N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 2/14/22	Client Initials J.L.	Age 53	Gender Female
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Divorced	Allergies No known allergies
Code Status FULL	Height 5'5"	Weight 145 lb (65.8 kg)	

Medical History (5 Points)

Past Medical History: Chronic obstructive pulmonary disease (COPD), hypertension (HTN), substance abuse, hypokalemia, left knee pain, right wrist pain, smoke inhalation, sleep apnea, thrush, depression.

Past Surgical History: The patient states that she has had surgery on her "toes and elbow." Her chart does not display any past surgical history.

Family History: Mother: breast cancer and hypertension. Father: heart attack.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient states that they have smoked one cigarette every day for the past 18 years. Her chart says that she smokes 0.5 packs per day. The patient denies any history of alcohol use, vaping, tobacco use, or drug use. The patient's chart states that she is being monitored and treated for alcohol withdrawal (CIWA protocol).

Assistive Devices: The patient wears glasses to read but has no other assistive devices.

Living Situation: The patient lives with her 16-year-old daughter.

Education Level: The patient did not discuss her education level, but does not appear to have any learning barriers.

Admission Assessment

Chief Complaint (2 points): The patient complains of "pain from burns" on her face.

History of Present Illness – OLD CARTS (10 points):

On February 14, a 53-year-old Caucasian female was admitted to OSF Sacred Heart Medical after arriving at the Emergency Room via ambulance due to severe burns on her face. The patient states that she woke up at "2 AM and lit a cigarette" while receiving oxygen for her COPD. The patient sustained burns to her cheeks, lips, and chin, as well as the nasal cannula melting in her nares. The patient waited until noon to call for an ambulance but stated that she initially declined to go to the hospital after the first evaluation. The patient called for the ambulance later than the day when she began to experience an increase in pain and difficulty breathing. The patient states that her pain is a 9 out of 10 on the numeric scale. The patient claims that pain medication does not seem to be helping at this time. The patient denies any other signs or symptoms at this time. The patient appears to be very anxious.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute chronic respiratory failure with hypoxia.

Secondary Diagnosis (if applicable): Second-degree burn on face

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

Acute chronic respiratory failure with hypoxia occurs when the pulmonary system cannot oxygenate blood or sufficiently eliminate carbon dioxide. When the body has a standard arterial carbon dioxide (PaCo2), but the pressure of arterial oxygen (PaO2) is less than 60 mm Hg, hypoxemic respiratory failure occurs. Continual arterial blood gases (ABGs) are monitored in patients with respiratory issues to ensure that there is not a gradual increase in PaCo2 with a decrease in PaO2. Hypoxia is insufficient oxygen levels in the blood, which cannot meet the needs of the tissue. Many conditions can alter the gas exchange and induce hypoxia. For example, the patient today inhaled smoke from her oxygen tank exploding and her nasal cannula

melting to her nares. The carbon monoxide inhaled caused hypoxia by preventing oxygen from binding to the hemoglobin molecule (Capriotti, 2020).

Signs and symptoms that a patient may be experiencing respiratory failure with hypoxia can include:

- The appearance of distress.
- The use of accessory muscles.
- Difficulty maintaining a standard respiratory rate even with the administration of supplemental oxygen.
- Dyspnea upon exertion.
- Crackles in the lungs (which can indicate fluid in the lungs).

Patients at risk of respiratory failure should have intubation equipment ready at the bedside prepared for emergencies. However, today, the patient did not show signs of respiratory distress, any use of accessory muscles, or difficulty maintaining a regular respiratory rate. The patient did show signs of dyspnea upon exertion due to generalized weakness. There was also evidence of slight crackles in the lower right lobe upon auscultation of the lungs. Crackles, also called rales, are lung sounds that occur when deflated alveoli open and close against the fluid. Wheezes, a high-pitched whistling sound, was also heard in the patient during inspiration. Wheezing can be related to constricted airways (Capriotti, 2020).

Diagnostic testings for respiratory failure include ABGs (to provide information about gas exchange) and a chest x-ray (to visualize the structure of the chest and lungs). Pulse oximetry readings monitor the oxygen saturation in the blood. An average oxygen saturation level is between 95-100% (Capriotti, 2020).

The treatment for respiratory failure with hypoxia can include a variety of medications such as bronchodilators, antibiotics, and decongestants. Bronchodilators allow the bronchi to expand to allow air through. Antibiotics treat any suspected respiratory infections. Decongestants help reduce inflammation and edema in the nasal passages. Nebulizers deliver humidified oxygen with medication easily absorbed in the lower bronchial airways. This patient used bronchodilators, nebulizers, and supplemental oxygen to help treat her respiratory failure and hypoxia (Capriotti, 2020).

