N321 Care Plan #2

Lakeview College of Nursing

Riley Black

Demographics (3 points)

Date of Admission 10/30/2021	Patient Initials LG	Age 01/06/1943 (78 yo)	Gender Male
Race/Ethnicity White	Occupation Retired	Marital Status Married	Allergies NKMA
Code Status Full Code	Height 176.5 cm	Weight 94.4 kg	

Medical History (5 Points)

Past Medical History: CAD, Arthritis, T2DM, GERD, High cholesterol, HTN, Hyperlipidemia, Obesity, Colon polyps, AAA, depression

Past Surgical History: Cholecystectomy (03/22/2021), ERCP with stent (03/18/2021), CABG (2000), Colonoscopy polypectomy (11/28/2017)

Family History: Mother, Father, and Sister all had an MI

Social History (tobacco/alcohol/drugs): Patient smoked half a pack a day from the age of 17 until 2016, patient denied alcohol or recreational drug use

Assistive Devices: top dentures and glasses

Living Situation: home with wife

Education Level: high school

Admission Assessment

Chief Complaint (2 points):Coughing up blood and severe chest pain

History of present Illness (10 points): On 10/30/2021, a 78-year-old male patient presented to the emergency department after coughing up blood-tinged sputum. The coughing spells started "a couple days" before the patient came in, but the blood is what prompted the visit. The patient also was experiencing severe chest pain. The pain started when the coughing started, and both have been consistent. The coughing lasts all day, and the pain is

present any time the patient is awake. The patient claims the pain was a "ten out of ten," and it progressed to an "eleven out of ten" when he was coughing. The pain at rest was dull and achy, but coughing led to a sharp, stabbing pain. Tylenol made the pain go away briefly, and coughing made it worse. The patient denied any other symptoms.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Bronchitis

Secondary Diagnosis (if applicable): N/A

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

Acute bronchitis is the inflammation of the bronchi or bronchioles caused by a pathogen or some kind of irritant (Capriotti, 2020). Common pathogens that lead to bronchitis are viruses and bacteria. Specific viruses that can cause bronchitis are Influenza A and B, parainfluenza, respiratory syncytial virus, and coronavirus (Capriotti, 2020). Each of the viruses cause upper respiratory infections. The possible bacterial infections that can cause bronchitis are *Mycoplasma* species, *Chlamydia pneumoniae, Streptococcus pneumoniae, Moraxella catarrhalis*, and *Haemophilus influenzae* (Capriotti, 2020). The bronchial inflammation can cause difficulty breathing and a lot of coughing. Oftentimes, this coughing is accompanied with a lot of purulent sputum. Bronchitis causes a lot of sputum production because the mucus membranes become edematous with irritation (Capriotti, 2020). The coughing is usually what exacerbates the irritation. If there is enough sputum and bronchial edema, the mucociliary function will be diminished (Capriotti, 2020). This diminished function can result in the need to cough more often because the mucus is not moving well anymore. In more severe cases, the

sputum produced will be tinged with blood from severe irritation of the bronchial tree (Hinkle & Cheever, 2018).

Excessive mucus production causes an obstruction in the airway, leading to decreased ventilation. With decreased ventilation comes decreased perfusion, causing complications throughout the body related to poor oxygenation. Some systemic complications that can arise from poor oxygenation are shortness of breath, dizziness, confusion, and hypertension (Capriotti, 2020). It is important to monitor pulse oximetry when a patient is diagnosed with bronchitis for this reason. Another complication the patient is at risk for is pneumonia (Capriotti, 2020). If the patient cannot expectorate the mucus, it can become trapped in the airway and eventually make its way into the lungs. A case of aspiration pneumonia from bronchitis can be severe depending on the pathogen that caused the bronchitis.

