N441 Care Plan

Lakeview College of Nursing

Happy Kalavadia

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
3/6/2022	BD	68	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Licensed Practical nurse (Retired)	Not married	None
Code Status	**Height**	**Weight**	
Full	5 feet 4 inch	152.3 kg	

Medical History (5 Points)

Past Medical History:

- Arthritis
- Bulging lumbar disc
- Hyperlipidemia
- Morbid obesity
- Hypertension
- DVT
- Type 2 diabetes mellitus
- Osteoarthritis
- Psoriasis
- Anxiety disorder
- Umbilical Hernia (Left side)
- Obstructive sleep apnea
- Polycystic Ovarian syndrome
- Iron deficiency anemia
- Urinary tract infection

Past Surgical History:

- **None**

Family History: Cancer in mother , diabetes in her brother , father , mother and sister.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): No smoking , alcohol and drugs.

Assistive Devices: None

Living Situation: Lives alone in nursing home.

Education Level: Licensed practical nurse, Associate degree (Worked as a nurse for many years)

Admission Assessment

Chief Complaint (2 points): Shortness of breath and difficulty breathing **.**

History of Present Illness – OLD CARTS (10 points): Patient is 68 years old and lives in nursing home . She is retired nurse and a former OSF employee. Patient stated, " I started to have shortness of breath and difficulty breathing after having lunch". She came to the nearest emergency room and was given oxygen 2L on nasal cannula and given her antianxiety medication. The onset of shortness of breath was after two hours after she had lunch. When asked about pain she stated " I do not have pain. I have shortness of breath only" The location of her shortness of breath was in the throat and she felt very uncomfortable. She was very scared and started to have panic attack as well. Patient stated, " The duration of pain is constant and unbearable ". She further stated that my shortness of breath decreases when she sits up. She mentioned that she did not have any associated manifestations. Patient stated, " I did not try any home remedies and went directly to emergency room". Patient also had generalized edema and she was given Lasix in the emergency room to decrease the edema. She was started on nasal cannula 2L and she mentioned that her shortness of breath was quite severe compared to her last

episode which was before few months. Patient was transferred from emergency room to ICU after her vitals and oxygen levels were stabilized. Currently she in on 4L oxygen and on a nasal cannula. Patient is currently stable, talkative and pleasant to talk.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute respiratory failure with pulmonary edema.

Secondary Diagnosis (if applicable): Pulmonary edema

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

Respiratory failure is an acute or chronic condition in which patient experiences difficulty breathing, low o2 saturation , dizziness and confusion (Capriotti and Frizzell, 2017)**.** There can be several reasons of respiratory failure such as COPD, any cancer or tumor, COVID 19 pneumonia etc (Capriotti and Frizzell, 2017). In respiratory failure, there is impaired gas exchange resulting in low O2 levels and high retention of CO2 (Capriotti and Frizzell, 2017). On a cellular level, impaired gas exchange has many negative consequences on patient's physical and mental health (Capriotti and Frizzell, 2017). The most common manifestation of acute respiratory failure is dyspnea (Capriotti and Frizzell, 2017).There is retention of CO2 in chronic respiratory failure leading to memory loss, confusion and short-term amnesia (Capriotti and Frizzell, 2017). My patient has severe shortness of breath and was admitted to emergency department due to dyspnea and decreased 02 levels. She was immediately started on 2L nasal cannula and given IV Lasix since she also had pulmonary edema due to fluid build up in her lungs. The research article describes about noninvasive mechanical ventilation that delivers positive pressure ventilation to lungs and improves shortness of breath and thus oxygen levels (Elliott, 2021) .There are two types of acute respiratory failure, type 1 and type 2. (Elliott,

