N431 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
03/03/2022	S. B	77	female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White Caucasian	Unemployed	Divorced	Shellfish containing products, Theophylline
Code Status	**Height**	**Weight**	
Full	148.6 cm	61.6kg	

Medical History (5 Points)

Past Medical History: Atrial Fibrillation, Coronary Artery disease, Emphysema, Hypercholesterolemia, hyperlipidemia, Macular degeneration, Myocardial infarction, Hypertension.

Past Surgical History: Eye surgery (left eye), Hernia repair, vaginal Hysterectomy, nose sinus surgery, appendectomy.

Family History: Mother had stroke, Hypertension, hearing loss and father had heart disease.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient is a former smoker, she smoked 2 packs daily for 30 years. She never used smokeless tobacco. She drinks alcohol occasionally.

Assistive Devices: Glasses.

Living Situation: Patient lives alone.

Education Level: Patient has a high school diploma and some college courses**.**

Admission Assessment

Chief Complaint (2 points): Dyspnea

History of Present Illness – OLD CARTS (10 points): Patient is a 77-year-old female patient who presented to the emergency department with worsening dyspnea (overnight) associated with non-productive coughing. Client used inhaler with no improvement, she is also on 3 litters of

oxygen at home. Moreso, patient noticed weight gain, lower limb swelling, orthopnea improving with inclined position. Patient also reported chest pain that resolved in morning, she denies fever, or chills. Chest x-ray was remarkable for pulmonary congestion.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Chronic Obstructive Pulmonary Disease (COPD).

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): Chronic obstructive pulmonary disease (COPD) is a combination of chronic bronchitis emphysema and hyperactive airway disease. Chronic bronchitis is characterized by hypersecretions of mucus in the large and small airways, cyanosis, and hypoxia (Capriotti, 2020) Excessive mucus creates obstacle to inspiratory airflow that prevents optimal oxygenation. Emphysema is characterized by overdistension of alveoli with trapped air which further creates obstruction to the expiratory, and high residue volume of carbon dioxide in the lung (Capriotti, 2020). Airways are also hyper reactive to irritants which make episodes of bronchoconstriction common in COPD.

Signs and symptoms of COPD include dyspnea which usually the first sign and symptom and as the disease progresses Dyspnea worsens (Capriotti, 2020). Productive cough, hypoxia, cyanosis, wheezing, fatigue are the classic signs of COPD. Over time Hypoxia stimulates pulmonary arterial vasoconstriction and signs and symptoms of right sided heart failure such as ascites, Jugular venous distension, ankle edema develops (Capriotti, 2020). The patient came into the emergency department complaining of shortness of breath, fatigue, and chest pain which these symptoms are consistent with a diagnosis of COPD.

Treatment for COPD begins with short acting bronchodilator for patients with mild disease and combines long- acting agents into the treatment plan. Inhaled bronchodilators are treatments of choice for patients for patients who have respiratory symptoms (Capriotti, 2020). Phosphodiesterase inhibitors like Theophylline can be included when patients do not respond to bronchodilators (Hinkle & Cheever, 2018). Oral corticosteroids are used when patient has an acute exacerbation and does not respond amply to bronchodilators, patient needs to use oral corticosteroids in low doses for a short time and tapered slowly (Hinkle & Cheever, 2018)

Upon arrival, the patient said she has had difficulties breathing all night on 3 liters of oxygen. She was noted to have labored breathing and consistent coughing. Upon auscultation of lung sounds, wheezing on exhalation was confirmed and her oxygen saturation was below normal which is consistent with his diagnoses of COPD. In addition to COPD, patient has a prior history of CAD, HTN, A Fib which can be underlying condition of her shortness of breath and the fact he smoked cigarette in the past and continues to drink alcohol occasionally puts her at higher risk for complications.

The physician ordered chest x-ray, CTA of lung to confirm diagnoses. She was given 3 liters of oxygen via nasal cannular, Fluticasone (one puff), and Furosemide.