A patient with bronchitis may present with many signs and symptoms similar to those of a patient with the common cold, like having a sore throat, a fever, nasal discharge, body aches, pleuritic chest pain, general malaise, and a persistent cough (Capriotti, 2020). Depending on the progression of the illness, there may be more severe symptoms present. One of these symptoms have already been discussed, like purulent sputum that has a possibility of being blood tinged. Other signs of bronchitis can be found during a more focused examination, like laryngeal erythema, localized lymphadenopathy, rhinorrhea, rhonchi, wheezes, and stridor (Capriotti, 2020).

With bronchitis, it is expected to find a low oxygen saturation through pulse oximetry. This is caused by the decreased ventilation and perfusion that can occur with any occlusions in the airway. Temperature can be elevated due to the response to an infection. Respirations may be increased because a patient may have an increased respiratory demand (Capriotti, 2020). Low

oxygen saturation may also cause and increased heart rate due to the heart trying to compensate for the low oxygen levels. Hypertension may also result from bronchitis (Hinkle & Cheever, 2018). The labs that will be increased will mainly be white blood cells as they are responding to the infection. Neutrophils can be highly elevated due to the acute immune response and specifically target bacteria and fungi, lymphocytes can be elevated due the initial infection response and the presence of viral infection, basophils can be increased due to a short-term inflammatory response, and monocytes can be elevated as they phagocytize pathogens (Hinkle & Cheever, 2018).

Typical tests done on a patient to diagnose bronchitis or rule out other infections include a sputum culture and sensitivity test to determine the type of infection, a chest x-ray to assess lung consolidation or the presence of pneumonia, and a CBC to identify if the infection is bacterial or not (Capriotti, 2020). My patient underwent multiple CBCs, and a chest x-ray, but he has not completed a sputum culture and sensitivity. His CBC showed elevated white blood cells that indicated infection and highly elevated neutrophils that indicate a bacterial infection. His chest x-ray showed no pneumonia was present, but there were signs of consolidation in the right lower lobe and some pleural effusion in the right lung.

Treatment of the disease depends on the cause of the infection. If the infection is bacterial, antibiotics like ampicillin or doxycycline may be prescribed based on the results from the culture and sensitivity. My patient did not receive antibiotic therapy. Antihistamines should be avoided, as they can dry up secretions and make it harder for the patient to cough them up, causing an obstruction in the airway (Hinkle & Cheever, 2018). Other treatments include increasing a patient’s fluid intake to thin secretions and make them easier to expectorate and having them rest. My patient is receiving methylprednisolone, a corticosteroid, to treat his

symptoms of inflammation, as well. He is being encouraged to increase his oral fluid intake, but he has not been started on an IV infusion of fluids. On top of the notable data from his labs and diagnostics, my patient also has some notable data in his vitals. His oxygen saturation was low, recorded at an 89% and a 92% during my shift. He was not administered oxygen therapy. Other than his oxygen saturation, the patient had an elevated blood pressure of 166/74 and 174/80. His other vitals were within normal limits.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology* (2nd ed.). F. A. Davis.

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

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.80-5.41**	**4.38**	**4.44**	
Hgb	**11.3-15.2**	**12.9**	**13.1**	
Hct	**33.2-45.3**	**38.3**	**38.7**	
Platelets	**149-393**	**175**	**188**	
WBC	**4.0-11.7**	**7.7**	**5.7**	
Neutrophils	**45.3-79.0**	**65.8**	**84.9**	**This patient has an active infection, as evidenced by the diagnosis of bronchitis, but has not undergone a culture and sensitivity to determine the type of infection yet. Regardless of the type of infection, the neutrophils will be increased in the early stages as an initial response to infection and will be elevated specifically during a bacterial infection (Pagana et al., 2019).**
Lymphocytes	**11.8-45.9**	**21.7**	**12.6**	