Thermal burns result from body exposure to temperatures greater than 112.4 degrees Fahrenheit. A type of thermal burn is a flame burn, which can cause direct tissue injury. Burn severity depends on the degree and duration of the heat, the burn depth, percentage of injured body surface area, the patient's age, and how much other body systems are affected. Expected findings related to burns are immense pain, scarring, disfigurement, organ dysfunction, and psychological trauma (Capriotti, 2020). Oxygen is highly flammable, and when the patient lit her cigarette while on oxygen, causing the nasal cannula to catch fire. The nasal cannula then melted into her nares. The patient also inhaled a significant amount of smoke. Necrosis can occur from burn wounds due to protein coagulation and cellular death. Protein coagulation can decrease tissue perfusion and increase the risk for vascular damage. Increasing blood flow to the burn area is essential to minimize edema, prevent infection, and potentially reverse the tissue damage. Necrosis can release histamine, free radicals, cytokine, and catecholamines, escalating vascular resistance and causing intravascular-to-extravascular fluid and protein shift. When albumin leaks from the cells, interstitial fluid is lost, and tissues begin to swell (Capriotti, 2020). The fluid change triggers a decrease in intravascular fluid volume. The shift alters the normal sodium and

potassium levels, releasing more significant amounts of potassium, putting the patient at risk for hyperkalemia (Capriotti, 2020).

Expected findings related to burn wounds can include hypotension, tachycardia, and decreased urine output. Patients can also experience an increase in respiratory rate, anxiety, pain, mucosal damage, and upper airway edema (Hinkle & Cheever, 2018). The CO2 in the smoke can bind to hemoglobin while pushing out oxygen, leading to hypoxia. A chest x-ray can visualize the lungs' ability to expand, any areas of consolidation, or the presence of fluid in or around the lungs (Capriotti, 2020). Burn injuries can provide opportunities for bacterial growth, in which can debridement is necessary to initiate increased blood flow.

A nurse should obtain the following labs from a patient with a burn injury upon admission: a complete blood count (CBC), electrolyte level, urinalysis, arterial blood gas, and a carboxyhemoglobin level (Hinkle & Cheever, 2018). The CBC will provide a white blood cell elevation baseline to identify an infection. Electrolytes monitor any fluid shifts in sodium and potassium levels. A peak in blood urea nitrogen (BUN) levels can indicate dehydration. A urinalysis can monitor nutritional status and renal perfusion. Arterial blood gases can identify hypoxia. Treatment for burns depends on the severity of the injury (Capriotti, 2020).

There are three phases of burn treatment: emergent phase, acute phase, and rehabilitation phase. The emergent phase starts at the onset of the damage and lasts until fluid resuscitation is complete. The emergent stage prevents shock and respiratory distress. The acute phase begins within 48-72 hours after the sustained injury to continue the assessment of respiratory and circulatory assessment while providing nutritional support and infection prevention. Pain prevention is also a primary goal during this time. The rehabilitation phase can go on for years, depending on the severity of the injury. Active and passive range-of-motion exercises are

essential to prevent contractures. Burn wound grafts and the application of support bandages can help to decrease scar formation. Pain management is one of the most challenging aspects of treating burn injuries. Partial-thickness burns cause constant pain due to exposed nerve endings and require aggressive treatment to control the pain. Continual assessment of the patient's pain ensures medication administration manages pain intensity appropriately (Capriotti, 2020). The patient sustained second-degree burns on her face with superficial partial-thickness that charred the epidermis. The burned skin appeared wet, raw, and cherry red. The patient stated that the burns were quite painful and that her pain medications did not seem to be helping.

Pathophysiology References (2) (APA):

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

Hinkle, J. L. &. Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed). Walters 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	**3.8-5.3**	**4.7**	**4.77**	**These lab values were within the normal range.**
Hgb	**12-15.8**	**14.5**	**14.8**	**These lab values were within the normal range.**
Hct	**36-47**	**41.2**	**41.4**	**These lab values were within the normal range.**
Platelets	**140-440**	**299**	**311**	**These lab values were within the normal range.**
WBC	**4-12**	**11.5**	**8.3**	**These lab values were within the normal range.**
Neutrophils	**47-73**	**59.9**	**88.3**	**The elevated neutrophil value may**

				be due to the burn wounds or anxiety (Lab Tests Online, 2021).
Lymphocytes	**18-42**	**27.2**	**10.6**	**The decreased lymphocyte value may be due to stress or from prednisone use (Lab Tests Online, 2021).**
Monocytes	**4-12**	**5.9**	**0.5**	**The decreased monocyte value may be due to the burn wounds or prednisone use (Lab Tests Online, 2021).**
Eosinophils	**0-5**	**5.9**	**0.1**	**The elevation in eosinophils may be due to inflammation from the burn wounds (Lab Tests Online, 2021).**
Bands	**0-10**	**n/a**	**n/a**	**n/a**

