N311 Care Plan 5

Lakeview College of Nursing

Kelsey Bierman

Demographics (5 points)

Date of Admission 08/06/2021	Client Initials TB	Age 66	Gender F
Race/Ethnicity Caucasian	Occupation Home	Marital Status Divorced	Allergies NKA
Code Status Full Code	Height 172.7 cm	Weight 194.2 kg	

Medical History (5 Points)

Past Medical History: Pneumonia due to streptococcus pneumoniae, acute respiratory failure with hypoxia, morbid obesity due to excess calories, chronic obstructive pulmonary disease, anemia, unspecified osteoarthritis, central pain syndrome, venous insufficiency (chronic) (peripheral), essential hypertension, obstructive sleep apnea, hyperuricemia, major depressive disorder, recurrent anxiety disorder, gout, dyspnea, COVID-19, lymphedema, congestive heart failure, and difficulty walking.

Past Surgical History: Colonoscopy (06/11/2019), Disc/vertebral space irrigation/aspiration (08/01/2018), Laminectomy decompression, Lumbar-thoracic (06.20/2018), Lumbar facet joint denervation with radiofrequency with fluoroscopy (left)(06/18/2018), Trigger point injections (05/14/2018), Denervation of spinal facet joint of lumbar vertebra (01/02/2015), Shoulder injection (07/10/2015), Intra-articular injection (01/02/2015), Gallbladder (1997), and Cholecystectomy (1996).

Family History:

Father: Heart failure and stroke

Mother: Arthritis and heart failure

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

The patient denies past use of alcohol, recreational drugs, and tobacco.

Admission Assessment

Chief Complaint (2 points): Pain in the lower extremities.

History of Present Illness – OLD CARTS (10 points): The 66-year-old Caucasian female presented to the nursing home on 08/06/2021 with pain in the lower extremities bilaterally and inability to care for herself independently at home. The patient states, “My lower legs hurts constantly but the pain get worse throughout the day.” The patient mentions that her legs feel heavy and described the pain as dull with intermittent sharp pains. The patient states that prolonged sitting with her legs down aggravates her pain and that elevating her legs as well the compression from her dressings helps alleviate her pain. The patient states that hydrocodone helps is the treatment that she has received for her leg pain. When I asked the patient the severity of her pain on a numeric pain scale of 0 to 10, 0 representing no pain and 10 being the most excruciating pain imaginable, she replied, “I would rate my pain a 7 out of 10 today”.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Chronic Obstructive Pulmonary Disease

Secondary Diagnosis (if applicable): Lymphedema

Pathophysiology of the Disease, APA format (20 points): Chronic Obstructive Pulmonary Disease (COPD) is characterized by poorly reversible airflow limitations caused by chronic bronchitis, emphysema, and hyperreactive airway disease (Capriotti, 2020). The characteristics of chronic bronchitis are hypersecretion of mucus in the large and small airways, hypoxia, and cyanosis (Capriotti, 2020). Excessive mucous creates an obstruction to the inspiratory airflow that inhibits optimal oxygenation (Capriotti, 2020). In emphysema, the characteristic finding is overdistention of alveoli with trapped air, which makes obstruction to expiratory airflow, loss of

