N321 Care Plan # 2

Lakeview College of Nursing

Emily Melecosky

Demographics (3 points)

Date of Admission 4/21/22	Client Initials JT	Age 68	Gender Male
Race/Ethnicity African American	Occupation Retired police officer	Marital Status Married – 45 years	Allergies Cat fur – 2022 Allergic Rhinitis – 2013 Seasonal allergies - 1996
Code Status Full Code	Height 190.5 cm (6'3")	Weight 112.7 kg (248 lbs 6.4 oz)	

Medical History (5 Points)

Past Medical History:

The patient has a past medical history of HTN and type 2 Diabetes Mellitus. Dates for the past medical history weren't listed. When the patient was asked, he stated "I don't know, sometime during my life."

Past Surgical History:

tonsillectomy 1989; Cholecystectomy in 2006

Family History:

Type II diabetes on the maternal side (maternal grandpa), HNT on the maternal side (maternal grandpa), CAD on the maternal side (maternal grandma), and lung cancer on the paternal side (paternal grandpa).

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

The patient does not use alcohol or drugs but is a former smoker of 20 years. He would smoke 10 packs of cigarettes a week. The patient stopped smoking in 2008. The patient does not drink or use any recreational drugs.

Assistive Devices:

The patient uses hearing aids in the left and right ears for diminished hearing, as well as eyeglasses to help with sight

Living Situation:

The patient lives alone in a 2 story house in Urbana, Il. He lives with is wife of 45 years and his 2 dogs, of 5 and 6 years. He states they just had to get rid of their can about 2 months prior due to a new allergy to cat fur. He has 2 children living in St. Joseph, who are grown now, but will frequently come to visit him with the grandchildren. The patient claims that he doesn't have any assistive devices such as handrails in the home.

Education Level:

The patient went ot University of Illinois and graduated in 1964 with associated in criminal justice.

Admission Assessment

Chief Complaint (2 points): "feeling crummy headache, runny nose, weakness, achiness, and hot and sweaty."

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

The patient, a 68-year-old male, with a history of HTN and Diabetes Mellitus II, was brought into the ED by his wife on 4/21/22 because he felt crummy, complaining of a headache, runny nose, feeling weaker, "achy all over" and hot to the touch and sweaty the past two days. When he woke up this morning, he no longer felt hot but began to. The patient presented with a persistent

"nagging cough" that continued to get worse throughout the day. He was admitted for further workup and treatment.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Covid -19

Secondary Diagnosis (if applicable): Pneumonia

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

Coronavirus is a disease that is caused by SARS-CoV-2. This disease is a respiratory disease which can be transmitted from person to person. Covid mimics flu-like symptoms but can progress to further complications, as the virus attacks host cells. In this patient's case, the virus created a secondary problem such as pneumonia.

As covid-19 progresses, a person can start to experience fever, a nonproductive cough, sore throat, fatigue, myalgia, nasal congestions, nausea, vomiting, and diarrhea. All of these symptoms can be easily confused with flu-like symptoms. Many people have also experienced a sense of loss of smell and taste along with these symptoms. However, there is a select population of people that also presented as asymptomatic, but still can be carriers and transmitters of the covid virus. Some people are more at risk for these symptoms and may be affected worse than others. This population is considered the vulnerable population. A vulnerable population to these symptoms includes the elderly and immune-compromised people, such as chemotherapy patients and people with autoimmune diseases. with this population, death can be more prominent due to a decrease in an immune response against viruses.

The process of testing for covid-19 includes using a nasal swab, that is administer into each nostril and swirled for 30 seconds at a time. The test is then put into a tube and sent to a lab. The test swab will then be tested for the virus. The test is a really quick and easy process. The results usually come back within 24-48 hours of the test.

Safety measures that can be implemented in order to protect people from Covid include, social distancing where you should leave at least six feet in between people, using covid isolation if there a person has a confirmed case of covid, wearing a face mask including an N95 face mask, and getting vaccinated against Covid. A couple of available covid vaccines include Maderna and Pfizer. Right now there is no cure for Covid-19, however, studies have been progressing in order to help fight against covid, such as the vaccine.