Pathophysiology References (2) (APA):

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

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	3.80-5.30 10^6mcl	**4.50**	**4.6**	
Hgb	**11-16g/dl**	**11.1**	**12.7**	
Hct	36.0- 47.0 %	**36.1**	**41.5**	
Platelets	140-440 10^3 mcl	**237**	**275**	
WBC	4.00-11.00 10^3 mcl	**9.45**	**10.34**	
Neutrophils	47.0-73.0 %	**11.51**	**N/A**	
Lymphocytes	**20-40%**	**11**	**N/A**	
Monocytes	**4-6%**	**6.5**	**N/A**	
Eosinophils	**>7%**	**0.9**	**N/A**	
Bands	**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-	**135-145 mmol/L**	**140**	**136**	
K+	**3.5-5.0 mmol/L**	**4.3**	**3.9**	
Cl-	**98-107 mmol/L**	**105**	**98**	

CO2	**22-29 mm Hg**	**28.0**	**31.0**	CO2 is lost during hyperventilation, tachycardia, hypokalemia, numbness, muscle cramp, seizure, and anxiety. Patient is retaining more CO2 due to labored breathing (Hinkle & Cheever, 2018
Glucose	**74-100mg/ dl**	**156**	**89**	
BUN	**8-26**	**18**	**20**	
Creatinine	0.6-1.3 mg/dL	**0.93**	**0.73**	
Albumin	**3.5-5.2 mg/ dL**			
Calcium	**N/A**	**N/A**	**N/A**	
Mag	**N/A**	**N/A**	**N/A**	
Phosphate	**N/A**	**N/A**	**N/A**	
Bilirubin	**N/A**	**N/A**	**N/A**	
Alk Phos	**N/A**	**N/A**	**N/A**	
AST	**N/A**	**N/A**	**N/A**	
ALT	**N/A**	**N/A**	**N/A**	
Amylase	**N/A**	**N/A**	**N/A**	
Lipase	**N/A**	**N/A**	**N/A**	
Lactic Acid	**N/A**	**N/A**	**N/A**	
Troponin	**N/A**	**N/A**	**N/A**	
CK-MB	**N/A**	**N/A**	**N/A**	
Total CK	**N/A**	**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	N/A	N/A	N/A	
PT	N/A	N/A	N/A	
PTT	N/A	N/A	N/A	
D-Dimer	N/A	N/A	N/A	
BNP	N/A	N/A	N/A	
HDL	40-60mg/dl	42	45	
LDL	0-100mg/dl	47	44	
Cholesterol	0-200mg/dl	120	118	
Triglycerides	<150mg/dl	170	175	
Hgb A1c	N/A	N/A	N/A	
TSH	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	colorless	yellow	yellow	
pH	5.0-8.0	5.5	5.0	
Specific Gravity	1.003-1.033	1.021	1.025	
Glucose	negative	negative	negative	
Protein	negative	negative	negative	
Ketones	negative	negative	negative	
WBC	N/A	N/A	N/A	
RBC	N/A	N/A	N/A	

Leukoesterase	**N/A**	**N/A**	**N/A**	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.31-7.41**	**7.361**	**N/A**	
PaO2	**35.0-45.0 mmhg**	**43.0**	**N/A**	
PaCO2	**41.0 -51.0 mmHg**	**48.7**	**N/A**	
HCO3	**21.5-25.5 Mmol/l**	**27.0**	**N/A**	
SaO2	**N/A**	**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	**N/A**	**N/A**	**N/A**	**N/A**
Blood Culture	**N/A**	**N/A**	**N/A**	**N/A**
Sputum Culture	**N/A**	**N/A**	**N/A**	**N/A**
Stool Culture	**N/A**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray and Computed tomography angiography (CTA) Lung.

Diagnostic Test Correlation (5 points):

Chest X ray**:** Findings revealed increasing right basilar airspace consolidation suggest possibility of infection versus atelectasis. Also revealed increasing left basilar pleural fluid and prominent bronchos vascular suggesting congestion.

Computed tomography angiography (CTA) Lung**:** Findings revealed acute pulmonary embolism. Peripheral dense atelectasis or consolidation of pleural fluid with associated volume overload and nodular pneumonitis.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference. St. Louis, MO: Elsevier.

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

Home Medications (5 required)

Brand/Generic	Acetaminophen / Tylenol	Albuterol/ ProAir HFA	Aspirin/ Bayer	Alendronate (Fosamac)	N/A