elastic recoil of the alveoli, and high residual volume of carbon dioxide in the lung (Capriotti, 2020). The airways are also hyperreactive to irritants, and episodes of bronchoconstriction are common in COPD (Capriotti, 2020). The pathological changes leading to airflow limitation in COPD include narrowing, excessive mucus and fibrosis in the bronchioles, loss of alveolar elastic recoil, and smooth muscle hypertrophy (Capriotti, 2020). Inflammatory changes of chronic bronchitis cause permanent remodeling of the pulmonary structure (Capriotti, 2020). The remodeled bronchioles demonstrate chronic inflammation of the lumens (Capriotti, 2020). Inflammation causes stimulation of macrophages followed by accumulation of neutrophils, T lymphocytes, and cytokines. Leukotrienes, interleukins, and tumor necrosis factors are among the inflammatory mediators that act in a proteolytic manner, chronically damaging lung structures (Capriotti, 2020). There is a proteolytic -antiproteolytic enzyme imbalance in the lungs of COPD patients that leads to changes consistent with emphysema (Capriotti, 2020). Neutrophils and macrophages secrete protease, elastases, and metalloproteinases, all proteolytic enzymes (Capriotti, 2020). In severe COPD, there is poor ventilation and hypoxia (Capriotti, 2020). In areas of inadequate ventilation, hypoxia stimulates pulmonary arterial vasoconstriction (Capriotti, 2020). Pulmonary arterial vasoconstriction causes increased resistance in the main pulmonary artery and increased resistance against the right ventricle (Capriotti, 2020). Chronic pulmonary hypertension causes right ventricular hypertrophy and eventually right ventricular failure (Capriotti, 2020). In severe COPD, increased levels of CO_2 become established, and the arterial chemoreceptors and respiratory center in the medulla become insensitive to high CO_2 levels (Capriotti, 2020). The regular respiratory drive stimulus changes from PCO_2 accumulation to low levels of PO_2 (Capriotti, 2020). In severe COPD, hypoxia becomes the stimulus for breathing (Capriotti, 2020). Signs and symptoms of COPD include dyspnea, productive cough,

hypoxia, cyanosis, jugular vein distention, ascites, hepatosplenomegaly, ankle edema, respiratory distress, use of intercostal muscles with breathing, and clubbing of fingers (Capriotti, 2020). My patient presented with ankle edema and the use of intercostal muscles with breathing. Diagnostic testing would include spirometry, chest x-ray, and an electrocardiogram (ECG) (Capriotti, 2020). My patient had an ECG and a chest x-ray. Labs done to support the diagnosis of COPD include a complete blood count (CBC), blood chemistry panel, and arterial blood gases (Capriotti, 2020). My patient received a CBC and a blood chemistry panel. Treatment includes smoking cessation, bronchodilators, inhaled steroids, combination inhalers, oxygen therapy, lung volume reduction surgery, lung transplant, and bullectomy (Mayo Clinic, 2020).

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *PATHOPHYSIOLOGY : introductory concepts and clinical perspectives.* (2nd ed.). F A Davis.

Mayo Clinic. (2020). *COPD - Diagnosis and treatment - Mayo Clinic*. Mayoclinic. https://www.mayoclinic.org/diseases-conditions/copd/diagnosis-treatment/drc-20353685

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor

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	N/A	4.74	N/A
Hgb	12.0-16.0	N/A	13	N/A
Hct	37.0-38.0	N/A	40.4	N/A
Platelets	90-450	N/A	204	N/A
WBC	4.0-10.0	N/A	18.4	A high WBC count is most commonly indicative of inflammation or an infection.
Neutrophils	40-80	N/A	89.8	A high neutrophil percentage in the blood can be caused by a bacterial infection.
Lymphocytes	20-40	N/A	6.4	A low lymphocyte level can be caused by blood diseases, autoimmune disorders, infectious diseases, and steroid therapy.
Monocytes	2.0-10.0	N/A	3.4	N/A
Eosinophils	1.0-7.0	N/A	0.3	N/A
Bands	0-2	N/A	0.1	N/A

All lab values from (Capriotti, 2020)

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	N/A	138	N/A
K+	3.5-5.0	N/A	4.4	N/A
Cl-	98-106	N/A	104	N/A
CO2	23-31	N/A	28	N/A
Glucose	70-99	N/A	279	High glucose levels can be caused

				by overeating between meals, lack of exercise, and steroid medication.
BUN	8-23	N/A	35	A high BUN can indicate that the kidneys are not functioning properly. A high Bun can also be caused due to dehydration, CHF, certain antibiotics, and a high protein diet.
Creatinine	0.8-1.3	N/A	1.04	N/A
Albumin	3.4-5.4	N/A	3.6	N/A
Calcium	9.0-10.5	N/A	8	Hypocalcemia can be caused by an inadequate calcium intake or absorption: Crohn's disease, VD deficiency with alcohol use disorder, chronic kidney disease.
Mag	1.3-2.1	N/A	N/A	N/A
Phosphate	3-4.5	N/A	N/A	N/A
Bilirubin	2-17	N/A	0.6	Obesity and CKD can contribute to a low bilirubin level as well as liver disease.
Alk Phos	30-120	N/A	73	N/A

All lab values from (Healthline, 2017; Taylor et al, 2019).

