N321 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
4/2/2022	RO	75 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Married	Sulfa Antibiotics – Unknown Reaction
Code Status	**Height**	**Weight**	
Full	167.6cm	58.6kg	

Medical History (5 Points)

Past Medical History: Bowel Obstruction / Carcinoma / Congestive Heart Failure / COPD / Coronary Artery Disease / Hyperlipidemia / Hypertension / MI (2015) / Sleep Apnea / Stroke (2022)

Past Surgical History: CABG / Cardiac Catheterization / Lumbar Fusion / Back Surgery (2016) / Upper GI Endoscopy (2020) / EGD with PEG (2020) / Femoral Popliteal Bypass Graft (Bilateral) / Central Venous Catheter (2021) / Upper GI Endoscope (2022)

Family History: Mother – Diabetes / Father - Stroke

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

Cigarettes – 50 packs/year for 30 years / No alcohol or drug use reported.

Assistive Devices: Walker

Living Situation: Lives at home with his wife

Education Level: GED

Admission Assessment

Chief Complaint (2 points): Community Acquired Pneumonia

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

Client presented to the emergency room with shortness of breath and chest pain on 4/2/2022. Symptoms of SOB and chest pain started on the same day of admission. Client reported chest

pain did not radiate. Blood work was drawn to determine Troponin levels and results came back within normal range. The chest pain was assessed as being associated to accessory muscle use due to the shortness of breath. Shortness of breath was described by the client as constant and rated chest pain a four out of ten on a numeric scale. No aggravating or relieving factors were reported by the client. The client has not sought treatment for their current issue prior to the admission date of 4/2/2022.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Community Acquired Pneumonia

Secondary Diagnosis (if applicable): N/A

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

Pneumonia is one the deadliest infections that affect the world today (Lanks et al., 2019). Community acquired pneumonia is a common infection caused by the Streptococcus pneumoniae (Lanks et al., 2019). Pneumonia is acquired in the hospital or by ventilator (Capriotti et al., 2020). Development of pneumonia is determined by frequency, strength, and amount of aspiration of the bacteria and host's immune system (Lanks et al., 2019). The host's immune system is weakened by comorbidities of chronic obstructive pulmonary disease (COPD), diabetes, smoking, malnutrition, autoimmune diseases, and much more (Capriotti et al., 2020). Chemotherapy can also lower the body's immune system leaving the client at risk for infection. As people get older their immune systems are not as strong because they are slower to react to the invasion of bacteria or viruses (Capriotti et al., 2020). Once the bacteria have overcome the body's defense mechanism it invades the lungs and travels to the air sacs (Capriotti et al., 2020). Clients who develop pneumonia will present with dyspnea, fever, productive cough, and body aches (Lanks et al., 2019). The most reputable means of diagnosing

pneumonia is a CT chest scan or a chest X-ray (Lanks et al., 2019). These radiographic diagnostics will be determined as pneumonia when the scans show signs of infiltration (Capriotti et al., 2020). Blood tests will be performed to determine if there is an infection, which is determined by elevation of white blood cell count (Lanks et al., 2019). The normal range for white blood cells is between 4.0 and 12.0 mcL (Capriotti et al., 2019). Healthcare professionals assessing clients with pneumonia will hear crackles when auscultating the lung sounds (Capriotti et al., 2019). Providers will prescribe antibiotics, such as Zosyn, to treat pneumonia infections (Lanks et al., 2019). Pneumonia symptoms are eased in various ways to provide the client as much comfort as possible while the body rids itself of the pneumonia infection. Elevating the head of the bed promotes better breathing because the airways become more open and less risk of aspirating (Capriotti et al., 2020). Clients are encouraged to stay hydrated to help thin out mucous in the respiratory tract (Capriotti et al., 2020). Clients who experience signs and symptoms of pneumonia must seek treatment promptly to avoid severe detrimental effects of the infection (Lanks et al., 2019).