Dose	500mg	2puff	325mg	70mg	
Frequency	Q 6hrs	Q 6hrs	daily	1 q 7 days	
Route	Oral	Oral	oral	oral	
Classification	Non-Opioid analgesic	Bronchodilator	To prevent MI	Bone resorption inhibitor	
Mechanism of Action	Blocks prostaglandin production and interferes with pain impulse generation in the central nervous system.	Reduces bronchospasm through two different mechanisms that will produce greater bronchodilation effects.	Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis. Anti-inflammatory.	Reduces activity of cells that cause bone loss, slows rate of bone loss after menopause and increasing amount of bone mass.	
Reason Client Taking	To relieve Pain	Treatment for COPD.	To relieve pain from inflammation	To prevent postmenopausal osteoporosis.	
Contraindications (2)	Severe hepatic impairment, hypersensitivity to acetaminophen	In patients with a history of hypersensitivity to any of its components, or to atropine and its derivates	Active bleeding & hypersensitivity	Hypersensitivity to alendronate. Hypocalcemia	
Side Effects/Adverse Reactions (2)	Hypertension, anxiety, fatigue, hypotension	Headache Runny nose Sore throat	confusion & depression	Abdominal distention and pain. Peripheral edema	
Nursing Considerations (2)	Use acetaminophen cautiously in patient with liver impairment, alcoholism, severe renal	Do not get into eyes, can cause enlarged pupils, blurry vision, and eye pain. Monitor for	Do not crush timed-release tablet & ask about tinnitus	Monitor patients' serum calcium level during and after treatment. Ensure adequate	

	impairment, chronic malnutrition	allergic reactions, hives, rash, swelling of face, eyelids, lips, throat or trouble swallowing		dietary intake of calcium and vitamin D before, during and after treatment.	
Key Nursing Assessment(s)/Lab (s) Prior to Administration	Monitor liver enzymes prior to administering this medication.	Monitor Serum potassium levels because albuterol may cause hypokalemia.	Monitor for liver function and ototoxicity.	Monitor patients' calcium levels before administering this medication.	
Client Teaching Needs (2)	Tell patient that tablets may be crushed or swallowed whole. Teach patient to recognize signs of hepatoxicity	Teach patient to wash mouthpiece with water ones a week and let it air dry. Advice patient to wait at least one minute between inhalations if dosage requires more than one inhalation.	Teach patient not to also take ibuprofen because it may reduce cardio protective and stroke preventing effects of aspirin. Advice patient not to take aspirin if it has a strong vinegar like odor.	Educate patient to take medication in the morning with a full glass of water. Teach patient not to chew or suck on this medication to prevent esophageal irritation.	

Hospital Medications (5 required)

Brand/Generic	Apixaban/ Eliquis **(**Jones &	Furosemide/ Lasix (Jones & Bartlett,	Metoprolol/ Toprol Xl (Jones & Bartlett,	Rosuvastatin / Crestor **(**Jones &	Sertraline/ Zoloft **(**Jones & Bartlett,

	Bartlett, 2020)	2020)	2020**)**	Bartlett, 2020)	2020)
Dose	5mg	20mg	50mg	20mg	50mg
Frequency	2 times daily	daily	Bid	daily	daily
Route	oral	oral	oral	oral	oral
Classification	Anticoagulant	Anti Hypertensive Diuretic	Antianginal/ antihypertensive	Antilipidemic	Antianxiety/ anti-depressant.
Mechanism of Action	Inhibits free and clot-bound factor Xa and prothrombinase activity. It indirectly inhibits platelet aggregation induced by thrombin.	Inhibits sodium and water reabsorb in the loop of Henle and increases urine formation	Inhibits stimulation of beta receptor sites located mainly in the heart, resulting in decrease cardiac excitability.	Rosuvastatin inhibits the enzyme 3-hydroxy-3-methylgutary A reductase. This inhibition reduces lipid levels by increasing the number of hepatic low-density lipoproteins.	It inhibits reuptake of the neurotransmitter serotonin by the CNS neurons, thereby increasing the amount of serotonin available in nerve synapses.
Reason Client Taking	To reduce risk for stroke	To reduce edema	To treat acute MI or evolving acute MI	To treat hyperlipidemia	To treat social anxiety disorder**.**
Contraindications (2)	Hypersensitivity to apixaban or its components. Active bleeding.	Anuria, hypersensitivity to furosemide or its components	Hypersensitivity to metoprolol Heart failure.	Active liver disease. Hypersensitivity to Rosuvastatin.	Concurrent use of Disulfiram. Hypersensitivity to sertraline and its components**.**
Side Effects/Adverse Reactions (2)	GI bleeding, Syncope	Weakness Tachycardia	Anxiety, confusion	Cognitive impairment. headache	Confusion. Tremor, syncope
Nursing Considerations (2)	Should not be given to patient with	Use furosemide cautiously	Use cautiously in patient who	Discontinue medication if AST and	Do not administer this