Monocytes	**4.4-12.0**	**10.6**	**2.3**	**With an increase in the percentage of neutrophils and lymphocytes present, the percentage of monocytes circulating will have to decrease. Because monocytes are responsible for fighting against viral infections, they are likely lowered during a bacterial infection (Pagana et al., 2019).**
Eosinophils	**0.0-6.3**	**1.4**	**N/A**	
Bands	**0.0-10.0**	**N/A**	**N/A**	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**136-145**	**141**	**139**	
K+	**3.5-5.1**	**3.9**	**4.1**	
Cl-	**98-107**	**105**	**101**	
CO2	**21-31**	**28**	**29**	
Glucose	**74-109**	**186**	**500**	**This patient is a type 2 diabetic, but his blood glucose has not been well monitored during his stay. It could have elevated to extreme levels due to a combination of acute stress, a recent meal, and the use of corticosteroid therapy (Pagana et al., 2019).**
BUN	**7-25**	**10**	**12**	
Creatinine	**0.60-1.20**	**0.86**	**0.96**	
Albumin	**3.5-5.2**	**4.0**	**4.3**	
Calcium	**8.6-10.3**	**8.7**	**9.0**	

Mag	**1.6-2.4**	**1.6**	**1.6**	
Phosphate	**3.0-4.5**	**N/A**	**N/A**	
Bilirubin	**0.3-1.0**	**0.8**	**0.7**	
Alk Phos	**34-104**	**89**	**88**	
AST	**13-39**	**11**	**13**	**Two possible causes for this low AST level are acute inflammation caused by the bronchitis or symptoms of acute renal disease that may be caused by adverse effects of the combination of medications he is taking (Pagana et al., 2019).**
ALT	**7-52**	**10**	**10**	
Amylase	**30-220**	**N/A**	**N/A**	
Lipase	**0-160**	**15**	**N/A**	
Lactic Acid	**5-20**	**N/A**	**N/A**	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**0.86-1.14**	**N/A**	**N/A**	
PT	**11.9-15.0**	**N/A**	**N/A**	
PTT	**22.6-35.3**	**N/A**	**N/A**	
D-Dimer	**<250**	**N/A**	**N/A**	
BNP	**0-100**	**N/A**	**N/A**	
HDL	**23-92**	**N/A**	**N/A**	

LDL	**<100**	**N/A**	**N/A**	
Cholesterol	**<199**	**N/A**	**N/A**	
Triglycerides	**0-149**	**N/A**	**N/A**	
Hgb A1c	**0.45-5.33**	**N/A**	**N/A**	
TSH	**2-10**	**N/A**	**N/A**	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**5.0-8.0**	**N/A**	**N/A**	
pH	**1.005-1.034**	**N/A**	**N/A**	
Specific Gravity	**Negative**	**N/A**	**N/A**	
Glucose	**Normal**	**N/A**	**N/A**	
Protein	**Negative**	**N/A**	**N/A**	
Ketones	**Negative**	**N/A**	**N/A**	
WBC	**Negative**	**N/A**	**N/A**	
RBC	**Negative**	**N/A**	**N/A**	
Leukoesterase	**Negative**	**N/A**	**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**	**N/A**	

Blood Culture	**Negative**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2019). *Mosby's diagnostic & laboratory test reference* (14th ed.) Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- Chest CT
  - Aortic atherosclerosis
  - Right lower lobe consolidation
  - Small pleural effusion of the right lung
- Ultrasound Venous Duplex
  - Right femoral artery occlusion
  - Partial occlusion in left femoral vein
- Echocardiogram
  - >70% ejection fraction
  - Diastolic dysfunction
  - Mildly enlarged right ventricle
  - Mild-to-moderate right atrial dilation
  - Mild tricuspid regurgitation
  - Normal sinus rhythm

- Chest x-ray
    - Cardiomegaly
    - Degenerative spinal changes
    - Healed ribs from recent fractures

Diagnostic Test Correlation (5 points):