2021) .Type 1 is characterized by hypoxemia which is decreased oxygen levels in blood (Elliott, 2021) Type 2 is characterized by hypoxemia and hypercapnia which is decreased O2 levels and increased CO2 levels respectively (Elliott, 2021) .My patient had type 1 respiratory failure secondary to pulmonary edema. Patient had chest Xray and CT chest done, and it confirmed bilateral pulmonary edema and congestion. Patient was transferred to ICU after stabilization of her vitals in emergency department. Patient was started on continuous IV Lasix since she had pulmonary edema and excessive fluid retnetion. She was also started on ceftriaxone for urinary tract infection. The main treatment of acute respiratory failure is to stabilized oxygen levels by giving positive pressure ventilation or doing invasive mechanical ventilation like intubating a patient. Patient was also started on heart healthy diet and passive range of motion exercises. The main goal of this patient is to reduce the fluid retention and maintain O2 saturation levels. The vitals of patient are currently very stable, and patient does not have any pain and difficulty breathing. In summary, respiratory failure can be acute or chronic and can be of two types , type 1 and type 2. The main stay treatment of acute respiratory failure is to stabilize oxygen and CO2 levels by providing positive pressure ventilation or invasive mechanical ventilation such as intubation.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2017). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

Elliott, M. W. (2021). Noninvasive ventilation in acute hypercapnic respiratory failure. *Barcelona Respiratory Network*, *3*(4). https://doi.org/10.23866/brnrev:2017-m0053

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.0-4.9 10^6/ uL	N/A	2.6 * 10^6	RBC is decreased in iron deficiency anemia (Capriotti and Frizzell, 2017).
Hgb	12.0-16.0 g/dL	N/A	7.9	Patient has iron deficiency anemia . In iron deficiency anemia, hemoglobin is decreased due to decreased production of red blood cells (Capriotti and Frizzell, 2017).
Hct	37.0-48.0%	N/A	24.8	Hematocrit is decreased in iron deficiency anemia due to less production of red blood cells (Capriotti and Frizzell, 2017).
Platelets	150-400 10^3/uL	N/A	232 10^3	Within normal limits.
WBC	4.1-10.9 10^3/uL	N/A	11.3 10^3	Patient has Urinary tract infection and WBC is elevated in UTI (Capriotti and Frizzell, 2017).
Neutrophils	1.50-7.70 10^3/uL	N/A	6.60 10 ^3	Within normal limits.
Lymphocytes	1.00-4.90 10^3/uL	N/A	2.00 10^3	Within normal limits.
Monocytes	0.00-0.80 10^3/uL	N/A	0.40 10^3	Within normal limits.
Eosinophils	0.00-0.50 10^3/uL	N/A	0.02 10^3	Within normal limits.
Bands	0-5	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-	136-145 mmol/L	N/A	137	Within normal limits.

K+	**3.5-5.1 mmol/L**	**N/A**	**4.6**	**Within normal limits.**
Cl-	**98-107 mmol/L**	**N/A**	**102**	**Within normal limits**
CO2	**21.0-32.0 mmol/L**	**N/A**	**29**	**Within normal limits.**
Glucose	**60-99 mg/dL**	**N/A**	**329**	**Patient has chronic type 2 diabetes mellitus and hence her blood glucose is elevated (Capriotti and Frizzell, 2017).**
BUN	**5-20 mg/dL**	**N/A**	**6.0**	**Within normal limits.**
Creatinine	**0.5-1.5 mg/ dL**	**N/A**	**1.40**	**Within normal limits.**
Albumin	**3.4-5.4 g/dL**	**N/A**	**N/A**	**N/A**
Calcium	**8.5-10.1 mg/dL**	**N/A**	**10.0**	**Within normal limits.**
Mag	**1.6-2.6 mg/ dL**	**N/A**	**2.4**	**Within normal limits.**
Phosphate	**2.5-4.5**	**N/A**	**N/A**	**N/A**
Bilirubin	**Less than 0.3**	**N/A**	**0.2**	**Within normal limits.**
Alk Phos	**44-147 U/L**	**N/A**	**79**	**Within normal limits.**
AST	**14-36**	**N/A**	**8**	**Within normal limits**
ALT	**0-35**	**N/A**	**10**	**Within normal limits**
Amylase	**23 – 85**	**N/A**	**N/A**	**N/A**
Lipase	**0 - 160**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.50 – 2.20**	**N/A**	**N/A**	**N/A**
Troponin	**0.00-0.04**	**N/A**	**N/A**	**N/A**
CK-MB	**5-25**	**N/A**	**N/A**	**N/A**