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**133-144**	**139**	**138**	**These lab values were within the normal range.**
K+	**3.5-5.1**	**3.2**	**3.5**	**The decreased potassium value may be due to the burn wounds , albuterol use or acetaminophen use (Lab Tests Online, 2021).**
Cl-	**98-107**	**103**	**103**	**These lab values were within the normal range.**
CO2	**21-31**	**27**	**25**	**These lab values were within the normal range.**
Glucose	**70-99**	**93**	**147**	**The elevated glucose value may be due to the pain from the burn wounds or albuterol use (Lab Tests Online, 2021).**
BUN	**7-25**	**14**	**12**	**These lab values were within the normal range.**
Creatinine	**0.5-1**	**0.67**	**0.55**	**These lab values were within the normal range.**
Albumin	**3.5-5.7**	**4.3**	**n/a**	**These lab values were within the normal range.**

Calcium	**8.6-10.3**	**9.2**	**9.4**	**These lab values were within the normal range.**
Mag	**1.6-2.3**	**n/a**	**n/a**	**n/a**
Phosphate	**3-4.3**	**n/a**	**n/a**	**n/a**
Bilirubin	**0.2-0.8**	**0.8**	**n/a**	**These lab values were within the normal range.**
Alk Phos	**34-104**	**68**	**n/a**	**These lab values were within the normal range.**
AST	**13-39**	**14**	**n/a**	**These lab values were within the normal range.**
ALT	**7-52**	**11**	**n/a**	**These lab values were within the normal range.**
Amylase	**60-100**	**n/a**	**n/a**	**n/a**
Lipase	**0-160**	**n/a**	**n/a**	**n/a**
Lactic Acid	**0.5-1.5**	**n/a**	**n/a**	**n/a**
Troponin	**0-0.04**	**0.03**	**n/a**	**These lab values were within the normal range.**
CK-MB	**5-25**	**n/a**	**n/a**	**n/a**
Total CK	**30-223**	**52**	**n/a**	**These lab values were within the normal range.**

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	**1**	**n/a**	**n/a**	**n/a**
PT	**11-13.5**	**n/a**	**n/a**	**n/a**
PTT	**25-35**	**n/a**	**n/a**	**n/a**
D-Dimer	**Negative, less than 250**	**n/a**	**n/a**	**n/a**
BNP	**<100**	**48**	**n/a**	**These lab values were within the**

				normal range.
HDL	**60**	**n/a**	**n/a**	**n/a**
LDL	**100**	**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**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow and clear**	**Straw and clear**	**Dark yellow and clear**	**Urine color can range from pale yellow, and therefore this is a normal finding (Lab Tests Online, 2021).**
pH	**5-9**	**7.5**	**n/a**	**These lab values were within the normal range.**
Specific Gravity	**1.003-1.03**	**1.015**	**n/a**	**The lab value was within normal range.**
Glucose	**negative**	**negative**	**n/a**	**The lab value was within normal range.**
Protein	**negative**	**negative**	**n/a**	**The lab value was within normal range.**
Ketones	**negative**	**1+**	**n/a**	**This abnormal value may be due to stress (Lab Tests Online, 2021).**
WBC	**0-5**	**negative**	**n/a**	**The lab value was within normal range.**
RBC	**0-2**	**negative**	**n/a**	**The lab value was within normal range.**
Leukoesterase	**negative**	**negative**	**n/a**	**The lab value was within normal range.**

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	7.45	n/a	These lab values were within the normal range.
PaO2	80-100	55	n/a	These lab values were within the normal range.
PaCO2	35-45	39	n/a	These lab values were within the normal range.
HCO3	22-26	26.9	n/a	The elevated HCO3 value may be due to hypoxia or anxiety (Lab Tests Online, 2021).
SaO2	95-100	89	n/a	The decreased SaO2 value may be due to COPD or smoke inhalation (Lab Tests Online, 2021).

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/no growth	n/a	n/a	n/a
Blood Culture	Negative/no growth	n/a	n/a	n/a
Sputum Culture	Negative/no growth	n/a	n/a	n/a

Stool Culture	**Negative/no growth**	**n/a**	**n/a**	**n/a**

Lab Correlations Reference (1) (APA):

Lab Tests Online. (2021). *Patient education on blood, urine, and other lab tests*. https://labtestsonline.org/.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

The single-view chest x-ray is used to visualize structures in the chest, such as the lungs.