Pathophysiology References (2) (APA):

Kumar, M., Al Khodor, S. Pathophysiology and treatment strategies for COVID-19. *J Transl Med* **18,** 353 (2020). https://doi.org/10.1186/s12967-020-02520-8

Understanding COVID-19 PCR Testing. (2022, January 18). Genome.gov. https://www.genome.gov/about-genomics/fact-sheets/Understanding-COVID-19-PCR-Testing

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	**4.10-5.70 10^6/uL**	**47.2**	**N/A**	
Hgb	**12.0 – 16.0**	**12.8**	**N/A**	

	g/dL			
Hct	**37.0-51.0 %**	**38%**	**N/A**	
Platelets	**140-400 10^3/uL**	**224**	**N/A**	
WBC	**4.50-11.00 10^3u/L**	**3.5**	**N/A**	**Decreased WBCs could be due to Covid-19; however, with infections, WBCs should be increased. This lower amount could be due to the patient's age ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities -AARP", 2021).**
Neutrophils	**55-70%**	**92%**	**N/A**	**Elevated neutrophils indicates a viral infection ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities -AARP", 2021).**
Lymphocytes	**20-40%**	**8**	**N/A**	**Decreased lymphocyte is caused due to viral infections ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities -AARP", 2021).**
Monocytes	**0.0 – 1.10 10^3/uL**	**0**	**N/A**	
Eosinophils	**0.0 – 0.50 10^3/uL**	**0**	**N/A**	
Bands	**3-5%**	**0**	**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	**141**	**N/A**	
K+	3.5 – 5.1 mmol/L	**3.9**	**N/A**	
Cl-	98-107 mmol.L	**105**	**N/A**	
CO2	22.0 – 29.0 mmol/L	**16**		**Low CO2 levels can indicate the patient is in a state of metabolic acidosis, which can be manifested by inadequate tissue perfusion**

				caused by a viral and respiratory infection ("Understanding Routine Lab Test Results - Lab Test Errors, Abnormalities - AARP", 2021).
Glucose	74 – 100 mg/dL	**178**	**N/A**	
BUN	8-26 mg/dL	**18**	**N/A**	
Creatinine	**0.55 – 1.30 mg/dL**	**1.10**	**N/A**	
Albumin	**3.5-5.2 mg/dL**	**N/A**	**N/A**	
Calcium	**8.9 – 10.6 mg/dL**	**N/A**	**N/A**	
Mag	**1.6-2.6 mg/dL**	1.9	**N/A**	
Phosphate	**2.5-4.5 mg/dL**	4.1	**N/A**	
Bilirubin	**0.2 – 1.2 mg/dL**	0.3	**N/A**	
Alk Phos	**40-150 U/L**	120	**N/A**	
AST	**5-34 U/L**	22	**N/A**	
ALT	**0-55 U/L**	12	**N/A**	
Amylase	**30 - 110 U/L**	**N/A**	**N/A**	
Lipase	**0-160 U/L**	**N/A**	**N/A**	
Lactic Acid	**0.5 to 2.2 Mmol/L**	**1.9**	**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	**0.9 – 1.1**	**1.0**	**N/A**	
PT	**11.7-13.8**	**12.3**	**N/A**	
PTT	**22.4-35.9**	**24.6**	**N/A**	
D-Dimer	**≤250 ng/mL**	**132**	**N/A**	
BNP	>100 ng/ml	**N/A**	**N/A**	
HDL	**> 60 mg/dL**	**N/A**	**N/A**	
LDL	**< 130 mg/dL**	**N/A**	**N/A**	
Cholesterol	**< 200 mg/dL**	**N/A**	**N/A**	
Triglycerides	**< 150 mg/dL**	**N/A**	**N/A**	
Hgb A1c	**4% to 5.6%**	**N/A**	**N/A**	
TSH	**0.5 to 5.0 mLU/L**	**N/A**	**N/A**	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow & Clear or cloudy	**Yellow and clear**	**N/A**	
pH	**5.0 – 7.0**	**5.0**	**N/A**	
Specific Gravity	**1.003 – 1.035**	**1.018**	**N/A**	
Glucose	**Negative**	**Negative**	**N/A**	
Protein	**Negative**	**negative**	**N/A**	
Ketones	**Negative**	**negative**	**N/A**	
WBC	**0.0-20.0**	**19.0**	**N/A**	
RBC	**0.0-20.0**	**11**	**N/A**	
Leukoesterase	**Negative**	**negative**	**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	**4.5-8.0 pH**	**N/A**	**N/A**	
Blood Culture	**7.35-7.45 pH**	**N/A**	**N/A**	
Sputum Culture	**7.00 pH**	**N/A**	**N/A**	
Stool Culture	**6.5-7.5 pH**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Complete Blood Count (CBC) Analyzer: Decode Your Results. Verywell Health. (2021). Retrieved 15 February 2021, from https://www.verywellhealth.com/cbc-test-analyzer-4768236.