- CT of Chest – The CT of the chest was to evaluate the lungs and all other organs in the chest in a detailed view to assess any abnormalities related to the chest pain and shortness of breath and cough (Pagana et al., 2019). The findings indicate consolidation in the right lower lobe and a right lung pleural effusion
- Ultrasound venous duplex – completed to assess the presence of occluded vessels in the lower extremities (Pagana et al., 2019). Findings conclude that there is a complete occlusion in the right femoral artery and a partial occlusion in the left femoral vein
- Echocardiogram – completed to assess the functioning of the heart to see if there was a cardiac cause for the chest pain. The findings here did not find any acute causes for the chest pain, but they did find mild abnormalities, like diastolic dysfunction, a mild tricuspid regurgitation, a mild-to-moderate right atrial dilation, and a mild right ventricular enlargement
- Chest x-ray – ensure there is no pneumonia or tuberculosis present in the lungs associated with the cough and blood-tinged sputum. Findings did not show either pneumonia or tuberculosis, but they did indicate consolidation in the right lower lobe and a right lung pleural effusion

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2019). *Mosby's diagnostic & laboratory test reference* (14th ed.) Elsevier.

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

Home Medications (5 required)

Brand/ Generic	**Crestor rosuvastatin**	**Lopressor metoprolol**	**Norvasc amlodipine**	**Cymbalta duloxetine**	**Zestril lisinopril**
Dose	**40 mg**	**80 mg**	**5 mg**	**60 mg**	**5 mg**

Frequency	**Daily**	**Daily**	**Daily**	**Daily**	**Daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**HMG-CoA reductase inhibitor / antilipemic**	**Beta-adrenergic blocker / antihypertensive**	**Calcium channel blocker / antihypertensive**	**Selective serotonin and norepinephrine reuptake inhibitor / antidepressant**	**Angiotensin-converting enzyme inhibitor / antihypertensive**
Mechanism of Action	**Reduces lipid levels by increasing the number of LDL receptors to increase LDL catabolism / also reduces the number of LDL particles circulating by inhibiting hepatic synthesis of LDL (*Nurse's Drug Handbook*, 2021)**	**Decreases blood pressure and prevents damage from possible future MI by inhibiting cardiac excitability, cardiac output, and myocardial oxygen demand (*Nurse's Drug Handbook*, 2021)**	**Inhibits of influx of calcium ions across calcium channels to relax coronary and vascular smooth muscles, decreasing vascular resistance and lower blood pressure (*Nurse's Drug Handbook*, 2021)**	**Inhibits dopamine, serotonin, and norepinephrine reuptake to elevate mood and inhibit pain signals from peripheral nerves caused by constant high glucose levels (*Nurse's Drug Handbook*, 2021)**	**Inhibits conversion of angiotensin I to angiotensin II to prevent vasoconstriction to lower blood pressure (*Nurse's Drug Handbook*, 2021)**
Reason Client Taking	**To treat and prevent complications of hyperlipidemia**	**To control hypertension**	**To control hypertension**	**To elevate mood treat depressive symptoms**	**To control hypertension**
Contraindicat	**Active liver**	**Heart rate**	**Hypersensiti**	**Chronic**	**Concurrent**

ions (2)	**disease / hypersensitivity**	**less than 45 bpm / systolic blood pressure below 100 mmHg**	**vity**	**liver disease / hypersensitivity**	**aliskiren use in diabetic patients / history of angioedema related to previous use of an ACE inhibitor**
Side Effects/Adverse Reactions (2)	**Hepatic failure / bronchitis**	**Arrythmias / bronchospasm**	**Arrythmias / hypotension**	**Hepatotoxicity / hyperglycemia**	**Hyperglycemia / orthostatic hypotension**
Nursing Considerations (2)	**Use cautiously in patients that drink alcohol, as it can cause liver damage / monitor serum lipoprotein level to evaluate therapeutic effect (*Nurse's Drug Handbook*, 2021)**	**Medication should not be crushed or chewed / check for signs of poor glucose control in patients with DM, as metoprolol can interfere with the therapeutic effects of insulin and antidiabetic drugs (*Nurse's Drug Handbook*, 2021)**	**Assess patient frequently for chest pain, especially in patients with CAD / monitor blood pressure to avoid hypotension (*Nurse's Drug Handbook*, 2021)**	**Medication should not be crushed or chewed / monitor serum sodium level to assess for any decreases (*Nurse's Drug Handbook*, 2021)**	**Monitor blood pressure and plan to withhold if hypotension occurs / monitor for dehydration if the patient experiences vomiting or diarrhea because it can lead to hypotension (*Nurse's Drug Handbook*, 2021)**