Pathophysiology References (2) (APA):

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

Lanks, C. W., Musani, A. I., & Hsia, D. W. (2019). Community-acquired pneumonia and hospital-acquired pneumonia. *Medical Clinics*, *103*(3), 487-501. https://drleandromachado.com.br/images/Community-acquired-Pneumonia-and-Hospital-acquired-Pneumonia.pdf

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	4.4 – 5.8mL	2.34	2.56	The lab results suggest the client is anemic and has dietary deficiency (Pagana, 2019). The client has dietary deficiencies due to his PEG tube and scarred tongue.
Hgb	13.0 – 16.5g/ dL	8.0	8.0	The lab results suggest the client is anemic or has dietary deficiencies (Pagana, 2019). The client has dietary deficiencies due to his PEG tube and scarred tongue.
Hct	38 – 50%	22.8	23.7	N/A
Platelets	140 – 440mcl	261	308	N/A
WBC	4 – 12.0 mcl	10.80	5.0	The lab results indicate normal WBC range. The client was diagnosed with pneumonia and just finished his antibiotics. These lab results show the WBC is lower and the infection is removed.
Neutrophils	40 – 68%	87.7	60.8	Increased values of neutrophil indicate infection (Pagana, 2019). The client was admitted with a diagnosis of pneumonia. Today's lab results indicate the infection is gone.
Lymphocytes	19 – 49%	6.2	14.0	Lymphocytes are lowered by radiation therapy or immunodeficiency (Pagana, 2019). The client was treated for cancer on his tongue in the past.
Monocytes	3 – 13%	5.6	13.3	Monocytes are lowered by chronic inflammation, which was caused from the inflammation in the respiratory tract (Pagana, 2019).
Eosinophils	0.0 – 0.5mcl	0.3	0.4	N/A
Bands	3.0-6.0%	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 – 144mmol/L	132	133	N/A
K+	3.5 – 5.1mmol/L	3.3	5.7	The client's sodium was low on admission, which was due to infection (Pagana, 2019). The potassium is now elevated, which is due to deficiency in dietary intake or use of diuretics (Pagana, 2019).
Cl-	98 – 107mmol/L	96	95	Low levels of chloride indicate respiratory acidosis, which the client did report SOB on admission (Pagana, 2019).
CO2	21 – 31mmol/L	26	29	N/A
Glucose	70 – 99mg/dL	100	116	Glucose is elevated in the client's results due to sugary drinks, stress on the body, and diuretic use (Pagana, 2019).
BUN	7 – 25mg/dL	43	29	The client's BUN levels were significantly high on admission. Elevated BUN for the client indicates dehydration (Pagana, 2019).
Creatinine	0.5 – 120mg/dL	1.34	1.44	N/A
Albumin	3.5 – 5.7g/dL	3.8	N/A	N/A
Calcium	8.8 – 10.2mg/dL	8.4	N/A	N/A
Mag	1.6 – 2.6mg/dL	N/A	N/A	N/A
Phosphate	2.5 – 4.5mg/dL	N/A	N/A	N/A
Bilirubin	0.2 – 0.8mg/dL	N/A	N/A	N/A
Alk Phos	30 – 120 U/L	87	N/A	N/A

AST	13 – 39U/L	N/A	N/A	N/A
ALT	7 – 52U/L	N/A	N/A	N/A
Amylase	30-220 U/L	N/A	N/A	N/A
Lipase	0-160 U/L	N/A	N/A	N/A
Lactic Acid	0.5 – 2.0mmol/L	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	2:3	N/A	N/A	N/A
PT	9.5 – 11.3 seconds	N/A	N/A	N/A
PTT	30 – 40 seconds	N/A	N/A	N/A
D-Dimer	<250ng/mL	N/A	N/A	N/A
BNP		N/A	N/A	N/A
HDL	>60mg/dL	N/A	N/A	N/A
LDL	<130mg/dL	N/A	N/A	N/A
Cholesterol	<200mg/dL	N/A	N/A	N/A
Triglycerides	<150mg/dL	N/A	N/A	N/A
Hgb A1c	<7%	N/A	N/A	N/A
TSH	2 – 10mU/L	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	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
Color & Clarity	Clear and Yellow	N/A	N/A	N/A
pH	4.5 - 8	N/A	N/A	N/A
Specific Gravity	1.005-1.025	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	Negative	N/A	N/A	N/A
RBC	Negative	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 < 10,000 Positive > 100,000	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Normal URT	N/A	N/A	N/A
Stool Culture	Normal Intestinal flora	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-Ray

Diagnostic Test Correlation (5 points): Chest x-ray was performed to determine if the client had pneumonia (Pagana, 2019). The chest x-ray found infiltrates in the lung cavities, resulting in a positive finding for pneumonia (Pagana, 2019).