Understanding Routine Lab Test Results – Lab Test Errors, Abnormalities -AARP. AARP. (2021). Retrieved 17 February 2021, from https://www.aarp.org/health/doctors-hospitals/info-02-2012/understanding-lab-test-results.html

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- **Influenza – negative**
- **Covid-19 swab – positive**
- **Chest x-ray – ground glass appearance**

Diagnostic Test Correlation (5 points):

A routine covid test was performed when entering the hospital to find out if the patient is covid-positive or negative, to prevent exposure to others whenever possible. An influenza test was performed to rule out the possibility of the patient contacting the flu rather than covid. A chest X-ray was performed in order to look at the lungs better, in order to help further diagnose this patient. The ground glass appearance indicated possible covid. (Capriotti, 2020, p. 371).

Diagnostic Test Reference (1) (APA):

Capriotti, T. M. (2020). *PATHOPHYSIOLOGY : introductory concepts and clinical perspectives.* (2nd ed., pp. 371, 829). F A Davis.

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

Home Medications (5 required)

Brand/Generic	**Acetaminophen (Tylenol) tablet**	**Cyclobenzaprine (Flexenil)**	**Loratadine (Claratin)**
Dose	**500 mg**	**10 mg x 1 tablet**	**10 mg x 1 tablet**
Frequency	**Q4hr PRN**	**Daily PRN**	**Daily PRN**

Route	**oral**	**Oral**	**Oral**
Classification	**Analgesic/ non-salicylare**	**Skeletal Muscle Relaxant**	**2nd generation antihistamines**
Mechanism of Action	**Inhibits the enzymes cyclooxygenase, blocking prostaglandins production and interfering with pain impulse generation in the peripheral nervous system.**	**Helps to relieve skeletal muscle spasms locally without inhibiting the function of the muscles.**	**Activates peripheral histamine H1 receptors by activating tricyclic antihistamines with a long-acting reaction.**
Reason Client Taking	**Moderate – mild pain**	**Muscle spasms**	**Allergic Rhinitis**
Contraindications (2)	**1. Hypersensitivity to acetaminophen with any other medication** **2. Severe hepatic impairment** **3. Severe active liver disease**	**1. Heart failure** **2. Hyperthyroidism**	**1. Hypersensitivity to loratadine and it's components** **2. Could worsen asthma attacks**
Side Effects/Adverse Reactions (2)	**1. Hypertension** **2. Constipation** **3. Muscle spasms**	**1. Muscle twitches** **2. Unusual muscle weakness** **3. diarrhea**	**1. Rash** **2. Itching** **3. Swelling** **4. Trouble breathing**
Nursing Considerations (2)	**1. Use acetaminophen cautiously in patients with severe renal impairment** **2. Tell the patient that**	**1. This medication is not recommended for older adults due to a greater risk of side effects**	**1. Do not use while breastfeeding** **2. Monitor for signs of an allergic reaction such as breathing issues,**

	tablets may be crushed or swallowed whole **3. Instruct the patient to read the manufacturer s' label and follow dosage guidelines precisely.**	**while using the drug** **2. Do no crush or chew the capsule** **3. This medication should be used short-term (for 3 weeks or less), unless specified by a doctor**	**hallucinations, tremors, loss of coordination, and irregular heartbeat.**

Calcium carbonate (Tums)	**Magnesium oxide (Uro-Mag)**
500 mg x 1 tablet	**500 mg**
daily PRN	**Daily every morning**
Oral	**Oral**
Pharmacological: calcium salts **Therapeutic: Antacids**	**Pharmacological: mineral** **Therapeutic class: electrolyte replacement**
Neutralizes stomach acid to relieve comfort caused by hyperacidity	**To relieve constipation**
Taken for upset stomachs and heartburn relief	**To relieve constipation – stool softener** **Patient is elderly – patient having trouble having bowel movements**
1. Hypersensitivity to calcium salts and their components **2. Renal caniculi**	**1. Acute abdominal problems (nausea and vomiting)**