Hospital Medications (5 required)

Brand/Generic	**Lovenox enoxaparin**	**Solumedrol methylprednisolone**	**Protonix pantoprazole**	**Infumorph morphine**	**Zofran ondansetron**
Dose	**100 mg**	**60 mg**	**40 mg**	**2 mg**	**4 mg**
Frequency	**Q12H**	**Q12H**	**Daily**	**Q2H PRN**	**Q6H PRN**
Route	**Subcutaneous**	**IV Push**	**PO**	**IV Push**	**IV Push**
Classification	**Low-molecular weight heparin / anticoagulant**	**Glucocorticoid / corticosteroid**	**Proton pump inhibitor / antiulcer**	**Opioid / opioid analgesic**	**Selective serotonin receptor antagonist / antiemetic**
Mechanism of Action	**Binds with antithrombin III to inactivate thrombin. Without thrombin, fibrinogen cannot convert to fibrin and form clots (*Nurse's Drug Handbook*, 2021)**	**Binds to glucocorticoid receptors and suppresses inflammatory and immune responses by inhibiting accumulation of neutrophils and monocytes at inflammation sites and inhibiting the synthesis of inflammatory response mediators (*Nurse's***	**Inhibits the proton pump in gastric parietal cells from creating the end product of HCl, which is gastric acid (*Nurse's Drug Handbook*, 2021)**	**Binds with and activates opioid receptors to produce analgesia and euphoria (*Nurse's Drug Handbook*, 2021)**	**Blocks serotonin receptors in the chemoreceptor trigger zone and at the intestinal vagal nerve terminals to reduce nausea and vomiting (*Nurse's Drug Handbook*, 2021)**

		Drug Handbook, **2021)**			
Reason Client Taking	**To prevent clot formation and DVT prophylaxis**	**To reduce the inflammation in the bronchial tree caused by bronchitis**	**To prevent stomach irritation and the development of ulcers for the hospitalized patient lying in bed for long periods of time**	**To reduce chest pain associated with coughing as needed**	**To prevent feelings of nausea and vomiting that can be caused by medication administration or any other causes**
Contraindications (2)	**Active major bleeding / heparin-induced thrombocytopenia within the last 100 days**	**Hypersensitivity to cow's milk or other dairy products / systemic fungal infection**	**Concurrent therapy with rilpivirine-containing products / hypersensitivity**	**Concomitant anticoagulation therapy / gastrointestinal obstruction**	**Concomitant use of apomorphine / hypersensitivity**
Side Effects/Adverse Reactions (2)	**Hemorrhage / atrial fibrillation**	**Arrythmias / hyperglycemia**	**Hyperglycemia / hepatic failure**	**Respiratory depression / bradycardia**	**Bronchospasm / hypotension**
Nursing Considerations (2)	**Check serum potassium level for elevation / keep protamine sulfate on hand in case of accidental overdose (*Nurse's Drug***	**Arrange for low-sodium diet with increased potassium / monitor blood glucose level and expect to adjust insulin due to hyperglycemia (*Nurse's Drug***	**Symptomatic response to the drug does not rule out gastric tumor presence / proton pump inhibitors should not be given longer than**	**Morphine can lead to abuse, addiction, and misuse / use with extreme caution in patients with conditions associated with**	**Hypokalemia and hypomagnesemia should be corrected before ondansetron is administered / monitor for signs and symptoms of serotonin**