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/ Generic	folic acid / Folvite	Acetylsalicylic acid / Aspirin	Gabapentin / Neurontin	Metoprolol Tartrate/ Lopressor	Nicotine transdermal system / Nicoderm CQ
Dose	1mg	81mg	300mg Caplet	12.5mg	1 patch
Frequency	q.d.	q.d.	BID	BID	Every 24 hours
Route	Gastrostomy Tube via Syringe / PO	PO	Gastrostomy Tube via Syringe / PO	Gastrostomy Tube via Syringe / PO	Transdermal
Classification	Vitamin	Pharmacologic: salicylate Therapeutic: NSAID	Pharmacologic: 1-amino-methyl cyclohexane acetic acid Therapeutic: Anticonvulsa	Pharmacological: thiazide diuretic Therapeutic: Diuretic	Pharmacologic: nicotinic agonist Therapeutic: smoking cessation

			nt		
Mechanism of Action	A water soluble vitamin used to help the body produce red blood cells.	Blocks cyclooxygenase activity inhibiting prostaglandin inflammatory activity. Vasodilation and pain relief are a result.	Inhibits the rapid firing of neurons and prevents exaggerate responses to pain.	Promotes the movement of sodium, water, and chloride out of the blood causing a blood pressure reduction.	Binds to nicotinic cholinergic receptors in the brain. Reduces nicotine cravings and withdrawal symptoms.
Reason Client Taking	To produce more RBC because the client has low levels.	To prevent blood clots and myocardial infarctions	To help relieve neuralgia	To help treat hypertension	Smoking cessation.
Contraindications (2)	Severe hypersensitivity to folic acid / Benzyl alcohol hypersensitivty	Hypersensitivity to tartazine dye. Active bleeding and coagulation disorders.	Hypersensitivity to gabapentin or its components	Hypersensitivity to Metoprolol. Hypersensitivity to metoprolol components	Hypersensitivity to nicotine or methanol
Side Effects/Adverse Reactions (2)	Nausea, loss of appetite / depression	GI bleeding / bronchospasms	Delusions / hypotension	Hypotension / renal failure	Hypertension / Chest tightness
Nursing Considerations (2)	Monitor client for hypersensitivity. Do not take if client has pernicious anemia.	Do not take ibuprofen with aspirin use. Take aspirin with food to avoid upset stomach	Give drug two hours after an antacid. Renal function tests should be monitored.	Give in the morning or early evening. Advise patient to change positions slowly to reduce symptoms orthostatic hypotension.	Teach the client to read and follow the instruction for NicoDerm. Advise the client to not smoke while on nicotine treatment due to toxicity.

Hospital Medications (5 required)

Brand/ Generic	Amlodipine besylate/ NORVASC	Atorvastatin/ Lipitor	Clopidogrel bisulfate/ Plavix	Enoxaparin sodium /Lovenox	Amoxicillin /augmentin
Dose	5mg Tablet	10mg Tablet	75mg Tablet	40mg/10mL	250mg
Frequency	BID	Q.D.	Q.D.	Q.D.	Every 8 hours
Route	Gastrostomy Tube via Syringe / PO	Gastrostomy Tube via Syringe / PO	Gastrostomy Tube via Syringe / PO	SubQ	PO
Classification	Pharmacologic: Calcium channel blocker Therapeutic: antihypertensive.	Pharmacologic: HMG-CoA reductase inhibitor Therapeutic: antihyperlipidemic	Pharmacologic: P2Y12 platelet inhibitor Therapeutic: Platelet aggregation inhibitor	Pharmacologic: Low molecular weight heparin Therapeutic: anticoagulant	Pharmacologic: Aminopenicillin Therapeutic: Antibiotic
Mechanism of Action	Decreases calcium level intracellularly, relaxes muscles and reduces peripheral resistance to blood flow.	Reduces plasma cholesterol and lipoprotein levels (LDL).	Prevents fibrinogen from attaching to receptors, which results in platelets unable to form thrombi.	Enoxaparin binds with and inactivates clotting factors inhibiting formation of thrombin and clots are unable to form.	Kills bacteria by weakening their cell wall and causing the cell to lysis.
Reason Client Taking	Treat hypertension	To treat high blood pressure	To help thin the blood	To help thin the blood	To treat respiratory