Total CK	**22-198**	**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	**Less than - or equal to 1.0**	**N/A**	**N/A**	**N/A**
PT	**11 to 13.5 seconds**	**N/A**	**N/A**	**N/A**
PTT	**30-45 seconds**	**N/A**	**N/A**	**N/A**
D-Dimer	**100-399.0**	**N/A**	**N/A**	**N/A**
BNP	**Less than 100 pg/ml**	**N/A**	**98**	**Within normal limits.**
HDL	**<200**	**N/A**	**N/A**	**N/A**
LDL	**>60**	**N/A**	**N/A**	**N/A**
Cholesterol	**<200**	**N/A**	**N/A**	**N/A**
Triglycerides	**<140**	**N/A**	**N/A**	**N/A**
Hgb A1c	**<65**	**N/A**	**N/A**	**N/A**
TSH	**0.4-4.0**	**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	**Light yellow**	**N/A**	**Dark Yellow**	**Patient has UTI and the urine becomes more concentrated and darker in color (Capriotti and Frizzell, 2017).**
pH	**5.0-7.0**	**N/A**	**5.5**	**Within normal limits.**
Specific Gravity	**1.003-1.030**	**N/A**	**1.020**	**Within normal limits**

Glucose	**negative**	**N/A**	**negative**	**Within normal limits**
Protein	**negative**	**N/A**	**negative**	**Within normal limits**
Ketones	**negative**	**N/A**	**negative**	**Within normal limits**
WBC	**0-25 /ul**	**N/A**	**51**	**The number of WBC is increased in UTI (Capriotti and Frizzell, 2017).**
RBC	**0-25/ul**	**N/A**	**15**	**Within normal limits**
Leukoesterase	**negative**	**N/A**	**Negative**	**Within normal limits.**

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**	**N/A**	**7.35**	**Within normal limits**
PaO2	**80-100**	**N/A**	**100**	**Within normal limits**
PaCO2	**35-45**	**N/A**	**40**	**Within normal limits.**
HCO3	**22-26**	**N/A**	**23**	**Within normal limits**
SaO2	**92-100**	**N/A**	**98**	**Within normal limits**

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**	**N/A**

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2017). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X ray with contrast shows diffuse infiltrates in both lungs with pulmonary vascular congestion and pleural effusion. In addition, massive cardiomegaly was also noted.
CT chest showed ground glass infiltrated with low lung volumes , cholelithiasis and undetermined left rib fracture.

Diagnostic Test Correlation (5 points):

Chest x ray was important to rule out pulmonary congestion as patient had shortness of breath and acute dyspnea (Capriotti and Frizzell, 2017). In addition, patient has lower extremity edema and chest x ray would rule out if there is any evidence of pulmonary edema present or not.
CT chest would be more accurate diagnostic test to rule out pulmonary hypertension and pulmonary edema. Patient is morbidly obese and cholelithiasis is more common in obese female which is confirmed by CT chest (Capriotti and Frizzell, 2017).

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2017). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

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

Home Medications (5 required) – Patient has only 4 home medication listed in the chart.