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	N/A	N/A	N/A
pH	4.5-8	N/A	N/A	N/A
Specific Gravity	1.005-1.030	N/A	N/A	N/A
Glucose	Normal	N/A	N/A	N/A
Protein	Negative or trace	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A

WBC	<=5	N/A	N/A	N/A
RBC	0-3	N/A	N/A	N/A
Leukoesterase	Negative	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	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Brennan, D. (2021, May 11). *What Are Lymphocytes?* WebMD. https://www.webmd.com/a-to-z-guides/what-are-lymphocytes

Capriotti, T. M. (2020). PATHOPHYSIOLOGY : introductory concepts and clinical perspectives. (2nd ed., pp. 244, 277). F A Davis.

Healthline. (2017, February 18). *Basic Metabolic Panel: Procedure, Preparation, and Risks*. Healthline. https://www.healthline.com/health/basic-metabolic-panel#normal-results

Mayo Clinic. (2019). *Blood urea nitrogen (BUN) test - Mayo Clinic*. Mayoclinic. https://www.mayoclinic.org/tests-procedures/blood-urea-nitrogen/about/pac-20384821

NHS 24. (2021, November 1). *Hyperglycaemia (high blood sugar) - Illnesses & conditions*. Nhsinform. https://www.nhsinform.scot/illnesses-and-conditions/blood-and-lymph/hyperglycaemia-high-blood-sugar

Taylor, C., Lynn, P., & Bartlett, J. L. (2019). *Fundamentals of nursing: The art and science of person-centered care* (9th ed.). Wolters Kluwer.

Yazdi, P. (2019, November 23). *Causes of High / Low Bilirubin Levels + Health Benefits*. SelfDecode Labs. https://labs.selfdecode.com/blog/bilirubin-benefit-how-to-optimize/

Diagnostic Imaging

All Other Diagnostic Tests (10 points): My patient received two additional diagnostic testing. The first diagnostic tests my patient received was a electrocardiography (ECG). The ECG revealed sinus tachycardia with premature arterial contractions (PACs). This diagnostic test was pertinent to my patient because of her COPD. The long-term effects of hypoxic pulmonary vasoconstriction upon the right side of the heart, causes pulmonary hypertension and subsequent right atrial and right ventricular hypertrophy (Burns & Buttner, 2021). The second diagnostic test my patient received was a chest x-ray. The chest x-ray showed an enlarged heart with minimal change in bilateral lung opacity. This exam can help support the diagnosis of COPD by producing images of the lungs to evaluate symptoms of shortness of breath or chronic cough. While a chest x-ray may not show COPD until it is severe, the images may show enlarged lungs, air pockets (bullae) or a flattened diaphragm (Radiology (ACR), 2021). The final diagnostic test that my patient received was a computerized tomography (CT) coronary angiogram. The CT revealed diffuse interstitial ground glass and airspace opacity of the lungs and a partial filing defect of the subglottic larynx and cervical trachea. Cardiomegaly and moderate calcification the aortic valve and coronary artery was also revealed. Many patients with and at risk for COPD

undergo a chest CT in the outpatient setting for lung cancer screening, evaluation of pulmonary nodules detected on chest X-ray, assessment of concurrent interstitial lung disease, or planning for surgical options such as lung transplantation and lung volume reduction surgery (LVRS) (Labaki et al., 2017).

Diagnostic Imaging Reference (1) (APA):

Burns, E., & Buttner, R. (2021, September 6). *ECG in Chronic Obstructive Pulmonary Disease*. Life in the Fast Lane. https://litfl.com/ecg-in-chronic-obstructive-pulmonary-disease/

Labaki, W. W., Martinez, C. H., Martinez, F. J., Galbán, C. J., Ross, B. D., Washko, G. R., Barr, R. G., Regan, E. A., Coxson, H. O., Hoffman, E. A., Newell, J. D., Curran-Everett, D., Hogg, J. C., Crapo, J. D., Lynch, D. A., Kazerooni, E. A., & Han, M. K. (2017). *The Role of Chest Computed Tomography in the Evaluation and Management of the Patient with Chronic Obstructive Pulmonary Disease.* American Journal of Respiratory and Critical Care Medicine, *196*(11), 1372–1379. https://doi.org/10.1164/rccm.201703-0451PP