	***Handbook*, 2021)**	***Handbook*, 2021)**	**medically necessary (*Nurse's Drug Handbook*, 2021)**	**hypercapnia, hypoxia, or decreased respiratory reserve like asthma, COPD, or cor pulmonale since morphine can decrease respiratory drive (*Nurse's Drug Handbook*, 2021)**	**syndrome (*Nurse's Drug Handbook*, 2021)**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *Nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**A&O x 4** **Patient appears to be anxious, patient states "I'm a little scared and nervous because when the doctor cancels a test it usually means bad news"** **Patient is well groomed with hair intact and had good hygiene**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Usual for ethnicity, white discolored spots over bilateral upper extremities from sun damage** **Skin is tight all over, many wrinkles on face** **Warm to the touch** **Elastic** **No rashes** **Abdominal bruises from injections** **No wounds** **20**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Normocephalic and symmetrical** **No drainage or inflammation** **PERRLA, patient has prescription lenses** **No drainage or inflammation, patent nares** **Patient has top dentures**
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:**	 **No murmurs, clicks, or rubs** **S1 and S2 sounds heard** **Regular heart rhythm** **Pulses +2 radial bilateral, +1 pedal bilateral** **<3 seconds**
RESPIRATORY (2 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	**Expiratory wheezes auscultated in upper lobes bilaterally, breaths were deep and at a regular rhythm**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet**	**No home restrictions, but aware of monitoring sugars with diabetes** **Caffeine free, heart healthy 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:**	**176.5 cm** **94.4 kg** **Hyperactive bowel sounds all four quadrants** **11/01/2021 during shift (diarrhea twice)** **No masses or tenderness upon palpation** **None** **None** **Right upper quadrant (cholecystectomy)** **None** **None**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	 **Dark yellow** **Clear** **Unmeasured** **Clean and appropriate for age and ethnicity**
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☐**	 **Skin warm to touch, pink nail beds** **Full active ROM in all extremities** **Walker, dentures, glasses** **5/5 all extremities** **70 = fall risk**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:**	

Mental Status: **Speech:** **Sensory:** **LOC:**	**Oriented to person, place, time, situation** **Alert and clear mentation** **Clear** **Sensation intact** **Alert**
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 is nervous and under high stress, his wife helps him calm down when he gets worked up Patient's development is appropriate for age Patient does not claim any religious affiliation Patient lives with his wife at home, but she seems to have some confusion and impaired memory07

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	**76 bpm**	**166/74** **mmHg**	**18 rpm**	**36.3 C**	**89% RA**
.1130	**80 bpm**	**174/80** **mmHg**	**20 rpm**	**37.1 C**	**92% RA**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	**Numeric**	**Chest/ribs**	**2/10**	**Dull and achy**	**Patient did not want medicine until he was up for the day and had breakfast**
1045	**Numeric**	**Chest/ribs**	**3/10**	**Dull and achy**	**Administered 600 mg Tylenol**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge

Location of IV:	Right antecubital
Date on IV:	10/30/2021
Patency of IV:	Flushes easily
Signs of erythema, drainage, etc.:	Dry, intact, nor redness
IV dressing assessment:	No signs of phlebitis or infiltration Saline Lock

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
100% of breakfast **240 ml orange juice** **240 ml 2% milk** **480 ml water**	**One unmeasured void** **2 unmeasured defecations, both diarrhea**

Nursing Care

Summary of Care (2 points)

Overview of care: Administered all medications, checked blood glucose, administered sliding scale insulin, completed a head-to-toe assessment

Procedures/testing done: patient underwent an ultrasound arterial duplex

Complaints/Issues: Uncomfortable in bed, could not adjust bed on his own, anxious about having a stress test canceled without hearing from the doctor, breakfast was not as good as it was the day before

Vital signs (stable/unstable): stable but blood pressure was elevated

Tolerating diet, activity, etc.: dizziness with orthostatic hypotension when getting out of bed, does not like his dietary restrictions but believes they are good for him

Physician notifications: Notified hospitalist of a glucose of 500, hospitalist instructed us to administer more insulin

Future plans for patient: Because the patient has bronchitis, he will likely need to complete a culture and sensitivity to find out what the infection is from and what drugs will be used to treat it. Patient will have his occluded vessels in his legs addressed, stress test is currently still supposed to happen following the ultrasound arterial duplex