Diagnostic Test Correlation (5 points):

The chest X.R. could have been ordered to ensure that the patient doesn't have pneumothorax or consolidation from the burns or smoke inhalation.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/ Generic	**Albuterol/ Proair HFA**	**Budesonide-formoterol fumarate/ Symbicort**	**Ipratropium-albuterol/ duoneb**	**Lisinopril/ Prinivil,zestril**	**The patient was only one four home**

					medications.
Dose	**2 puffs of 108 (90 base) mcg/act aerosol solution**	**2 puffs of 160-4.5 mcg/act aerosol**	**3 mL**	**10mg tablet**	**n/a**
Frequency	**Every 4 hours as needed**	**Twice daily**	**Four times daily**	**Daily**	**n/a**
Route	**Inhalation**	**Inhalation**	**Nebulizer**	**PO**	**n/a**
Classification	**Pharmacologic: adrenergic Therapeutic:bronchodilator**	**Pharmacologic: corticosteroid Therapeutic:antiasthmatic**	**Pharmacologic: anticholinergic Therapeutic: bronchodilator**	**Pharmacologic: angiotensin-converting enzyme (ACE) inhibitor Therapeutic: antihypertensive**	**n/a**
Mechanism of Action	**Relaxes the bronchial smooth-muscle cells and inhibit histamine release.**	**Inhibits inflammatory cells and mediators, possibly by decreasing influx into nasal passages, bronchial walls, or the intestines.**	**Relaxes smooth muscles and causes bronchodilation.**	**May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II.**	**n/a**
Reason Client Taking	**Wheezing/cough**	**To provide maintenance therapy,**	**To provide maintenance therapy for bronchospasm associated with COPD.**	**To treat hypertension.**	**n/a**

Contraindications (2)	**Hypersensitivity to albuterol or its components.**	**Nasal trauma, status asthmaticus**	**Hypersensitivity to atropine, ipratropium bromide, or their components.**	**Concurrent aliskiren use, hypersensitivity to lisinopril.**	**n/a**
Side Effects/ Adverse Reactions (2)	**Hypokalemia, hyperglycemia**	**Rectal bleeding, urinary tract infection**	**Atrial fibrillation, bowel obstruction.**	**Hypotension, necrosis.**	**n/a**
Nursing Considerations (2)	**Use cautiously in patients with hypertension. Be aware that drug intolerance can develop with prolonged use.**	**Assess patient for effectiveness of budesonide therapy. Monitor patient for hypersensitivity.**	**Monitor patient for hypersensitivity that could be life-threatening. When using a nebulizer, apply a mouthpiece to prevent drug from leaking out around mask and causing blurred vision or eye pain.**	**Use cautiously with fluid volume deficit. Monitor blood pressure often.**	**n/a**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor serum potassium levels.**	**Determine if patient has a milk allergy.**	**Check inhaler technique.**	**This medication should not be given to a patient who is hemodynamically**	**n/a**

				unstable after an acute myocardial infarction.	
Client Teaching needs (2)	**Instruct patient to wash mouth piece with water once a week and allow to air-dry. Advise patient to wait at least 1 minute between inhalations if dosage requires more than one inhalation (Jones and Bartlett Learning, 2020).**	**Instruct patient to shake container before each use. Advise patient to rinse her mouth with water after each orally inhaled dose (Jones and Bartlett Learning, 2020).**	**Advise patient to report decreased response to ipratropium as well as difficulty voiding, eye pain, nasal dryness, nose bleeds, palpitations, and vision changes. Caution patient not to use ipratropium to treat acute bronchospasm (Jones and Bartlett Learning, 2020).**	**Explain the lisinopril helps to control, but does not cure hypertension. Warn patient to seek immediate emergency treatment if she experience difficulty breathing or swallowing (Jones and Bartlett Learning, 2020).**	**n/a**

Hospital Medications (5 required)

