaneous vasculitis, erythema multiforme, exfoliative dermatitis, photosensitivity, putouts, rash, Steven-Johnson's syndrome, toxic epidermal necrolysis, urticaria Other: Anaphylaxis, dehydration, Hypercalcemia, hyperuricemia, hypochloremia, hypokalemia, hypomagnesemia, hyponatremia, hypo bulimia, metabolic alkalosis, weight loss**		**Mild pruritus / Rapid / 1.0-1.0 restlessness / Early / Incidence not known diaphoresis / Early / Incidence not known sneezing / Early / Incidence not known urticaria / Rapid / Incidence not known nausea / Early / Incidence not known weakness / Early / Incidence not known injection site reaction / Rapid / Incidence not known**

Nursing Considerations (2)	**• use clonazepam cautiously and patience with mixed seizure disorder (because drug can increase the risk of generalized tonic clonic seizures), renal failure, or troublesome secretions (because clonazepam increases salvation) and in elderly patients (because there are more sensitive to drug's CNS effects). Also use cautiously and patients with compromised respiratory function and porphyria.** **• Monitor Blood drug level, CBC, and liver enzymes during long-term or high-dose therapy as ordered** **• Monitor patient closely for signs of loss of effectiveness of anti-convulsant activity, especially within the first three months of administration. Notify prescriber if noted, because it dosage adjustment may reestablish effectiveness.** **WARNING: know that the drug should not be stopped abruptly. Instead, expect to taper dosage gradually by**	**• give iron tablets and capsules with a full glass of water or juice. Do not crush enteric coated tablets are open capsules** **• dilute and administer with a straw or place drops in the back of patients throat, because iron solutions may stay in teeth. Mix that elixir form in water. Fer-in-sol drops or syrup maybe be extra juice or water.** **• know that to maximize absorption, iron salt should we give him one hour before or two hours after meals. If G.I. irritation occurs, give with or just after meals** **• protect the liquid form from freezing.** **• administer injectafer intravenously, either as an undiluted so IV push or by infusion. When administering a slow IV push give out the rate of about 100 mg or two ML's per minute. When administering via**	**- give hydrochlorothiazide in the morning and early evening to avoid nocturia** **- Monitor blood pressure, daily weight, fluid intake and output, and serum levels of electrolytes, especially potassium** **- assess for evidence of hypokalemia such as muscle spasms and weakness** **- check blood glucose level often, as ordered, and diabetic patients, and expect to increase anti-diabetic dosage, as needed and prescribed** **- know that if patient has Gouty arthritis, expect increased risk of gout attacks during therapy** **- Monitor bun in serum creatinine levels, as ordered, especially in patients with chronic kidney disease, Renal artery stenosis, severe congestive heart failure, or volume depletion, because of increased risk of acute renal failure with hydrochlorothiazide therapy. Notify prescriber if serum creatinine levels**	**NA**	Hepatic Impairment It appears that no dosage adjustments are needed. Renal Impairment It appears that no dosage adjustments are needed. Intermittent hemodialysis Patients on dialysis may have increased needs for thiamine. Peritoneal dialysis Patients on dialysis may have increased needs for thiamine

	0.125 mg twice daily every three days, until the drug is completely discontinued, to void withdrawal symptoms and seizures. **• Monitor patient closely for evidence of suicidal thinking or behavior, especially when therapy starts or dosage changes** **• be aware that paradoxical and psychiatric reactions have occurred with benzodiazepines. Because clonazepam is a benzodiazepine, monitor patient for aggression, agitation, anger, anxiety, hallucinations, irritability, nightmares, and psychoses. Children and elderly patients are at a greater risk of developing paradoxical reactions. If noted, notify prescriber and expect drug to be discontinued gradually.** **WARNING: be aware that benzodiazepine therapy like clonazepam should only be used concomitantly with opioids and patience**	**infusion, dilute up to 750 mg of iron in no more than 250 ML of sterile 0.9% sodium chloride injection, US P, such that the concentration of the infusion is not less than 2 mg of iron per ML, and administer over at least 15 minutes. Once diluted, solution is stable for 72 hours at room temperature.** **• avoid extravasation with IV administration because brown discoloration of the extravasation site may be long lasting.** **WARNING: Monitor patients closely for hypersensitivity reactions for at least 30 minutes after IV administration. If present, discontinue drug immediately, notify prescriber, and be prepared to provide supportive care, as needed.** **• Monitor patient's blood pressure after each IV dose for significant increases, as hypertension may**	**become elevated, as drug may need to be withheld or discontinued.** **- Monitor patient for decreased visual acuity or ocular pain, especially within hours two weeks of beginning drug therapy and in patients with a history of penicillin or sulfonamide allergy, as acute myopia and acute angle closure glaucoma may develop. If left untreated, permanent blindness may occur if present, notify prescriber immediately, expect to discontinue hydrochlorothiazide, and assist with prompt medical or surgical intervention, as indicated.** **WARNING: be aware that even minor alterations and fluid and electrolyte balance may precipitate hepatic coma in patients with impaired hepatic function**		