	severe hepatic dysfunction. Discontinue medication 48 hours before an invasive procedure**.**	with hepatic cirrhosis especially those with a history of electrolyte imbalances because it may lead to hepatic coma. Administer drug slowly I.V. over 1 to 2 minutes to prevent ototoxicity	have Congestive Heart failure because metoprolol can further depress myocardial contractility, worsening heart failure. Check for signs of poor Glucose control in patients with diabetic mellitus.	ALT levels increase. Use cautiously in patients who consume alcohol.	medication to patient with bradycardia. Watch patient closely for suicidal ideations.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver function prior to administering this medication.	Monitor blood pressure and electrolytes**.**	Before administering this medication check patients' pulse and blood pressure. If pulse is less than 60, hold medication.	Monitor liver enzymes and kidney function before administering this medication**.**	Monitor liver enzymes and BUN and Serum creatinine levels**.**
Client Teaching Needs (2)	Take medication exactly as prescribed. Teach patient to report any unusual bleeding.	Teach patient to take this medication at the same time every day to maintain therapeutic effect. Advice patient to change position slowly to minimize	Instruct patient to with food at the same time each day. Notify provider if pulse rate falls below 60.	Encourage patient to follow low fat and cholesterol diet. Instruct patient to notify provider about muscle pain, tenderness**.**	Do not stop taking this medication abruptly. Consult provider before taking over the counter medications.

		the effect of orthostatic hypotension .			

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed.). Burlington, MA.1

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client appears alert and oriented to person, time, and place. Well groomed, no acute distress. She is a fluent English speaker
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** .	The client's skin is warm, pink, and dry. Skin turgor is expected because the client is not dehydrated. She does not have rashes, bruises, wounds, and no drains noted. Braden scale: 20

Braden Score: **Drains present: Y☐ N ☒** **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical, trachea is midline, no deviation. Patients' ears were free of discharge, slightly visible cerumen. Patient did not corporate for PERRLA assessment. Cornea clear, no drainage. Septum is midline, turbinate is dry and pink bilaterally. Teeth were well maintained
CARDIOVASCULAR: **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 were present No murmurs Pulses are 2+ throughout bilaterally Capillary refill less 3 seconds in all extremities No visible edema or Neck vein distention.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	.Severe respiratory distress, wheezing, No use of accessory muscles, and lung sounds were diminished in the left lower lobe.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention: No distention** **Incisions: No incision** **Scars: No scars** **Drains: No Drains** **Wounds: no wounds** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒**	Regular diet at home Cardiac diet. 148.6cm 61.6kg Normal bowel sounds No BM during my shift No CVA tenderness No abnormalities were found upon inspection for distention, incisions, scares, drains, or wounds

Type:	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The client reports that urine is yellow, average quantity. She has no pain during urination**,** Emptied Urinal at 1015, 200 mL.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 12** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient tested negative for the Homan sign. Normal range of motion, equal strength 5/5, does not use an assistive device. The patient can do activities of daily living. Fall risk score is 12. The patient is active, able to stand up alone and walk
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☐ N☒** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Was not able to perform PERLLA assessment Orient x4 Patients speaks fluent English No gross facial neurological deficits, no sensory deficit
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):**	. Family friends Mature Patient lives at home by herself, gets helps with transportation and errands from her children and other close relatives.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0830am	94	**130/69** Supine Left arm	16	97.9 F(oral)	95% (Nasal canular)
1015am	90	120/68 Supine Left arm	16	97.6 F (Oral)	96% (Nasal canular)

Vital Sign Trends: The client has a history of hypertension and stated that she was stressed due to possibility of an upcoming procedure, which increased her systole blood pressure. Blood pressure was back to normal when patient took her medications and felt more relaxed.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830am	0-10	Client denial any pain	Client denial any pain	Client denial any pain	N/a
1015am	0-10	Client denial any pain	Client denial any pain	Client denial any pain	N/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G **Location of IV:** cephalic vein on left and	Patient had no fluids running.

right arm. **Date on IV:** 03/08/22 **Patency of IV:** Easily Flushed **Signs of erythema, drainage, etc.:** N/A **IV dressing assessment:** Clear, dry, and intact dressing	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
10% breakfast consumed 240ml of water 180ml of protein shake 40 ml of chicken broth	**200ml**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was admitted on 03/03/2022, complaining of shortness of breath and chest pain. Patient is on 3 liters oxygen (24 hours). The nurse and I performed a head-to-toe assessment and vital signs.

Procedures/testing done: Patient had Chest X ray and CTA Lung done upon arrival at hospital.

Complaints/Issues: Patient complains of shortness of breath.

Vital signs (stable/unstable): Systolic blood pressure dropped from 130 to 120. Other vital signs are stable

Tolerating diet, activity, etc.: Patient did not have appetite for food this morning. She ate few bites and drank all his drinks. Active orders stated activity as tolerated. Patient was not willing to get out of bed.