Discharge Planning (2 points)

Discharge location: patient will return home with his wife

Home health needs (if applicable): patient has no specific needs as of now, subject to change with diagnostic test results

Equipment needs (if applicable): patient will continue to use walker to ambulate

Follow up plan: patient will likely need to consult with specialists regarding the results of his arterial occlusions and his postponed stress test

Education needs: patient will need further education on monitoring and controlling his blood glucose, he will also likely need to be educated on how to change his environment and activities to prevent falls

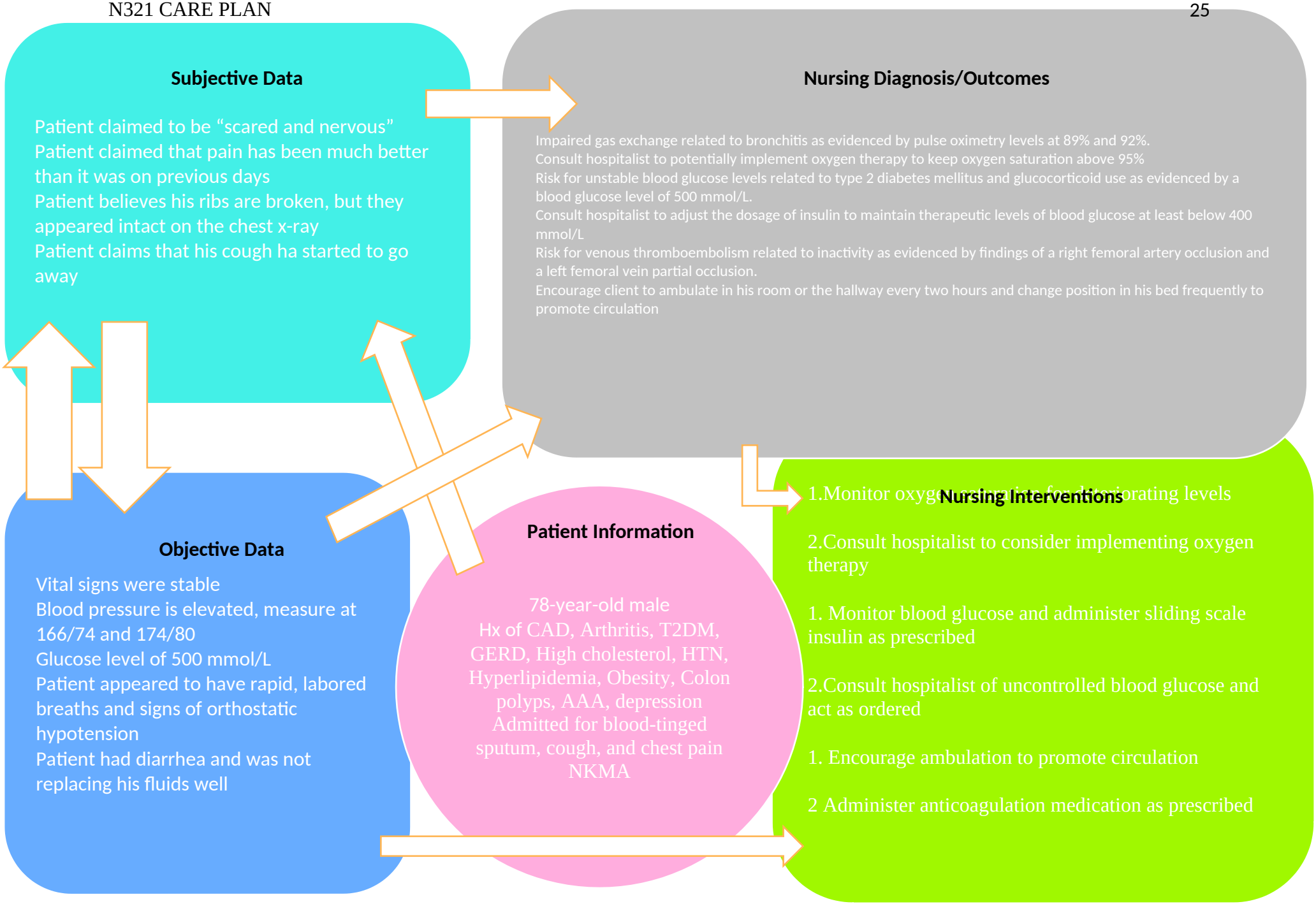
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired gas	**The patient**	**1.Monitor oxygen**	**- Patient's**