			and prevent blood clots	and prevent blood clots	tract infection
Contraindications (2)	Hypersensitivity to amlodipine and its components	Active hepatic disease / hypersensitivity to atorvastatin	Active pathological bleeding / Intracranial hemorrhage	Hypersensitivity to Benzyl alcohol. Hypersensitivity to enoxaparin.	Hypersensitivity to amoxicillin or its components
Side Effects/Adverse Reactions (2)	Hypotension / arrhythmias	Hypoglycemia / arrythmias	Fatigue / acute liver failure	Hyperkalemia / thrombosis	Steven-Johnson syndrome / Agitation
Nursing Considerations (2)	Monitor the client for impaired hepatic function. Assess the client for chest pain when starting the medication.	It is an adjunct to a low cholesterol diet. Measure lipid levels 2 to 4 weeks after starting medication.	Educate that clopidogrel prolongs bleeding time. Educate risk for bleeding precautions.	Educate client on risk for bleeding and bleeding precautions. Monitor serum potassium levels.	Take the antibiotic for the prescribed length of time. Expect the treatment to last 7 to 10 days.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert, oriented x3 to person, place, and time. Client was not oriented to situation. Patient is well groomed with no acute distress. Client appeared sleepy and groggy.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 12 **Drains present:** **Y**☒ **N** ☐ **Type:** PEG and Chest Port	Skin color is clear, warm and dry upon palpation. No rashes, lesions, or bruises. There is presence of mild ecchymosis. Normal quantity, distribution and texture of hair. Nails without clubbing or cyanosis. Skin turgor is normal mobility. Braden score of 12. PEG tube placement in LUQ. Incision scar on right upper chest. Chest port present on right infraclavicular fossa.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Atraumatic, oral cavity is pink/moist/clear, dentition is good. The is scarring on the tongue from chemotherapy. Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink no visible drainage from eyes. Bilateral lids are moist and pink without lesions or discharge noted. PERRLA bilaterally, red light reflex present bilaterally. Rosenbaum 20/20, EOMs intact bilaterally. Head and Neck are symmetrical, trachea is midline without deviations, thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. No lymphadenopathy in the head or neck is noted. Bilateral auricles no visible or palpable deformities, lumps or lesions. Bilateral canals clear with pearly grey tympanic membranes. Septum is midline, turbinate is moist and pink bilaterally and no visible bleeding or polyps. Bilateral frontal sinuses are nontender to palpation.
CARDIOVASCULAR:	S1 and S2 are heard with no murmur, gallop or

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:**	rub present. PMI palpable at 5th intercostal space at MCL normal rate and rhythm. Client has a history of MI. All extremities pink, warm, dry and symmetrical. Pulses 2+ throughout bilaterally. Capillary refill less than 3 seconds fingers and toes bilaterally. No edema inspected or palpated in all extremities. Epitrochlear lymph nodes non palpable bilaterally. Homan's sign negative bilaterally. No neck vein distention.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Bilateral equal air entry, no crackle. Lung sounds had some wheezing when auscultating. No use of accessory muscle for inspiration. Normal rate and pattern of respiration bilaterally.
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: Gastrostomy Tube**	Normal bowel sounds present. Abdomen soft, non-distended and non-tender, no mass noted, no hepatosplenomegaly upon palpation of all four quadrants. Diet at home: Soft diet PO and nutrition solution via PEG tube. Current Diet: soft diet PO and nutrition solution vie PEG. Incisions on the right upper chest, implanted chest port, and LUQ PEG tube placement. No visible wounds. No Ostomy. No nasogastric. The client is 5 feet 6 inches and weighs 129 pounds. Last bowel movement was yesterday afternoon.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine assessment is yellow and clear, quantity of urine n/a. no dysuria, no urgency, no frequency or herniations. Genitals are normal with no signs of infection or injury. No catheter is in place. Client does not receive dialysis.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:**	Client is alert and oriented x3 to person, place, and time. All extremities have full range of motion. Hand grips and pedal pushers and pulls