	2. **Fecal impaction**
1. **Nausea** 2. **Vomiting**	1. **Flatulence** 2. **vomiting**
1. **encourage patient to chew the chewable tablets thoroughly before swallowing and drink a glass of water afterwards** 2. **Instruct patient to take calcium carbonate tablets 1-2 hours after meals**	1. **This drug isn't metabolized It remains in the GI tract and produces watery stool within 30 minutes to 3 hours after consumption.** 2. **Avoid giving other oral drugs within 2 hours of magnesium-containing antacids**

Hospital Medications (5 required)

Brand/Generic	**Polyethylene glycol (Miralax)**	**Folic acid (*Ferraplus*)**	**Azithromycin (Zithromax**
Dose	**17 g**	**1 mg x 1 tablet**	**500 mg**
Frequency	**2 x daily**	**Daily**	**1 x daily**
Route	**Oral**	**Oral**	**oral**

Classification	**Laxative and cathartics**	**Folic acid preparation**	**antibiotic**
Mechanism of Action	**Osmotic laxative that causes increased water retention in the lumen of the colon by binding to water molecules, thereby producing loose stools.**	**Methyl groups are used to create homocysteine during the methylation cycle, while utilizing methionine.**	**Binds to ribosomal bacter blocks peptide translocati inhibits RNA-dependent p synthesis**
Reason Client Taking	**Old age – hospital protocol**	**To replenish the folic acid in the body – vitamin deficient**	**Pneumonia – viral infecti**
Contraindications (2)	**1. Dehydration** **Abdominal pain and cramping**	**1. Hypersensitivity to folic acid and its components** **2. Neuropathy** **Anemia**	**1. History of jaundic dysfunction** **2. Hypersensitivity to azithromycin or ot macrolide antibiot**
Side Effects/Adverse Reactions (2)	**1. constipation** **dehydration and fluid depletion**	**1. Difficulty sleeping** **2. Allergic reaction** **3. Irritability**	**1. Hypertension** **2. arrhythmias**
Nursing Considerations (2)	**1. Check how many bowel moments patient had prior to administering** **Regularly check intake and output of the patient to make sure they are retaining adequate fluid levels**	**1. Check vitamin B12 levels in the body prior to starting folic acid to check for anemia to prevent neuropathy.** **Monitor patient for hypersensitivity reactions**	**1. Monitor elderly pa arrhythmias.** **2. Monitor liver e closely**

Calcium carbonate (Tums)	**Magnesium oxide (Uro-Mag)**
500 mg x 1 tablet	**500 mg**
daily PRN	**Daily every morning**
Oral	**Oral**

Pharmacological: calcium salts **Therapeutic: Antacids**	**Pharmacological: mineral** **Therapeutic class: electrolyte replacement**
Neutralizes stomach acid to relieve comfort caused by hyperacidity	**To relieve constipation**
Taken for upset stomachs and heartburn relief	**To relieve constipation – stool softener** **Patient is elderly – patient having trouble having bowel movements**
3. Hypersensitivity to calcium salts and their components **4. Renal caniculi**	**3. Acute abdominal problems (nausea and vomiting)** **4. Fecal impaction**
3. Nausea **4. Vomiting**	**3. Flatulence** **4. vomiting**
3. encourage patient to chew the chewable tablets thoroughly before swallowing and drink a glass of water afterwards **4. Instruct patient to take calcium carbonate tablets 1-2 hours after meals**	**3. This drug isn't metabolized It remains in the GI tract and produces watery stool within 30 minutes to 3 hours after consumption.** **4. Avoid giving other oral drugs within 2 hours of magnesium-containing antacids**

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2021). *2021 Nurse's Drug Handbook*. (pp. 8- 10, 88, 95-96,378-379, 457-458).Burlington, MA: Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert and Orient x 4 Appears anxious. Well developed, hydrated, and nourished
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:**	 Skin is appropriate for ethnicity. Skin appeared ashy though, which could indicate dehydration. Dry and intact without rashes or lesions Skin is cool to the touch.