exchange related to bronchitis as evidenced by pulse oximetry levels at 89% and 92%.	**could have an obstructed airway that is making it difficult for proper ventilation to occur, which prevents the lungs from fully saturating the blood with oxygen.**	**saturation for deteriorating levels 2.Consult hospitalist to consider implementing oxygen therapy**	**oxygen saturation was assessed multiple times during the shift - Hospitalist was not contacted, but the patient's oxygen saturation was gradually returning to 95% on room air**
2. Risk for unstable blood glucose levels related to type 2 diabetes mellitus and glucocorticoid use as evidenced by a blood glucose level of 500 mmol/L.	**The patient is in critical levels of blood glucose, and it needs to be under control before he enters diabetic ketoacidosis.**	**1. Monitor blood glucose and administer sliding scale insulin as prescribed 2.Consult hospitalist of uncontrolled blood glucose and act as ordered**	**- Patient was given insulin as prescribed - Hospitalist adjusted order for insulin, and it was administered as ordered**
3. Risk for venous thromboembolism related to inactivity as evidenced by findings of a right femoral artery occlusion and a left femoral vein partial occlusion.	**The patient is at risk for developing clots in his lower extremities due to his inactivity, and the occluded vessels can either be existing clots or enough of an obstruction to cause clot formation.**	**1. Encourage ambulation to promote circulation 2 Administer anticoagulation medication as prescribed**	**- Patient ambulated to the bathroom on his own and changed his position in his bed multiple times - Lovenox was administered as prescribed to prevent coagulation**

Other References (APA):

Concept Map (20 Points):


Subjective Data
Patient claimed to be "scared and nervous"
Patient claimed that pain has been much better than it was on previous days
Patient believes his ribs are broken, but they appeared intact on the chest x-ray
Patient claims that his cough ha started to go away
Nursing Diagnosis/Outcomes
Impaired gas exchange related to bronchitis as evidenced by pulse oximetry levels at 89% and 92%.
Consult hospitalist to potentially implement oxygen therapy to keep oxygen saturation above 95%
Risk for unstable blood glucose levels related to type 2 diabetes mellitus and glucocorticoid use as evidenced by a blood glucose level of 500 mmol/L.
Consult hospitalist to adjust the dosage of insulin to maintain therapeutic levels of blood glucose at least below 400 mmol/L
Risk for venous thromboembolism related to inactivity as evidenced by findings of a right femoral artery occlusion and a left femoral vein partial occlusion.
Encourage client to ambulate in his room or the hallway every two hours and change position in his bed frequently to promote circulation
Objective Data
Vital signs were stable
Blood pressure is elevated, measure at 166/74 and 174/80
Glucose level of 500 mmol/L
Patient appeared to have rapid, labored breaths and signs of orthostatic hypotension
Patient had diarrhea and was not replacing his fluids well
Patient Information
78-year-old male
Hx of CAD, Arthritis, T2DM, GERD, High cholesterol, HTN, Hyperlipidemia, Obesity, Colon polyps, AAA, depression
Admitted for blood-tinged sputum, cough, and chest pain
NKMA
Nursing Interventions
1.Monitor oxygen saturation for deteriorating levels
2.Consult hospitalist to consider implementing oxygen therapy
1. Monitor blood glucose and administer sliding scale insulin as prescribed
2.Consult hospitalist of uncontrolled blood glucose and act as ordered
1. Encourage ambulation to promote circulation
2 Administer anticoagulation medication as prescribed