Brand/Generic	**Acetaminophen /tylenol**	**Heparin/ porcine**	**Hydralazine/ apresoline**	**Lorazapam /ativan**	**Ondansetron/ zofran ODT**
Dose	**650 mg tablet**	**5,000 units**	**10mg**	**1mg tablet**	**4mg disintegrating tablet**
Frequency	**Every 6 hours**	**Every 8 hours**	**Every 4 hours as needed**	**Every 2 hours as need**	**Every 6 hours as needed**
Route	**PO**	**Subcutaneous injection**	**Intravenous**	**PO**	**PO**
Classification	**Pharmacologic: nonsalicylate Therapeutic: nonopioid analgesic**	**Pharmacologic :amticoagulant Therapeutic: anticoagulant**	**Pharmacologic: vasodilator Therapeutic: antihypertensive**	**Pharmacologic: benzodiazepine Therapeutic: anxiolytic**	**Pharmacologic: selevtive serotonin receptor antagonist Therapeutic: antiemetic**
Mechanism of Action	**Blocks prostaglandin production and interferes with pain impulse generation in the peripheral nervous system.**	**Inhibits factor Xa and prevents conversion of fibrinogen to fibrin; without firbin, clots can't form.**	**Exerts a vasodilating effect on vascular smooth muscle.**	**GABA inhibits excitatory stimulation, which helps control emotional behavior.**	**Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminal in the intestine. This action reduced nausea**

					and vomiting by preventing serotonin release in the small intestine and blocking signals to the central nervous system.
Reason Client Taking	**To relieve mild to moderate pain**	**To prevent peripheral arterial embolism or pulmonary embolism.**	**High blood pressure, systolic BP >180**	**Withdrawal, CIWA score 6-10**	**Nausea first line**
Contraindications (2)	**Hypersensitivity, severe hepatic impairment**	**Uncontrolled active bleeding, sensitivity to pork**	**Coronary artery disease, mitral valvular rheumatic heart disease**	**Acute angle-closure glaucoma, sleep apnea syndrome**	**Concomitant use of apomorphine, hypersensitivity**
Side Effects/Adverse Reactions (2)	**Stridor, hypokalemia**	**Thrombosis, asthma**	**Angina, anorexia**	**Coma, respiratory depression**	**Shock, laryngeal edema**
Nursing Considerations (2)	**Do not confuse doses in milligrams with doses in milliliters. Monitor the end of a paternal infusion to prevent possibility of air embolism.**	**Use cautiously in alcoholics. Alternate injection sites and watch for signs of bleeding and hematoma.**	**Anticipate that drug may change color in solution. Monitor blood pressure and pulse rate regularly and weight the patient daily during therapy.**	**Use drug cautiously in patients with a history of alcohol or drug abuse. Monitor patient's respiratory status closely because drug may cause life-**	**Be aware that disintegrating tablets may contain aspartame, which is metabilized to phenylalanine and must be**

				threatening respiratory depression.	**avoided in patients with phenylketonuria. Place disintegrating tablet on patient's tongue immediately after opening package.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Know that before and during long-term therapy, liver tests results, including AST, ALT, bilirubin, and creatinine levels, as ordered must be monitored because acetaminophen may cause hepatotoxicity.**	**Read heparin label carefully to reduce the risk of medication errors.**	**Monitor ANA titer and CBC before therapy and periodically as ordered during long-term treatment.**	**Before stating lorazepam therapy in a patient with depression, make sure they already take an antidepressant, because of the increased risk of suicide in patients with untreated depression.**	**Know that if hypokalemia or hypomagnesemia is present, these electrolyte imbalances should be corrected before ondansetron is administered because of increased risk for QT-interval prolongation, which could predispos**

					e the patient to develop torsades de pointes.
Client Teaching needs (2)	**Instruct patient to read manufacturer's label and follow dosage guidelines precisely. Teach patient to recognize the signs of hepatotoxicity, such as bleeding, easy bruising, and malaise, which commonly occur with chronic overdose (Jones and Bartlett Learning, 2020).**	**Explain that heparin cannot be taken orally. Inform patient about increased risk of bleeding (Jones and Bartlett Learning, 2020).**	**Advise patient to change positions slowly, especially in the morning. Urge patient to report numbness and tingling in limbs, which may require treatment with another drug (Jones and Bartlett Learning, 2020).**	**Instruct patient to take lorazepam exactly as prescribed and not to stop without consulting prescriber because of the risk of withdrawal symptoms. Instruct patient to report excessive drowsiness and nausea (Jones and Bartlett Learning, 2020).**	**Advise patient to immediately report signs of hypersensitivity, such as a rash. Reassure patient with transient blindness that it will resolve within a few minutes to 48 hours (Jones and Bartlett Learning, 2020).**