Brand/Generic	**Lipitor/ Atorvastatin**	**Zorprin/ Aspirin**	**Xarelto/ Rivaroxaben**	**Zestril/Lisinopril**
Dose	**40 mg**	**81 mg**	**20 mg**	**10 mg**
Frequency	**Once a day**	**1 tablet daily**	**1 capsule every day**	**1 capsule every day**
Route	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Statins(Lipid lowering agents).**	**Anticoagulants**	**Anticoagulants**	**ACE inhibitors**
Mechanism of Action	**It lowers plasma cholesterol and LDL levels by increasing uptake and catabolism of LDL cholesterol (Jones & Bartlett , 2020).**	**It inhibits platelet aggregation and thus decreasing formation of blood clots (Jones & Bartlett , 2020).**	**It inhibits factor X and prothrombin activity thus decreasing formation of blood clots (Jones & Bartlett , 2020).**	**It inhibits angiotensin enzyme preventing the conversion of angiotensin 1 to angiotensin 2 thus lowering blood pressure (Jones & Bartlett , 2020).**
Reason Client Taking	**Patient is morbidly obese .**	**Due to risk of DVT from less mobility in nursing home.**	**Due to history of DVT**	**Patient has hypertension.**

Contraindications (2)	**Liver failure Alcoholism**	**Bleeding Rash**	**Bleeding Liver failure**	**Hypotension Hyperkalemia**
Side Effects/Adverse Reactions (2)	**Rash Steatorrhea**	**Heart burn Stomach cramps**	**Nausea Bleeding**	**Diarrhea Sneezing**
Nursing Considerations (2)	**Take at the same time every day for maximal absorption. Give Lipitor with evening meals as it is highly absorbed in evening.**	**Take aspirin at the same time everyday . Do not excess the dose as it can cause bleeding .**	**Take at the same time every day for maximal absorption. Monitor patient for any bleeding episodes.**	**Take at the same time every day for maximal absorption. Monitor patient for hypotension .**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**None**	**None**	**None**	**None**
Client Teaching needs (2)	**Take the medication at the same time each day. Skip the missed dose and do not double the dose.**	**Take at the same time every day for maximal absorption. Skip the missed dose and do not double the prescribed dose.**	**Take the medication at the same time every day. Skip the missed dose and do not double the missed dose.**	**Take the medication at the same time each day. Take the exact dose and do no double the dose if missed.**

Hospital Medications (5 required)

Brand/Generic	**Neurontin/ Gabapentin**	**Lasix/ Furosemide**	**Novolog/ Insulin aspart**	**Ativan/ Lorazepam**	**Humalog/ Insulin Lispro**
Dose	**600 mg**	**40 mg**	**Depends on blood sugar levels**	**50 mg**	**2-12 units (depending on her blood glucose levels)**
Frequency	**1 tablet**	**Twice daily**	**Before and after meals**	**Once daily**	**4 times daily with meals**
Route	**Three times daily**	**Iv push**	**Subcutaneous**	**Oral**	**Subcutaneous**
Classification	**Gabapentinoids**	**Loop diuretics**	**Insulins**	**Benzodiazepines**	**Insulin**
Mechanism of Action	**It inhibits the alpha 2-delta subunit of voltage-gated calcium channels (Jones & Bartlett , 2020).**	**Increase the excretion of water and Na by inhibiting the reabsorption from proximal and distal tubules (Jones & Bartlett , 2020).**	**It decreases blood glucose levels by pushing glucose into cells (Jones & Bartlett , 2020).**	**It enhances the inhibits effects of GABA (Jones & Bartlett , 2020).**	**It pushes blood glucose into cells lowering blood glucose (Jones & Bartlett , 2020).**
Reason Client Taking	**Due to peripheral neuropathy related to vitamin B12 deficiency**	**Due to fluid rendition secondary to pulmonary edema.**	**Type 2 DM**	**Due to anxiety**	**Due to type DM**
Contraindications (2)	**Depression COPD**	**Kidney failure Hypersensitivity**	**Kidney failure Hepatic dysfunction**	**Allergy Sedation**	**Allergy Hypoglycemia**
Side Effects/Adverse Reactions (2)	**Hypotension Tremor**	**Hypokalemia Muscle**	**Hypoglycemia Dizziness**	**Sedation Bad taste in mouth**	**Hypoglycemia Dizziness**