Supportive devices: **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 10 **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	demonstrate normal and equal strength. Balanced gait with slight shuffling. PERRLA present. Cranial nerves intact. Negative Rhombergs. Deep tendon reflexes all locations 2+ bilaterally. Client does not require assistance for activities of daily living, but does use a walk to get from room to room. Client is a fall risk with a fall score of 10. The client's activity should be restricted to light/ moderate. Client needs assistance with equipment or to stand and walk. Strength is weak in all extremities bilaterally and legs are showing signs of atrophy. Client does have general weakness in all extremities bilaterally.
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW: No PERLA: yes Strength equal: general overall weakness in all extremities. Legs showed signs of atrophy and weakness. Orientation: alert Mental Status: Adult Speech: clear Sensory: present and equal LOC: Alert and oriented times 3
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):**	Coping method: Sleeping and talking with his wife. Developmental level: Generativity vs. Stagnation Religion and what it means to pt: Christian Personal/Family Data: Lives with his wife and has a healthy relationship. The client's home environment is good and lives in a house near the hospital.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	75 bpm	128/67mmHg	11 breaths/min	97.7 Degrees Fahrenheit (Temporal)	96% O2 at room air
1150	81bpm	118/59mmHg	13 breaths/min	97.7 Degrees Fahrenheit (Temporal)	97% O2 with Nasal Cannula @ 2L

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	Numeric	Low Back	5/10	Constant - Achy	Pain Medication (Oxy-Acetaminophen)
1150	Numeric	Low Back	3/10	Constant - Dull	N/A

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:**	Chest Port Location of IV: Right Infraclavicular Fossa Port placement 02/22/2021 Patency of IV: good and clear Signs of erythema, drainage: none IV dressing assessment: clear, dry, intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
250mL (Nutrition via PEG) 90mL (Flush via PEG) 120mL (Laxative via PEG) 30mL (Medication Administration via PE) 480mL (PO) 500mL (IV)	500mL Urine

Total: 1,470mL	Total: 500mL

Nursing Care

Summary of Care (2 points)

Overview of care: The client appeared tired and slept off and on throughout the day. There were no signs of distress when observing the client. The client received his medication at 0900. Medications were administered via PO and through the PEG tube. The doctor evaluated the patient and signed off for the client to be discharged tomorrow. The client expressed he was ready to go home where he felt more comfortable.

Procedures/testing done: The client had an X-ray of his chest done upon admission to determine the cause of his shortness of breath. It was concluded in the chest X-ray the client had pneumonia.

Complaints/Issues: The client only complained of chronic low back pain, but had no other issues.

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

Tolerating diet, activity, etc.: Current tolerated diet is a soft diet PO and nutrition by PEG tube. Client's activity is minimal and appears tired.

Physician notifications: Client is to be discharged tomorrow to the client's home with his wife. The client and his wife should be educated on any new medication and review current medications.

Future plans for client: The client will have a follow up appointment in two weeks with his primary care physician to ensure the client recovers completely.

Discharge Planning (2 points)

Discharge location: The client's home with his wife.

Home health needs (if applicable): The client should be provided information on home health needs, but it is not required for discharge.

Equipment needs (if applicable): N/A

Follow up plan: The client has a follow-up appointment in two weeks to ensure full-recovery.

Education needs: The client should be educated on smoking cessation. The client should be educated on the hazards at home regarding fall risk. Education on skin integrity and chemo therapy effects should also be provided to the client.

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. Impaired gas exchange related to pneumonia as evidence by opacity of lungs in chest x-ray.	The client got a chest x-ray to determine if he had pneumonia because he complained of shortness	**1.**Provide the client with oxygen by nasal cannula to increase oxygen saturation in the lungs (Phelps, 2020).	**1.** The client will agree to attend a smoking cessation program and adhere to alternative means to smoking such as nicotine patches.	The client and his wife responded well to the nurse's actions by asking questions and accepting the informative packets on how to quite smoking.