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and orientated to person, place, time, and reason for the visit. The patient does not have noticeable distress but states that she is in pain. The patient's overall appearance is slightly unkempt.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 15** **Drains present: Y☐ N ☒** **Type:**	The patient's skin is warm, pink, and dry. The patient's skin turgor was assessed with immediate recoil. The patient did not appear to have any rashes, bruises, or wounds other than the second-degree burns on her cheeks, nares, lips, and chin. The patient's Braden score is 15, indicating that the patient has an average risk for pressure sore or impaired skin integrity. The patient also had slight reddening around both of her big toes and stated that they “felt painful.”
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is equal and round. She states that she has "warts" on her head from HPV that she would like to talk to her primary care provider about. The patient's neck is supple with no obvious tracheal deviation. Her ears are symmetrical, clean, and clear, with no cerumen or drainage noted bilaterally. The patient was not wearing glasses during the assessment. Both of her eyes were symmetrical and proportionally placed. Her sclera was white, and the conjunctiva was red in both eyes without any drainage present. Upon inspection of the nose, her nares were equal bilaterally, with no deviated septum, but did show layers of eschar. The patient's sinuses could not be palpated due to her burns. The patient's lips were covered in burns. She was able to open her mouth enough for me to

	determine that the inside of her mouth was free of sores. Her gums and oral mucosa were pink and slightly dry. Her teeth were all intact without any abnormalities. Her soft palate rises and falls equally. Uvula was central, pink, and moist. The patient was not asked to stick out her tongue and say, "ah," because I did not want to cause her unnecessary pain.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 2+** **Capillary refill:< 3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	S1 and S2 sounds were present. No S3 sounds, S4 sounds, or murmurs were heard. Both carotid pulses were palpated one at a time and 2+. Radial, posterior tibial, dorsalis pedis pulse sites were 2+ bilaterally. The patient's capillary refill was less than 3 seconds on their fingers and toes bilaterally. No pitting edema or swelling was present when assessing the patient's extremities.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **E.T. Tube: n/a** **Size of tube: n/a** **Placement (cm to lip): n/a** **Respiration rate: n/a** **FiO2: n/a** **Total volume (TV): n/a** **PEEP: n/a** **VAP prevention measures: n/a**	Upon auscultation, the patient's breath sounds slightly diminished bilaterally, with crackles heard in the left lower lobe upon inspiration. The patient did not have an E.T. tube.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height: 5'5"** **Weight: 145 lb** **Auscultation Bowel sounds:** **Last B.M.: 2/14/22** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒**	The patient states that she does not have the best diet. The patient states that she smokes "three joints" of marijuana a day to increase her appetite. The patient's daughter says that her mother mostly eats doughnuts. While at the hospital, the patient is on a mechanical soft diet. The patient attempted to eat her omelet and toast but mostly picked at it. The patient states that her last bowel movement was before she was admitted to the hospital on 2/14/22. Upon inspection, there were no evidence of abdominal distention, incisions, scars, drains, or wounds. Active bowel sounds were auscultated in all four quadrants. Upon palpation, the patient's abdomen was soft and non-tender.

Nasogastric: Y ☐ N ☒ **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY: **Color: dark yellow** **Character: clear** **Quantity of urine: 1000 mL** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: n/a** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	The patient's urine was clear and dark yellow. The patient stated that her urine had a "strong odor." She voided 1000 mL total during my clinical rotation. The patient denied any pain, burning, hesitancy, or urgency during urination. The patient denies being on dialysis. I did not inspect the patient's genitals. The patient did not have a urinary catheter. The patient's daughter assisted her to the bedside commode.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score: 30** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☒	The patient appears to have generalized weakness in all extremities. Her daughter assists her with activities of daily living, such as getting dressed. She moves all of her extremities without difficulty. She has equal strength and grip in hands and feet bilaterally. With the patient's Morse fall risk score being 30, she has a moderate risk for falls but still needs to utilize her call light before getting out of bed.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	She moves all of her extremities without difficulty. She has equal strength and grip in hands and feet bilaterally. Her pupils are equal, round, and reactive to light and accommodation. She is alert and oriented to person, place, time, and reason for the visit. She does not appear to have any impaired mental status. Her speech is clear and concise, without any slurring or stuttering. She denies any loss of consciousness.
PSYCHOSOCIAL/CULTURAL: **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 appeared to be coping well but stated that she was "still feeling anxious and in pain." The patient's developmental level seems appropriate for her age. The patient lives with her daughter, who appears to be her caretaker and support system. The patient did not discuss her religion.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
09:00	**86**	**138/86**	**13**	**98.2 F**	**97%**
12:00	**91**	**104/58**	**14**	**97.6 F**	**98%**

Vital Sign Trends/Correlation:

The patient's vitals stayed relatively the same besides the slightly decreased pulse, increased blood pressure, and temperature early in the morning, possibly due to her pain.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
08:00	**0-10**	**face**	**9**	**Burning, throbbing.**	**The patient was given pain medications as prescribed.**
11:00	**0-10**	**face**	**8**	**Burning, throbbing.**	**The patient's daughter gave her a back massage with cocoa butter lotion.**