		cramps			
Nursing Considerations (2)	**Do not lie down immediately after taking the drug to prevent hypotension** **Monitor for fall episodes**	**Lasix need to be pushed slowly as it causes hearing loss if pushed fast.** **Flush Lasix with normal saline before and after to prevent toxicity.**	**Rotate the injection sites to prevent the formation of hematoma.** **Give insulin 30 minutes after breakfast for maximal effect.**	**Monitor for fall risk.** **Take tablet after evening meals and before bedtime.**	**Rotate the injection sites .** **Do not rub skin after administering injection.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**None**	**None**	**None**	**None**	**None**
Client Teaching needs (2)	**It can be taken with or without food.** **Swallow the tablet and do not crush it .**	**It is normal to observe increase urinary output .** **The color of the urine is pale yellow and is normal .**	**Teach patient how to self-administer insulin by themselves when at home.** **Demonstrate proper technique of needle safety to patient in order to prevent any injury.**	**Take with evening meals to prevent sedation.** **Do not drive if taking this medication.**	**Teach the client to self-administer insulin.** **Demonstrate proper safety needle technique after administering insulin.**

Medications Reference (1) (APA):

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

MA

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is alert, oriented to person, place and time. She is not distressed , very talkative and pleasant to talk . She is resting on her bed and currently planning to order lunch. She is very well mannered and is a sweet hearted woman.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 12** **Drains present: Y☒ N ☐** **Type: Port**	**Patient has bruised skin especially in the abdominal area due to insulin shots. She also has panniculitis and erythema of groin. She has abdominal hernia on her left lower abdominal area. She has 3 + pitting edema. Her skin is pale , bruised and her capillary refill is less than 3 seconds.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck symmetrical, trachea midline no deviation, thyroid palpable, no noted nodules. Bilateral carotid pulses palpable. Nose septum midline turbinate's moist and pink.** **•Eyes bilateral sclera white, bilateral cornea foggy, conjunctive pink, slight drainage in left eye. Dentures noted upon oral examination.**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):**	**Clear S1 and S2 heard without gallops or rubs. Pt in normal sinus rhythm with PVC'S, Peripheral pulses palpable. Capillary refill less then 3sec. No murmur heard. 3+ pitting**

Peripheral Pulses: **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema: Lower bilateral legs**	**edema on bilateral lower extremity. Generalized edema also noted upon physical examination.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube: None** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	**Respiration are shallow and irregular. But shortness of breath is not noted on rest, but only on exertion.**
GASTROINTESTINAL: **Diet at home:** **Current Diet: Heart healthy diet** **Height: 5 feet 4 inch** **Weight:152.3 kg** **Auscultation Bowel sounds:** **Last BM: (3/8/2022)** **Palpation: Pain, Mass etc.: None** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Bowel sounds are present and normoactive in all four quadrants . Abdomen is soft, symmetric with no pain or tenderness. Aorta is midline with bruit or visible pulsation. No hepatomegaly or splenomegaly noted. Left abdominal hernia notes upon physical examination.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:**	**Patient does have urgency or frequency. The color of urine is dark yellow . Urine culture is not obtained as patient is not symptomatic.**

Catheter: Y ☒ N ☐ **Type: External catheter** **Size: Large** **CAUTI prevention measures: Daily catheter care.**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score: 18** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☒**	**Patient is not currently stable to walk and does not use any assistive devices. She needs help with ADL as well as walking and standing due to her morbid obesity. Her ROM and musculoskeletal are normal.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Patient is alert, awake and oriented to place ,person and time. Motor function is normal with muscle strength2/2Reflexes 1+ bilaterally. Patient cannot walk by her and needs assistance.**
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):**	**Patient lives in nursing home since many years and she mentioned that she feels lonely . She is catholic in religion but does not go to church . Her husband lives in some nursing home as well but in different state.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
9:00 AM	**68**	**130/90**	**14**	**96.8 F**	**98 (4L oxygen)**
11:00 AM	**78**	**135/90**	**12**	**97.0 F**	**98 (4L**

					oxygen)