Wounds: . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Normal turgor found near right clavicle bone. No rashes were found on the body. The patient has no bruising present or noted during head to toe assessment. No External wounds found on the patient 18 No drains present.
HEENT: **Head/Neck:**	The head is normocephalic and atraumatic without tenderness, visible or palpable masses, depressions, or scarring. Hair is of normal texture and evenly distributed. The neck appeared normal in size without abnormal swelling glands. The trachea is midline. The carotid pulse was not taken.
Ears:	Ears are symmetrical to the patient's head. No ear drainage was noted. The external ear was not tender to the touch, nor was there any skin break down from the nasal cannula noted. The hearing was diminished bilaterally, but the patient has access and was using his hearing aids for assistance.
Eyes:	Eyes located in the proper place on the patient's face. No eye drainage was noted. Eyelids are normal in appearance without swelling or lesions. Sclera appears to be white in color. EOMs are intact and PERRLA is normal. Eyesight seems to be normal as the patient can see approximately 10 feet away to see the T.V., with the assistance of prescription eyeglasses.
Nose:	Nose located in the proper place on the patient's face. The nasal septum is in midline. No nose drainage or mucous was noted. No breakdown of skin tissue surrounding the nose from the nasal cannula.
Teeth:	

	No abnormal discoloration of the mouth was noted. The oral mucosa was pink and moist throughout the mouth. No lesions or sores were noted. Posterior pharynx and tonsils are moist and pink without exudate noted. Tonsils were +2 bilaterally. The uvula is midline; the soft palate rises and falls symmetrically. An absence of all teeth was noted, and the patient does not have dentures for the assistance of chewing and communicating
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:**	The external chest is normal in appearance without lifts or heaves. PMI is not visible and is palpated over the 5th intercostal space. No murmurs, gallops, or rubs were found during auscultation. S1 and S2 are heard and are of normal intensity. The patient does have a pacemaker on the left side of her chest. The peripheral pulses were equal x 2. Capillary refills are less than 2 seconds. The nail beds do not appear to have any cyanosis, pitting, or clubbing. No jugular vein distension was noted. No edema was noted on any all extremities bilaterally.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No accessory muscles used to breathe The chest wall is symmetric and without deformities. No signs of trauma or respiratory distress. The chest wall is not tender. Fine, dry crackles with diminished aeration on inspiration and expiration Episodic nonproductive cough. The patient did experience SOB when talking. The patient spoke in short sentences due to shortness of breath

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 has no restrictions on foods. Due to age though, a low-sodium diet is preferred. The patient is not on a diet restriction while at the hospital. 190.5 cm (6'3") 112.7 kg (248 lbs 6.4 oz) Bowel sounds are present and normoactive in all four quadrants The day before (2/09/22) during the prior night shift, so Polyethylene glycol was not administered during the shift, to prevent excessive fluid loss through defecation. The abdomen is soft and symmetrical. The LLQ, near the umbilicus, was tender to deep direct pressure during the head-to-toe assessment. Umbilicus does not have herniation and is located midline. A normal pulse was found in the midline of the abdomen. No masses, enlarged liver, enlarged spleen are noted. No distention was observed. No incisions were found. There was a minor scar located on the RUQ, resulting from prior gallbladder surgery. The star was white in color and was 3.81 centimeters in length. No significant discoloration, swelling, or sign of infection was noted around the scar. The patient does not have any drains. The patient does not have any visible wounds in any quadrants on the stomach. The patient does not have an ostomy. The patient is not on a nasogastric tube.

	The patient is not on a feeding tube/ PEG tube.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Bright yellow hazy The patient excreted 200 mL within a time span of 6 hours. The patient did not experience any pain with urine. The patient was not on dialysis. Rectal sphincter tone was not examined.External genitalia was normal in appearance without lesions, swelling, masses, or tenderness. The patient did not have a catheter present
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	Appropriate mood, good judgment, and insight. No visual or auditory hallucinations were noted. No suicidal or homicidal ideation. The patient behaves appropriately according to his age. The patient seemed axious and nervous. The patient had a normal range in motion. The patient does not use any supportive devices when active and mobile. The patient has equal strength of +5 bilaterally in both upper and lower extremities. The patient can get up and down with help of hospital staff during his stay at the hospital, but is able to get up and down by himself at home. 18

	The patient's need for assistance to stand and walk in the hospital was not observed during the clinical, as the patient was too weak to stand.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient can move all extremities well and is consistent for age. EOM are intact and PERLA is normal, with the pupils constricting appropriately to light. Muscle strength in both arms and hands are equal and strong. Leg and feet strength both equal and strong. The patient is awake and oriented x 4. The patient appears to behave as stated age. The patient uses logical and comprehendible speech when communicating Memory is normal and the thought process is intact. No sensory deficits were noted. The patient has not experienced any loss of consciousness recently.
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 uses effective coping skill such as counting to 10 or saying a prayer in his head when he needs to cope. He states that he "leaves every problem to God." The patient appears to act and think as stated age would behave. The patient is an active member in his church at Vineyard Church in Urbana, Il. He believes in God and an afterlife, hoping he was able to live according to God / be able to go to Heaven after death.