	of breath.	**2.**Educate the client on smoking cessation (Phelps, 2020).		Client agreed to attend a smoking cessation program and use nicotine patches. Client's lung sounds improved significantly and had significantly less infections. Modification to the plan is to taper the use of nicotine patches.
2. Ineffective airway clearance related to fatigue and decreased energy as evidence by the client slept for most the day and had no energy to do any activity.	While caring for the client, he slept throughout the day and seemed very fatigued. The client's wife also addressed how tired her husband was compared to other visits.	1**.** Educate the client on deep-breathing exercises (Phelps, 2020). 2.Encourage the client to ambulate more frequently to improve efficiency of breathing (Phelps, 2020).	**1.** The client will express understanding of ineffective airway clearance and show ways to improve it.	The client and his wife understood the factors that correlate with ineffective airway clearance and were motivated to learning how to improve breathing. The client listened attentively to the teaching on ways to improve breathing. The client's energy shows improvement. No modifications should be done.
3. Risk for bleeding related to presence of ecchymosis throughout the skin as evidence by low RBC and	While examining the client's skin there was ecchymosis present in some spots throughout the body.	1. Educate the client on nutritional modifications to his normal diet to help produce adequate RBCs (Phelps, 2020).	1. The client understands there are certain precautions that must be followed to reduce the risk of bleeding. The precautions would include to use an electric shaver,	The client and his wife are understanding of the necessary precautions to prevent bleeding. The client agrees to talk with his provider about his

hemoglobin lab levels.	Ecchymosis can be caused by bruising or bleeding (Lucena et al., 2019).	2. Instruction the client on bleed precautions (Phelps, 2020).	not to pick his nose, not to pick scabs, and report any bleeding of the gums. (Phelps, 2020).	nutrition and adhere to the precautions to prevent bleeding. The client reports less bruising and understands what signs and symptoms that require immediate treatment.

Other References (APA):

Lucena, A. D. F., Laurent, M. D. C. R., Reich, R., Pinto, L. R. C., Carniel, E. L., Scotti, L., & Hemesath, M. P. (2019). Nursing diagnosis risk for bleeding as an indicator of quality of care for patient safety. *Revista Gaúcha de Enfermagem*, *40*. https://www.scielo.br/j/rgenf/a/ywbZm9hxDKjkJgmFj4gMkYz/abstract/?lang=en

Phelps, L.L. (2020). *Sparks and Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The client presented to the ED with shortness of breath and chest pain. Troponin was checked to rule out MI and a chest x-ray was done to determine cause of SOB. The client reported his chest pain did not radiate and was determined to be caused by accessory muscle use.

Objective Data

The chest x-ray showed infiltrates and was diagnosed as pneumonia. The client was prescribed Zosyn for treatment and remained in the hospital for observation. The client's vitals: HR- 75, BP-128/67, RR-11, T-97.9F, and O2 sat-96%. The client reported mild pain for his lower back. Ecchymosis was observed on the client's skin.

Client Information

Client has a PMH: Bowel Obstruction / Carcinoma / Congestive Heart Failure / COPD / Coronary Artery Disease / Hyperlipidemia / Hypertension / MI (2015) / Sleep Apnea / Stroke (2022). The client is a 75-year-old man that lives at home with his wife. He has an allergy to Sulfa-antibiotics.

Nursing Diagnosis/Outcomes

Impaired gas exchange related to pneumonia as evidence by opacity of lungs in chest x-ray. The client will agree to attend a smoking cessation program and adhere to alternative means to smoking such as nicotine patches.

Ineffective airway clearance related to fatigue and decreased energy as evidence by the client slept for most the day and had no energy to do any activity. The client will express understanding of ineffective airway clearance and show ways to improve it.

Risk for bleeding related to presence of ecchymosis throughout the skin as evidence by low RBC and hemoglobin lab levels. The client understands there are certain precautions that must be followed to reduce the risk of bleeding. The precautions would include: use an electric shaver, not to pick his nose, not to pick scabs, and report any bleeding of the gums (Phelps, 2020).

Nursing Interventions

Educate the client on nutritional modifications to his normal diet to help produce adequate RBCs (Phelps, 2020).

Instruction the client on bleed precautions (Phelps, 2020).
Educate the client on deep-breathing exercises (Phelps, 2020).

Encourage the client to ambulate more frequently to improve efficiency of breathing (Phelps, 2020).

Provide the client with oxygen by nasal cannula to increase oxygen saturation in the lungs (Phelps, 2020).

Educate the client on smoking cessation (Phelps, 2020).