Vital Sign Trends/Correlation:

Patient's vital signs are well controlled currently since she takes her prescribed medications.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:00 AM	**Numeric scale 0**	**None**	**None**	**None**	**None**
11: 00 AM	**Numeric scale 0**	**None**	**None**	**None**	**None**

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:**	None
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion: June 2019** **Patency: Patent** **Signs of erythema, drainage, etc.:** **Dressing assessment: Port patent and has two alcohol caps .** **Date on dressing: None**	Patient has port on her right neck since many years. No erythema and drainage present. Port is

CUROS caps in place: Y ☒ N ☐ **CLABSI prevention measures: Port care with alcohol impregnated caps.**	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
Orange juice (8 oz) **Milk (8 oz)** **Cereal (30 gm)**	**850 ml**

Nursing Care

Summary of Care (2 points)

Overview of care: The goal is to maintain patient's O2 saturation and her blood pressure as well**.**

Procedures/testing done: Patient had chest x ray and chest CT done.

Complaints/Issues: Patient had shortness of breath on exertion and is non complaint with using bi pap machine.

Vital signs (stable/unstable): Vital signs are currently stable**.**

Tolerating diet, activity, etc.: Patient is tolerating diet but needs assistance with ADL's **(activity of daily living).**

Physician notifications: Monitor O2 saturation , blood pressure as well as edema.

Future plans for client: Current plan is to teach deep breathing exercises as well as educating patient to use BI-pap machine at night. Patient is educated to consume low salt diet when discharged.

Discharge Planning (2 points)

Discharge location: Danville

Home health needs (if applicable): none

Equipment needs (if applicable): none

Follow up plan: None

Education needs: Low sodium diet and use of bipap machine at home. Patient is sometimes noncompliant with the using bipap machine, so goal is to teach her to be complaint and also do deep breathing exercises**.**

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

Nursing Diagnosis • Include full nursing diagnosis with	**Rationale** • Explain why the nursing diagnosi	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's

"related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	s was chosen			actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired gas exchange related to shortness of breath and evidenced by low O2 saturation when patient removes nasal cannula.	**Patient presented to ED with severe shortness of breath and was transferred to ICU after stabilization . But patient still requires continuous 4L oxygen .**	**1.Patient was placed in semi fowlers position and she stated that she felt better.** **2. Patient was started on 4L nasal cannula to improve her shortness of breath and o2 saturation levels.**	**1. Patient's O2 saturation was 98 percent after nursing interventions .**	**Patient stated that she felt better after interventions and she does not have any pain or shortness of breath. She is complaint when it comes to breathe air with nasal cannula.**
2. Ineffective breathing pattern related to patient's snoring episodes as evidenced by use if Bipap machine by the patient.	**Patient has chronic obstructive sleep apnea and uses Bipap machine at night since she wakes up in middle of night due to difficulty breathing.**	**1. Patient was taught proper technique on how to use Bipap machine.** **2.Patient was also taught deep breathing exercises which was liked by the patient .**	**1. Patient's breathing pattern improved as patient mentioned during the assessment that she slept all night long without waking up for air.**	**Patient mentioned that she will be complaint with Bipap machine and she liked breathing exercises which she planned to do three times a day .**
3. Risk for fluid volume deficient related to	**This diagnosis was chosen because continuous**	**1. Patient was encouraged to drink more fluids .**	**1. Patient had an positive outcome as her urine**	**Patient is noncompliant with drinking more fluids because she**