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 has a peripheral IV line with one 20-gauge in her right median cubital vein (antecubital fossa) that was placed on 2/14/22, as indicated by the tape over the insertion site. She was currently receiving an infusion of lactated ringers at 100 mL/hr. The patient's IV

	was patent and flushed without difficulty. No drainage, swelling, warmth, or redness was present around the dressing.
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☒** **CLABSI prevention measures:**	The patient has a peripheral IV line with one 20-gauge in her left metacarpal vein (top of hand) placed on 2/14/22, as indicated by the tape over the insertion site. She was not currently receiving any infusions, and the IV was heparin-locked. The patient's IV was patent and flushed without difficulty. No drainage, swelling, warmth, or redness was present around the dressing. CLABSI prevention measures: hand hygiene was performed and appropriate skin antiseptic was applied.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
2946.7 mL of IV fluids.	**1000 mL urine.**

Nursing Care

Summary of Care (2 points)

Overview of care: I administered medications during my clinical rotation, monitored the patient's pain level, and performed a head-to-toe assessment.

Procedures/testing done: There were no procedures or testing done during my clinical rotation.

Complaints/Issues: The patient complained of pain and nausea during my clinical rotation. I administered her scheduled medication as prescribed. I checked up on the patient's pain level, and she stated that she was still in an immense amount of pain. The patient's daughter gave the patient a back massage to help her take her mind off the pain. The patient was calmer but stated that she was still in pain. The nurse preceptor gave her something for the pain before the end of my clinical rotation.

Vital signs (stable/unstable): The patient's vitals remained stable other than her increase in blood pressure from the morning, which could be due to her pain level.

Tolerating diet, activity, etc.: The patient attempted to eat but stated that she did not have "much of an appetite." The patient did not get out of bed unless going to the bathroom due to feeling "weak." The patient depended on her daughter to meet all of her needs.

Physician notifications: The physician was not notified at all during my rotation.

Future plans for the client: The future plans for this patient are to continue to monitor and treat her burns and manage her pain level. It is anticipated that client will require home health upon discharge.

Discharge Planning (2 points)

Discharge location: The patient will be discharged home with her daughter.

Home health needs (if applicable): The patient will require home health to deliver and set up her equipment.

Equipment needs (if applicable): The patient needs her oxygen equipment replaced. The patient requires a home oxygen system, a nebulizer, and her home oxygen and respiratory equipment set up to 3 liters at night as needed.

Follow-up plan: The patient will need to follow up with her primary care provider.

Education needs: The patient requires oxygen management precautions and fire safety education.

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 • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. **Acute pain related to the destruction of skin tissues as evidenced by**	**I chose this diagnosis, because the patient**	**1. Administer pain medication as prescribe**	**1. Reports pain is reduced/controlled.**	**The client and her daughter were frustrated by**

reports of severe pain.	**stated that on a numeric scale of 0-10 that her pain was a 9.**	**d.** **2. Provide basic comfort measures such as massage.**		**the lack of pain relief for the patient. The back massage helped to take her mind off of the pain for a little while, but the client continued to ask for more medication even after it was explained that it was not time for her next dose. The status is ongoing.**
2. **Imbalanced nutrition related to anorexia as evidenced by the patient stating that she "smokes 3 joints a day" to increase her appetite.**	**The patient states that she does not have "much of an appetite" and that she "needs to smoke marijuana to eat."**	**1. Provide small, frequent meals, and snacks.** **2. Ascertain food likes and dislikes to encourage patient to eat.**	**1. Demonstrate nutritional intake adequate to meet metabolic needs as evidenced by tissue regeneration.**	**The client and her daughter were appreciative of the nurse's attempt to find foods that the patient liked. The patient was agreeable and attempted to eat the meals brought to her. However, the patient did not finish the meals. The status is ongoing.**
3. **Impaired physical mobility related to**	**I chose this nursing diagnosis,**	**1. Perform ROM exercises consistent**	**1. To promote independence, enhance self-esteem, and**	**The patient did not appear to be interested in**