Radiology (ACR). (2021, July 30). *Chronic Obstructive Pulmonary Disease (COPD)*. RadiologyInfo. https://www.radiologyinfo.org/en/info/copd#:~:text=Chest%20x%2Dray%3A%20This%20exam

Current Medications (10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/ Generic	Symbicort/ Budesonide-Formoterol	Torsemide/ Demadex	Lisinopril/ Prinivil	Norco/ Hydrocodone-Acetaminophen)	Citalopram / Celexa
Dose	160/4.5 mcg/ACT	40 mg	20 mg	7.5-325 mg	40 mg
Frequency	2 puff twice a day	1 tablet once a day	1 tablet once a day	1 tablet every 8 hours PRN	1 tablet once a day
Route	Oral Inhaler	P.O.	P.O.	P.O.	P.O.
Classification	Pharmacologic class: Corticosteroid, selective $beta_2$-adrenergic antagonist Therapeutic class: Antiasthmatic, anti-inflammatory, bronchodilator	Pharmacologic class: loop diuretic Therapeutic class: Antihypertensive, diuretic	Pharmacologic class: Angiotensin-converting enzyme (ACE) inhibitor Therapeutic class: Antihypertensive	Pharmacologic class: Opioid Antagonist Therapeutic class: Analgesia	Pharmacologic class: Selective serotonin reuptake inhibitor Therapeutic class: Antidepressant
Mechanism of Action	The budesonide inhibits inflammatory cells and mediators, possibly by decreasing influx into nasal passages, bronchial walls, or the intestines. As a result, nasal or airway inflammation decreases. Formoterol selectively attaches $beta_2$	Blocks active chloride and sodium reabsorption in the ascending loop of Henle by promoting rapid excretion of chloride, sodium, and water. Torsemide also increases the production of renal prostaglandins, increasing	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II. Angiotensin II is a potent vasoconstrictor that also stimulates adrenal cortex to secrete aldosterone.	Hydrocodone interacts with the mu-receptors and, to a lesser extent, with delta receptors in the body. Activated mu-opioid receptors lead to inhibition of nociceptive pain reflexes and induce profound analgesia without affecting other	Blocks serotonin reuptake by adrenergic nerves, which normally release this neurotransmitter from their storage sites when activated by a nerve impulse. This blocked

	receptors on bronchial membranes, stimulating the intracellular enzyme adenyl cyclase to convert adenosine triphosphate to cAMP. The resulting increase in the intracellular cAMP level inhibits histamine release, relaxes bronchial smooth muscle.	the plasma renin level and renal vasodilation. As a result, blood pressure falls, reducing preload and afterload.	Lisinopril may also inhibit renal and vascular production of angiotensin II. Decreased release of aldosterone reduces sodium and water reabsorption and increases their excretion, thereby reducing blood pressure.	sensory modalities such as touch. Additionally, activated opioid receptors inhibit neurotransmitter release, including substance P. Hydrocodone must be metabolized by CYP2D6 to its active form, hydromorphone. Acetaminophen's mechanism of action of analgesia is not fully understood. The hypothesis has been that it results from COX inhibition and activation of descending serotonergic inhibitory pathways in the CNS. Antipyretic effects occur via inhibition of the hypothalamic heat-regulating center.	reuptake increases serotonin levels at nerve synapses, which may elevate mood and reduce depression.

				Acetaminophen is readily absorbed from the gastrointestinal tract. Plasma protein binding of acetaminophen is about 10 to 25%.	
Reason Client Taking	Exacerbation of COPD	CHF	Hypertension	Severe pain	Depression
Contraindications (2)	Recent septal ulcers or status asthmaticus	Anuric patients and hepatic coma	Concurrent aliskiren use in patients with diabetes and hereditary or idiopathic angioedema.	Patients with hepatic failure and patients with renal impairment.	Hypersensitivity to citalopram or its components and pimozide therapy use within 14 days of MAO inhibitor therapy including I.V. methylene blue or linezolid.
Side Effects/ Adverse Reactions (2)	Hypertension and peripheral edema	ECG abnormalities and hypocalcemia	Pulmonary embolism and bronchospasm.	Constipation and respiratory depression	Heart failure and CVA

Data for Norco from (Habibi & Kim, 2020).