	for whom other treatment options are in adequate. If prescribed together, expect dosing and duration of the opioid to be limited. Monitor patient closely for signs and symptoms of decreasing consciousness, including coma, profound sedation, and significant respiratory depression. Notify prescriber immediately and provide emergency supportive care, as death may occur. **• know that although the risk of teratogenicity is inconclusive, administration of benzodiazepines like clonazepam immediately before or during childbirth can cause a syndrome of difficulty feeding, hypothermia, hypotonia, and respiratory depression in the infant after birth. Also know that if mothers have taken clonazepam during the later stages of pregnancy, their infants may develop a dependency on the**	**occur immediately after administration but usually resolves within 30 minutes.** **• be aware that at usual dosages, serum hemoglobin level and usually normalizes in about two months and less blood loss continues. Treatment may last for 3 to 6 months to help replenish iron stores.** **WARNING: Monitor patient for signs of iron overdose, which may include abdominal pain, diarrhea, nausea, severe vomiting, and sharp abdominal cramps. In case of iron toxicity or accidental iron overdose, give deferoxamine, as prescribed. As few as three at all iron tablets can cause serious poisoning in young children.** **• don't give antacids, Coffee, dairy products, eggs, tea, or whole-grain bread or cereals within one hour before or two hours after iron.** **• remember that**			

	drug and experience withdrawal after birth.	**unabsorbed iron turns stool black or green and can mask blood in stool. Check stool for occult blood as ordered**			

Medications Reference (1) (APA):

Dabaja, A. (2021, May 4). *Polyethylene Glycol*. StatPearls [Internet]. Retrieved October 28, 2021, from https://www.ncbi.nlm.nih.gov/books/NBK557652/.

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

PDR Search. Thiamine (thiamine hydrochloride) dose, indications, adverse effects, interactions... from PDR.net. (n.d.). Retrieved October 28, 2021, from https://www.pdr.net/drug-summary/Thiamine-thiamine-hydrochloride-2546.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alert** **Orientation: orientated x3** **Distress: no apparent distress, but does seem restless** **Overall appearance: well-kept, restless**	**Alert and orientated to person, place and time** **Opens eyes spontaneously** **Patient is no apparent distress, but does seem a little restless**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes: none** **Bruises: yes** **Wounds: none** **Braden Score: 18** **Drains present: Y☒ N ☐** **Type: Trach (trach contents are being suctioned), NG Tube**	**Skin is warm, dry, intact and elastic** **No skin discoloration noted** **Pressure points without redness** **Patient has bruising (ecchymosis) in his upper extremities near his trach** **Braden score is 18**
HEENT (1 point): **Head/Neck:**	Pupils: perrla

Ears: **Eyes:** **Nose:** **Teeth:**	**Left: 3mm round brisk; equal and normal response** **Right: 3mm round brisk; equal and normal response** **Mouth: normal conjunctiva, moist oral mucosa, drooling** **Head: normocephalic, atraumatic** **Eyes: clear junctiva** **Trachea midline** **Upper airway stridor**
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:**	.**S1 and S2 are present, no murmurs heard upon auscultation.** **Peripheral pulses are equal strength and quality, 3+ bilaterally throughout.** **Capillary refill is less than 3 seconds on fingers and toes bilaterally.** **No edema visualized or palpated on upper or lower extremities.** **Homans sign is negative**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Lung sounds are clear to auscultation bilaterally, patient's breathing is being assisted mechanically with optiflow **No crackles or wheezes noted** **Rhonchi heard throughout all lung fields**
GASTROINTESTINAL (2 points): **Diet at home: Normal** **Current Diet: NPO, tube feedings** **Height: 5'8 feet** **Weight: 186lbs 9.6 oz** **Auscultation Bowel sounds: normoactive** **Last BM: NA** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention: NON-DISTENDED** **Incisions: NONE** **Scars: NONE** **Drains: NONE** **Wounds: NONE** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☒ N ☐** **Size: doesn't state** **Feeding tubes/PEG tube Y ☒ N ☐** **Type: Nasogastric**	. **Bowel sounds are audible and active in all 4 quadrants** **Abdomen is nondistended, soft in all quadrants.** **Abdomen is free of incisions, scars, drains, and wounds**