continuous use of Lasix as evidenced by low urine output and dark yellow urine.	**IV Lasix can cause fluid volume deficit due to fluid**	**2 Patient was given electrolyte solution to drink to replenish the electrolytes lost.**	**output improved and her color of urine was light yellow after the interventions .**	**mentioned that she does like to drink water and just want soda.**
4. Imbalanced nutrition related to patient's excess body fat as evidenced by morbid obesity and heavy weight.	**This diagnosis was chosen because patient has excess fat in her body and her BMI is 34 which make her at risk for imbalanced nutrition due to excessive calorie intake.**	**1. Patient was offered heart healthy diet which is low in calorie and sodium.** **2. Patient was taught how to control portion size during the stay of her hospital and was encouraged to continue after discharged.**	**1. Patient wants to lose weight and she is very complaint and liked above mentioned interventions .**	**Patient is complaint and she really wish to lose weight which will also help her to have less episodes of shortness of breath.**
5. Risk for depression related to patient living in nursing home and evidence by no family member and patient's eagerness to talk with	**Patient stated that she feels depressed and lonely in nursing home and she does not any family or kids. She mentions that she wants to talk with someone**	**1. Therapeutic communication was initiated with her by asking her more open-ended questions.** **2. Patient was referred to pastoral care since she is catholic, and she liked it.**	**1. Patient was very happy after detailed conversation and thanked me and my instructor to spend time with her.**	**Patient is very eager to talk with nurse and other health care team members . She is very pleasant to talk and sweet hearted woman.**

someone as she feels lonely.	**and felt better after talking with me and my instructor.**			

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health. St. Louis, MO: Elsevier.

Concept Map (20 Points):

Subjective Data

Patient currently is stable, and she does not have difficulty breathing . Patient stated that she does not have any pain and feels good. She is also tolerating normal diet but needs assistance with ADL.

Nursing Diagnosis/Outcomes

Impaired gas exchange related to shortness of breath and evidenced by low O2 saturation when patient removed nasal cannula.
Outcome- Goal is to maintain O2 saturation of 98 % prior to discharge.

Ineffective breathing pattern related to patient's snoring episodes as evidenced by use if Bipap machine by the patient.
Outcome – Goal is to increase compliance of using Bipap machine and decrease episodes of slepp apnea.

Risk for fluid volume deficient related to continuous use of Lasix as evidenced by low urine output and dark yellow urine.
Outcome- Goal to increase urine output and replenish electrolytes by drinking energy drink.

Imbalanced nutrition related to patient's excess body fat as evidenced by morbid obesity and heavy weight.
Outcome- To control portion size and implement heart healthy diet low in sodium.

Risk for depression related to patient living in nursing home and evidence by no family member and patient's eagerness to talk with someone as she feels lonely.
Outcome- Encourage patient to join support groups and making friends at nursing home.

Objective Data

Chest x ray showed pulmonary congestion and edema.
CT chest showed bilateral pulmonary infiltrates and fluid retention .
Patient O2 saturation is 98 percent and she is on 4L nasal cannula.

Client Information

Patient is 62 years old female who presents to ED for severe shortness of breath. She is 5 feet 4 inch and her weight are 152.3 kg. She is full code and currently on continuous IV Lasix due to fluid retention and generalized edema.

Nursing Interventions

Drink plenty of fluids since the patient has risk of dehydration due to fluid lose from Lasix.
Patient was placed on semi fowlers position which helped her to breath easily.
Bed was in lowest position to keep patient safe and prevent falls.
Patient was given continuous IV Lasix to treat her generalized edema.
Patient was taught deep breathing exercises so that patient can breather easily.
Patient was given antibiotics to treat his UTI.
Patient was on 4L nasal cannula to keep her oxygen levels and o2 saturation normal.
Patient was taught to use Bipap machine to treat her obstructive sleep apnea.
Patient was scheduled appointment with dietitian to follow heart healthy diet and tips to control portion size.
Patient was taught deep breathing exercises to help with her shortness of breath.