Physician notifications: Patients showed no further signs of unusual distress. Discharge notes from Physician.

Future plans for client: N/A

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): Patient is to be on continues oxygen at home

Equipment needs (if applicable): CPAP machine ordered. Patient already has oxygen equipment at home.

Follow up plan: Patient needs to contact primary care provider if they notice any unusual symptoms and if his oxygen saturation goes below 90 on 3 liters of Oxygen

Education needs: Patient need to be educated on deep breathing and relaxation technic and on how to use and clean a CPAP machine

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

Nursing Diagnosis	**Rationale**	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation**
• Include full nursing diagnosis with "related to" and "as evidenced by"	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client response, status of goals

components • Listed in order by priority – highest priority to lowest priority pertinent to this client				and outcomes, modifications to plan.
1. Ineffective airway clearance related to COPD as evidenced by wheezing and diminished lung sounds in the left lower lobe	Patient was diagnosed with COPD and is usually on 3 liters of oxygen at home.	**1.** Position the patient upright (fowlers, semi fowlers, or high fowlers). **2.** Monitor pulse oximetry readings to keep SpO2 levels between 88-92%.	**1.** Demonstrate behaviors to improve airway clearance, for example cough effectively and expectorate secretions.	Tried to position the patient in a high-fowlers position but she requested to lower the head of the bed, she felt most comfortable at 30 degrees
2. Ineffective breathing pattern related to COPD as evidenced by non - productive cough	This diagnosis was chosen because client has labored breathing when talking and shortness of breath.	**1.** Teach deep breathing exercises and relaxation techniques **2.**Assess patients' respiratory status every 2 to 4 hours and notify any abnormal finding	**1.** Improvement of breathing pattern and maintain a respiratory rate within normal limits.	Patient was not willing to do breathing exercise**.**
3. Imbalanced Nutrition: less than body requirement related to Dyspnea as evidenced by "I do have	Patient's breakfast arrived and did not want to eat, he verbalized that she was just tired.	**1.** Refer the patient to dietitian **2**. Offer protein drink	**1.** Display progressive interest in food and eat more calory dense food**.**	Patient ate few bites and food and preferred and drank all protein drinks

appetite, I'm just really tired".				
4. Activity intolerance related to imbalanced between oxygen supply and demand due to inefficient work of breathing as evidenced by Dyspnea	Patient chiefs complain was dyspnea and she also reported having chest pain.	**1.** Teach and assist the patient with active ROM exercises. 2. Provide time of undisturbed rest in between activities	**1.** Reports reduced episodes of dyspnea during an activity	Patient was not willing to perform any range of motion and other exercises. She stated feeling tired

Other References (APA):

Phelps, L. L., & Ralph, S. S. (2018). *Sparks & Taylor's nursing diagnosis pocket guide*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Patient said she had trouble breathing / shortness of breath prior to admission. She also stated that she felt tired.

Patient said, "I'm just really tired"

Nursing Diagnosis/outcomes

Ineffective airway clearance related to COPD as evidenced by wheezing and diminished lung sounds in the left lower lobe.
Goal: Patient is positioned upright and O2 stats improved.

ective breathing pattern as evidenced by non -productive cough.
Goal: Client's respiration pattern will be effective Without causing fatigue.

Imbalanced Nutrition as evidenced by patient stating that "I have no appetite, I'm just really tired".
Goal: Have patients eat some food and drink a protein shake (Ensure).
Activity intolerance related to imbalanced between oxygen supply and demand due to inefficient work of breathing as evidenced by Dyspnea
Patient will Reports reduced episodes of dyspnea during an activity

Client Information

77-year-old white
ucasian female
Admitted on 03/03/2022
Diagnoses : COPD
Allergies : Shell Fish containing Product
Full code, Theophylline.

Objective Data

Weight: 61.6kg
Vitals:
B/P: 130/68
Heart Rate: 94
Respirations: 16
Temperature: 97.7 F
O2: 96 % on 3liters Oxygen (Canula)
Pain: 0/10

Urine output at 200 mL

Nursing Interventions

Position the patient upright (fowlers, semi fowlers, or high fowlers
Monitor pulse oximetry readings to keep SpO2 levels between 88-92%.
Teach deep breathing exercises and relaxation techniques
Assess patients' respiratory status every 2 to 4 hours and notify any abnormal finding
Refer the patient to dietitian.
Offer protein dense drink (Ensure
Teach and assist the patient with active ROM exercises.
Provide time of undisturbed rest in between activities