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: Temp probe** **Size: 16 FR**	**Patient is freely voiding with a catheter with no reported or observed signs of difficulty** **Voided urine is clear and yellow with no foul odor**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 19** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment X** **Needs support to stand and walk☐**	Fall risk score: 19 **Patient ambulates with a standby assist within patient room. Patient does not require any assistive devices besides a standby assist in activities and walking.**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. Patient is currently unable to speak due to trach but is communicating with hand gestures and mouthing words out **Perceptive to touch, heat/cold, and pain** **Patient is alert and orientated to place, month and time of day.**
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):**	Patient lives at home by himself and recently moved to Illinois while his family resides in Ohio. **Patient did not state any specific religion or coping mechanisms that he practices.** **Reports a healthy strong home environment**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0404	**75 bpm**	**108/71** **Right arm**	**16**	**99.6 F** **Oral**	**97%** **Optiflow** **30L/min**
0724	**72 bpm**	**158/74** **Right arm**	**16**	**98.6 f** **Oral**	**95%** **Optiflow** **30L/min**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0616	**Faces**	**No pain**	**NA**	**NA**	**NA**
0830	**FACES**	**No pain**	**NA**	**NA**	**NA**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 16G **Location of IV: Anterior distal left lower forearm** **Date on IV: 10-20-2021** **Patency of IV: patent, flushes easily** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: intact**	Lactated Ringers @ 50ml/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
450ml	**175ml**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was admitted for epiglottis and a tracheostomy was done and placed due to airway obstruction and patient has been placed on optiflow 30L/min and a NG tube has been inserted for feedings.

Procedures/testing done: glucose and labs

Complaints/Issues: No complaints/issues were verbalized

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: tolerating diet and activity

Physician notifications: none during this shift

Future plans for patient: Patient will be meeting with therapy

Discharge Planning (2 points)

Discharge location: possibly home

Home health needs (if applicable): na

Equipment needs (if applicable): na

Follow up plan: follow up with primary care physician upon discharge

Education needs: education of tube feedings and trach care, cessation of smoking and alcohol use

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. Ineffective	**The ABG**	**1.Maintain oxygen**	**The patient's oxygen**

gas exchange related to the patient's obstructed airway resulting from his epiglottis as seen in the patient's labs and ABG's	**drawn for this patient indicates respiratory acidosis and is the main reason the patient was admitted.**	**administration through optiflow and keep oxygen saturation above 90%** **2.Position the patient in a semi-fowlers position to promote ventilation**	**level is being maintained above 90% with the use of optiflow assistance and patient remained in semi-fowler's position throughout the shift**
2. Anxiety related to treatment with Optiflow and placement of NG tube and Tracheostomy	**Patient was restless in his room and unable to relax due to secretions in his trach and appeared kind of annoyed while receiving feedings through NG**	**1. Medications to decrease anxiety/panic such as the clonazepam the patient is taking** **2.promote a calm environment by eliminating extra staff, decreasing sound and stimulation, and reducing lights in room**	**The clonazepam seems to be successful in helping treat the patient's anxiety/panic.** **By eliminating extra stressors in the room it helped to provide a calm therapeutic environment.**
3. Risk for falls and injury related to falls as evidenced by patient's overall health	**Patient is considered to be a high fall risk due to inability to ambulate without assistance and the condition he is in with his epiglottis care**	**1. Eliminate hazards in the room** **2. education provided on safe ambulation and the use of a call light for assistance**	**Patient used the call light appropriately and voiced needs when present.** **Patient allowed for staff to assist in ambulation and transfers to prevent injuries**