	The patient lives alone in a 2 story house in Urbana, Il. He lives with is wife of 45 years and his 2 dogs, of 5 and 6 years. He states they just had to get rid of their can about 2 months prior due to a new allergy to cat fur. He has 2 children living in St. Joseph, who are grown now, but will frequently come to visit him with the grandchildren. The patient claims that he doesn't have any assistive devices such as handrails in the home.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**118 (regular)**	**154/88**	**20 (regular)**	**100.6 F (38.8 C) Oral**	90-91% room air
0900	**112 (regular)**	142/84	**18 (regular)**	**100.6 F (38.8 C) Oral**	**93% 2 L n/c**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0710	**1-10**	**All over**	**5**	**"achy" "continuous" "all over"**	**Administer pain medication PRN**
0947	**1-10**	**generalized**	**4**	**Continual pain and generalized achiness**	**Administer pain and fever reducing medcation PRN**

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:**	22 gauge Right medical cubital for arm 4/21/22 There is no kinks or obstructions in the IV line. No redness, swelling, or drainage was noted around the sit of the IV. The patient state, "The IV feels fine and isn't causing any pain The dressing is clean dry and intact for the IV. The adhesive tape was replaced on 4/24 after a bed bath.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
480 mL of water **500 mL of IV solution (normal saline 0.9% sodium chloride)** **No food was consumed during stay.** **Total: 980 mL of fluids**	**200 mL: excreted as urine in a 6 hour time frame.**

Nursing Care

Summary of Care (2 points)

Overview of care:

One 4/21/22, John Taylor, a 68-year-old African-American male with a history of type II diabetes and hypertension was brought into the emergency department (ED) because he felt

crummy, complaining of a headache, runny nose, feeling weaker, “achy all over” and hot to the touch and sweaty the past two days. When he woke up that morning, he no longer felt hot but began to develop a persistent “nagging cough” that continued to get worse throughout the day. During his stay, vitals were monitored, a chest x-ray was done, an influenza test, covid test, a CBC, a CMP, BMP, and a urine culture were all performed. His oxygen saturation was low and he complained of difficulty breathing, so oxygen was administered via nasal canula and tritrated at 2 L/min. He was admitted to the hospital for further workup and observation.

Procedures/testing done:

During his stay, vitals were monitored, a chest x-ray was done, an influenza test, covid test, a CBC, a CMP, BMP, and a urine culture was all performed

Complaints/Issues:

The patient had no complaints or issues during his stay that the hospital.

Vital signs (stable/unstable):

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**118 (regular)**	**154/88**	**20 (regular)**	**100.6 F (38.8 C) Oral**	90-91% room air
0900	**112 (regular)**	142/84	**18 (regular)**	**100.6 F (38.8 C) Oral**	**93% 2 L n/c**

The patient’s oxygen improved, but all of his other vitals remained unstable and decreased.

Tolerating diet, activity, etc.:

The patient is still weak and can only tolerate moderate activity. His diet can resume as normal. Drinking plenty of fluid is an important part of the patient's recovery process to try and get rid of the pneumonia.

Physician notifications:

The physician was/will be notified if the patient's oxygen drops below 92 %, and the physician was notified about the covid test results, chest x-ray results, and blood test.

Future plans for client:

At this time there is no future plans set for this patient. Once strength returns, and condition stables/ no longer covid precautions. He will need to go to the

Discharge Planning (2 points)

Discharge location:

The client will be discharged to a long care facility near by for a short-period of time once the quarantine for covid is over with. He will remain there until he is assess and is strong/stable enough to go home.

Home health needs (if applicable):

No health needs apply to this patient.

Equipment needs (if applicable):

The client may need to be sent home with an oxygen tank to improve oxygen saturation if it is not improved prior to discharge. The patien also will need an incinitive spirometer to take home to help get the fkuid form the lungs.