dependence of daughter for the completion of daily activities as evidenced by the patient's reluctance to move.	**because the patient appeared to be dependent on her 16 year old daughter to meet all of her needs and did not take any initiation in caring for herself.**	**ly, initially passive, and then active.** **2. Encourage patient participation in all activities as individually able.**	**facilitate the recovery process.**	**participating in any of her daily activities. The patient was content to let her daughter do everything for her.**
4. **Risk for ineffective airway clearance related to direct trauma of the upper airway as evidenced by scorched nares and the patient stating "I cannot breathe through my nose."**	**I chose this nursing diagnosis, because the patient stated that she was having trouble breathing through her nose.**	**1. Monitor respiratory rate, rhythm, and depth.** **2. Elevate head of the bed.**	**1. Demonstrate clear breath sounds, respiratory rate within normal range, and be free of dyspnea.**	**The client and her daughter responded positively. The client tried to take deep breaths to help clear breath sounds. The status is ongoing.**
5. **Deficient knowledge related to information misinterpretation as evidenced by lighting a cigarette while using supplemental oxygen.**	**I chose this nursing diagnosis, because the patient stated that she did not know that she could not smoke while on**	**1. Review condition, prognosis, and future expectations.** **2. Have patient repeat the proper use of supplemental oxygen**	**1. Verbalize condition and potential complications. Have the patient correctly perform the necessary procedures and explain reasons for actions.**	**The patient and the daughter were appreciative of the information given regarding supplemental oxygen precautions. The patient**

	oxygen, stating that she "smokes" with her oxygen all of the time.	**precautions.**		**was able to verbalize why it was dangerous to lit a cigarette while on supplemental oxygen.**

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

The patient states that she has “warts” on her head from HPV that she would like to talk to her primary care provider about. The patient states that she does not have the best diet. The patient states that she smokes "three joints" of marijuana a day to increase her appetite. The patient's daughter says that her mother mostly eats doughnuts. The patient states that her last bowel movement was before she was admitted to the hospital on 2/14/22. The patient stated that her urine had a "strong odor." The patient appeared to be coping well but stated that she was "still feeling anxious and in pain."

Nursing Diagnosis/Outcomes

1. Acute pain related to destruction of skin tissues as evidenced by reports of pain that is not eased with medication.
   - The client and her daughter were frustrated by the lack of pain relief for the patient. The back massage helped to take her mind off the pain for a little while, but the client continued to ask for more medication even after explaining that it was not time for her next dose. The status is ongoing.
2. Imbalanced nutrition related to anorexia as evidenced by the patient stating that she “smokes 3 joints a day” to increase her appetite.
   - The client and her daughter were appreciative of the nurse’s attempt to find foods that the patient liked. The patient was agreeable and attempted to eat the meals brought to her. However, the patient did not finish the meals. The status is ongoing.
3. Impaired physical mobility related to dependence of daughter for the completion of daily activities as evidenced by the patient’s reluctance to move.
   - The patient did not appear to be interested in participating in any of her daily activities. The patient was content to let her daughter do everything for her. The status is ongoing.
4. Risk for ineffective airway clearance related to direct trauma of the upper airway as evidenced by scorched nares and the patient stating “I cannot breathe through my nose.”
   - The client and her daughter responded positively. The client tried to take deep breaths to help clear breath sounds. The status is ongoing.
5. Deficient knowledge related to information misinterpretation as evidenced by lighting a cigarette while using supplemental oxygen.
   - The patient and the daughter were appreciative of the information given regarding supplemental oxygen precautions. The patient was able to verbalize why it was dangerous to lit a cigarette while on supplemental oxygen.

Objective Data

Vitals:
HR 91
BP 104/58
RR 14
Temp 97.6 F
O2 98%
Pain 8/10 on numeric scale

Abnormal lab values:
Neutrophils- 88.3
Lymphocytes-10.6
Monocytes-0.5
Eosinophils-5.9
Potassium-3.2
Glucose-147
Ketones- 1+
PaO2- 55
HCO3- 26.9
SaO2- 89

The patient has second-degree burns on her cheeks, lips, and chin, and inside her nares. The patient had slight reddening around both of her big toes. Upon auscultation, the patient's breath sounds slightly diminished bilaterally, with crackles heard in the left lower lobe upon inspiration. The patient appears to have generalized weakness in all extremities.

Client Information

The patient is a 53-year-old Caucasian woman who was admitted to OSF Sacred Heart Medical Hospital on 2/14/22 after sustaining second-degree burns to the face. The patient has a medical history of COPD, HTN, substance abuse, hypokalemia, left knee pain, right wrist pain, smoke inhalation, sleep apnea, thrush, depression. The patient is compliant.

Nursing Interventions

- Administer pain medication as prescribed.
- Provide basic comfort measures such as massage.
- Provide small, frequent meals and snacks.
- Ascertain food likes and dislikes to encourage the patient to eat.
- Perform ROM exercises consistently, initially passive, and then active.
- Encourage patient participation in all activities as individually able.
- Monitor the respiratory rate, rhythm, and depth.
- Elevate the head of the bed.
- Review the condition, prognosis, and future expectations.
- Have the patient repeat the proper use of supplemental oxygen precautions.