All other data from (Jones & Bartlett Learning, 2021).

Medications Reference (1) (APA):

Habibi, M., & Kim, P. Y. (2020). *Hydrocodone and Acetaminophen*. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK538530/

Jones & Bartlett Learning. (2021). *2022 Nurse's Drug Handbook.* Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Appears alert and oriented x person, place, and time, well-groomed, no acute distress.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient skin color is white. Skin is warm and dry upon palpation. The patient has multiple area where psoriasis is present. Some areas of the psoriasis are white and flakey while others are red. Patient has areas of ecchymosis from IV sticks at the hospital. Normal quantity, distribution, and texture of the hair. Nails without clubbing or cyanosis. Skin turgor normal mobility. Capillary refill less than 3 seconds fingers and toes bilaterally. The patient has multiple blisters on her left lower extremity. These blisters are open and weeping.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical, trachea is midline without deviation, thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. No lymphadenopathy noted. Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids moist and pink without lesions or discharge noted. PERRLA bilaterally. EOMs intact bilaterally. Bilateral auricles no visible or palpable deformities, lumps, or lesions. Septum is midline. No visible bleeding or polyps. Bilateral frontal sinuses are nontender to palpation. Uvula is midline; soft palate rises and falls symmetrically. Hard palate intact, Dentition is good, oral mucosa overall is moist and pink without lesions noted
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:**	Clear S1 and S2 with the presence of a murmur. PMI palpable at 5th intercostal space a MCL. Normal rate and rhythm. All extremities warm, pink, dry, and symmetrical. Peripheral pulses 2+ throughout bilaterally. Capillary refill less than 3

Capillary refill: **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	seconds finger and toes bilaterally. Edema inspected and palpated in lower extremities. The edema was pitting 3+ bilaterally. Epitrochlear lymph nodes nonpalpable bilaterally. Was unable to assess Homan's sign due to lymphedema.
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Rapid and shallow breathing. Respiration is symmetrical. Labored respirations. Crackles heard throughout anterior and posterior bilaterally. No wheezes or rhonchi noted.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	The patient's diet at home and currently is a cardiac diet. The patient is 172.7 cm tall and weighs 194.2 kg. Abdomen is soft, nontender, no organomegaly or masses noted upon palpation of all four quadrants. Bowel sounds are normoactive in all four quadrants. Some CVA tenderness noted bilaterally.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Clear, pale-yellow urine. Absence of pain, urgency, frequency, or retention. No blood in the urine noted. Patient urinated a moderate amount once during shift.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐**	All extremities have a slightly limited range of motion—imbalanced gait. The patient has a walker and a wheelchair. The patient demonstrates normal and equal strength. The patient is a standby assist. The patient has a Morse fall score of 40; therefore, she is a moderate fall risk. The patient can stand up and

Fall Score: **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	walk on her own. She needs a walker to push herself up from the bed and walk.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Hand grips and arm pushes and pulls demonstrate normal and equal strength. Patient alert and oriented to person, place, and time with normal speech. PERRLA bilaterally. The patient moves all extremities well. Memory is normal, and thought process is intact. Sensation is intact bilaterally to pain and light touch
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's coping method is to pray. The patient's developmental level is average for her age. The patient is a Christian, and religion is significant to the patient. The patient stated, "My sister, Gail comes to visit me every so often." The patient verbalized that she did not feel lonely. The patient also verbalized that she is no longer afraid to die and believes that God will guide her when she is ready.

Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0723	102 beats/minute	140/71	22	36.3°C	97% on 5L nasal cannula

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0733	Numeric Pain Scale	Lower extremities	7 out of 10	Heavy, dull, fullness, intermittent sharp pain	Pain medication, hydrocodone.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
180 mL of coffee 300 mL of water Total: 480 mL	Patient urinated once during shift. Patient urinated a moderated amount of urine that was a clear, pale-yellow appearance with no sediment noted.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

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. Excess fluid volume related to lymphedema of the lower extremities as evidence by weeping soars on the lower extremities.	This nursing diagnosis was a priority because the patient had severe edema of her lower extremities bilaterally which was causing her discomfort.	1.Give skin care every 4 hours. Change the patient's position every 2 hours. Elevate the edematous extremities (Phelps, 2020).	1. The patient will have increased venous return as evidence by a decrease in edema to the lower extremities and the patient's weeping soars will start to disappear by 04/13/2022.	Goal met: The patient's edema has decreased by 04/13/2022. The is an absence of weeping soars on the patients lower extremities.

		2.Apply antiembolism stockings or intermittent pneumatic compression stockings. Remove for 1 hour and inspect the skin every 8 hours or according to facility policy (Phelps, 2020).		
2. Ineffective breathing pattern related to COPD as evidence by shortness of breath when talking and the presence of crackles upon auscultation.	This nursing diagnosis was chosen because the patient had the presence of crackles and experience shortness of breath when talking.	1. Assist patient into a comfortable position by supporting the upper extremities with a pillow and elevating the head of the bed to promote chest expansion (Phelps, 2020). 2.Teach patient about pursed-lip breathing, abdominal breathing, and relaxation techniques (Phelps, 2020).	1. The patient will show an improvement in breathing patterns as evidence by a respiratory rate of 12-20 breaths per minute accompanied with a normal depth of respiration by the end of shift (03/24/2022).	Goal met: The patient's respiratory rate remains within established limits and demonstrates maximum lung expansion with adequate ventilation.

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's Nursing Diagnosis Reference Manual*. Wolters Kluwer Medical.

Concept Map (20 Points):

Subjective Data

The patient stated, “My lower legs hurts constantly but the pain gets worse throughout the day”.
The patient states, “The pain feels heavy and dull. I have a sensation of fullness in my legs and occasionally I will have a sharp pain in my legs”.
The patient repeatedly stated, “These legs are not mine, they do not belong to me”.
The patient winced in pain when her compression dressing was taken off when the patient received a shower.

Nursing Diagnosis/Outcomes

Excess fluid volume related to lymphedema of the lower extremities as evidence by weeping soars on the lower extremities.
Goal: The patient will have increased venous return as evidence by a decrease in edema to the lower extremities and the patient’s weeping soars will start to disappear by 04/13/2022.
Ineffective breathing pattern related to COPD as evidence by shortness of breath when talking and the presence of crackles upon auscultation.
Goal: The patient will show an improvement in breathing patterns as evidence by a respiratory rate of 12-20 breaths per minute accompanied with a normal depth of respiration by the end of shift (03/24/2022).

Objective Data

Vital Signs: 0723: Pulse: 102 bmp, BP: 140/71 mm hg, RR: 22 breaths/minute, Oxygen: 97% on 5L nasal cannula.
Braden score: 17
Morse Fall Score: 40
Diagnostic Tests: ECG, Chest x-ray, and a CT coronary angiogram.
Labs: VBG, CBC, CMP, and lactic acid.

Client Information

The patient was a 66-year-old Caucasian female. Her past medical history includes acute respiratory failure with hypoxia, morbid obesity due to excess calories, chronic obstructive pulmonary disease, anemia, lymphedema, and CHF. Her past surgical history includes Colonoscopy (06/11/2019), Disc/vertebral space irrigation/aspiration (08/01/2018), Laminectomy decompression, Lumbar-thoracic (06.20/2018), and Lumbar facet joint denervation with radiofrequency with fluoroscopy (left)(06/18/2018)

Nursing Interventions

Nursing Diagnosis 1:

1. Give skin care every 4 hours. Change the patient’s position every 2 hours. Elevate the edematous extremities (Phelps, 2020).
2. Apply antiembolism stockings or intermittent pneumatic compression stockings. Remove for 1 hour and inspect the skin every 8 hours or according to facility policy (Phelps, 2020).

Nursing Diagnosis 2:

1. Assist patient into a comfortable position by supporting the upper extremities with a pillow and elevating the head of the bed to promote chest expansion (Phelps, 2020).
2. Teach patient about pursed-lip breathing, abdominal breathing, and relaxation techniques (Phelps, 2020).