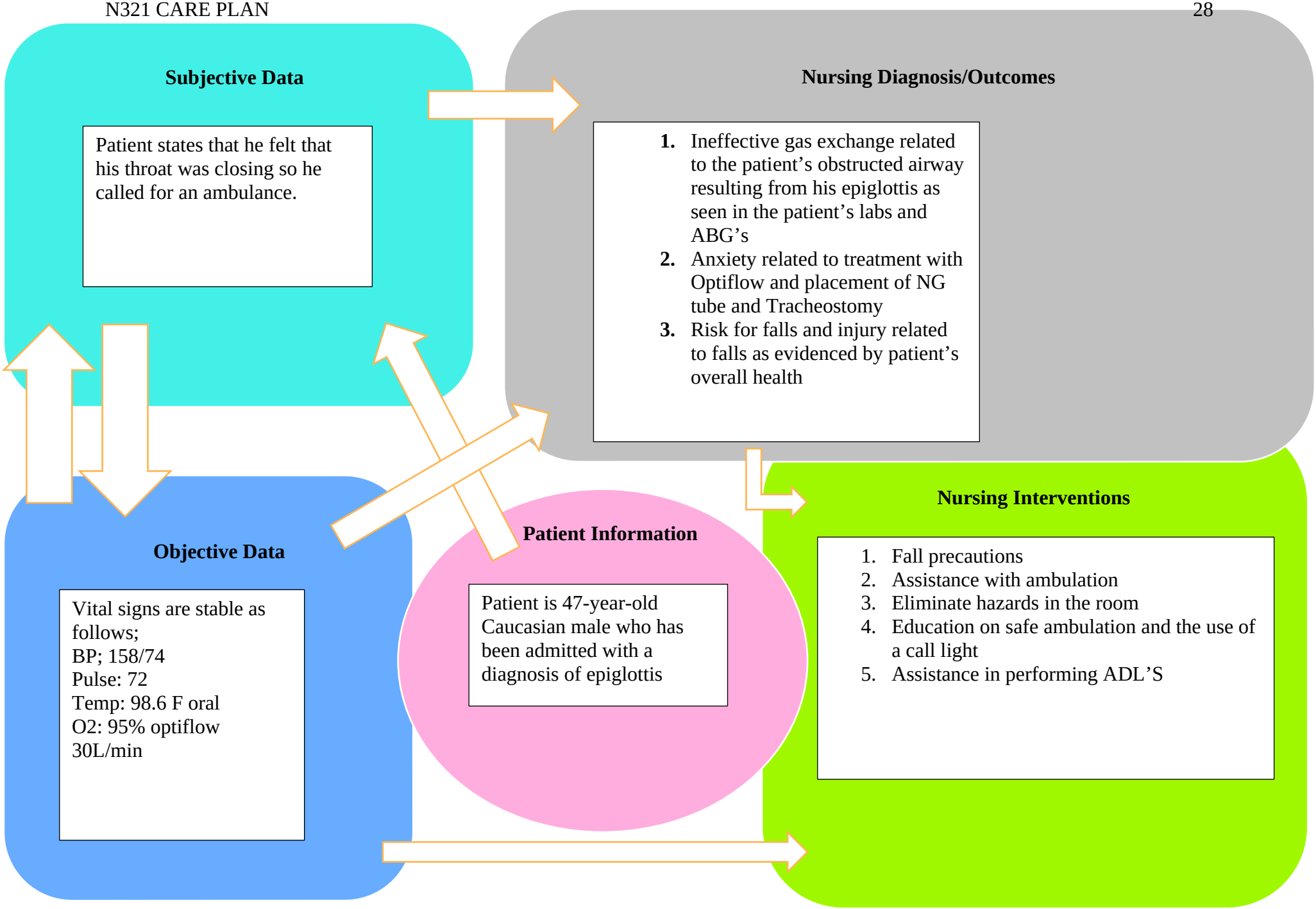
Other References (APA):

Swearingen, P. L., & Wright, J. (2018). *All-in-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health* (5th ed.). Mosby.

Wayne, G. B. (2017a, September 24). Risk for Falls Nursing Care Plan. Nurseslabs. https://nurseslabs.com/risk-for-falls/

Wayne, G. B. (2017, September 24). Risk for Injury Nursing Care Plan. Nurseslabs. https://nurseslabs.com/risk-for-injury/

Concept Map (20 Points):


Subjective Data
Patient states that he felt that his throat was closing so he called for an ambulance.
Nursing Diagnosis/Outcomes
1. Ineffective gas exchange related to the patient's obstructed airway resulting from his epiglottis as seen in the patient's labs and ABG's
2. Anxiety related to treatment with Optiflow and placement of NG tube and Tracheostomy
3. Risk for falls and injury related to falls as evidenced by patient's overall health
Objective Data
Vital signs are stable as follows;
BP; 158/74
Pulse: 72
Temp: 98.6 F oral
O2: 95% optiflow 30L/min
Patient Information
Patient is 47-year-old Caucasian male who has been admitted with a diagnosis of epiglottis
Nursing Interventions
1. Fall precautions
2. Assistance with ambulation
3. Eliminate hazards in the room
4. Education on safe ambulation and the use of a call light
5. Assistance in performing ADL'S