Follow up plan:

The client will be advised to follow up with his primary care provider within a certain time frame for evaluation of patient's condition/ if improvement has been made. The patient will also need to follow up with an occupational therapist to help promote lung strength, as well as a physical therapist to help regain muscle strength after being sick and this virus taking a toll on his body.

Education needs:

The client will need to be educated on how/why to use an incentive spirometer, on oxygen therapy and safety measures for at-home oxygen therapy, coping mechanisms for anxiety/fear, and safety measures to protect himself and other against covid-19.

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 Altered delivery of oxygen as evidenced	**The ground glass appearance to lungs as shown on x-ray can impair the effectiveness**	**1. Apply oxygen via nasal cannula starting at 2 L/min** **2.Raising the head of the bed to**	**1. The patient's oxygen saturation will be kept above 92% while on oxygen, and then**	**The family and the patient responded well to the nasal cannula being placed on the patient as they understood this**

by oxygen saturation	**of oxygen perfusion.**	**promote movement of oxygen through the body**	**eventually progress off of oxygen.**	**would help him breathe.**
2. Risk of insufficient tissue perfusion related to reduction of blood flow as evidence by dyspnea	**The client was experiencing shortness of breath just while talking, even being placed on a nasal canula. This airflow problem can indicate further organ damage from inadequate blood/oxygen perfusion to the tissues.**	**1. Assess pulse oximeter routinely to monitor adequate oxygen perfusion.** **2. Routinely auscultate the lung sounds to assess for wheezing, crackles, or rhonchi.** **3. Switch the client from a nasal canula to a face respiration mask and increase the volume of airflow** **4. Call the provider to get an order for and administer an albuterol nebulizer to dilate the bronchioles as needed.**	**1. Before discharge, the client should be able to maintain an oxygen of 95% or above on room air.**	**The patient was not observed for any changed or improvement as time did not allow.**

3. Risk of fall-related to altered mobility secondary to unsteady gait and patients age as evidence by weakness	**Due to the patient's generalized weakeness, and age, puts him at a risk for falling.**	1. The patient should wear a yellow fall risk bracelet and no-slip socks. **2.** A nurse should assist the patient when moving at all times and a gait belt should be placed on the patient to reduce the risk of falls	**1**. The patient should be able to maintain adequate strength in order to independently get up and down by himself at home.	The patient was not observed for any changed or improvement as time did not allow.

Other References (APA):

NANDA diagnostic List For Basic Human Needs | Nanda Nursing Diagnosis List. (2020). http://nandanursingdiagnosislist.org/nanda-diagnostic-list-for-basic-human-needs/#:~:text=NANDA%20diagnostic%20List%20For%20Basic%20Human%20Needs%201

Swearingen, P. L. (2008). *All-in-one care planning: medical-surgical, pediatric, maternity, and psychiatric nursing care plans*. Mosby/Elsevier.

Concept Map (20 Points):

Subjective Data

- The patient claims that "he doesn't have any assistive devices such as handrails in the home".
- The patient states that his pain was as a "5" and describes it as a "generalized achiness."
- He states that he "leaves every problem to God."

Nursing Diagnosis/Outcomes

Impaired gas exchange related to Altered delivery of oxygen as evidenced by oxygen saturation
Risk of insufficient tissue perfusion related to reduction of blood flow as evidence by dyspnea
Risk of fall-related to altered mobility secondary to unsteady gait and patients age as evidence by weakness

Objective Data

- Pulse was 118 @ 0700; 112 @ 0900
- Bp: 154/88 @ 0700; 142/84 @ 0900
- RR: 20 @ 0700; 18 @ 0947
- Temp: 100.6 F (orally) @ 0700 @ 0900
- SpO2: 90% (room air) @ 0700; 93% (nasal canula titrated to 2 L/min) @ 0900

Client Information

- Age: 68 years old
- Gender: male
- Race/ethnicity: African American
- Marital status: married
- Height: **190.5 cm**
- Weight: 112.7 kg
- Code status: full code
- Occupation: retired police

Nursing Interventions

- **Assess for levels of consciousness**
- **Assess respiratory rate, rhythm, and auscultate breath sounds.**
- **Assess pulse oximeter routinely to monitor adequate oxygen perfusion.**
- **Routinely auscultate the lung sounds to assess for wheezing, crackles, or rhonchi.**
- **Switch the client from a nasal canula to a face respiration mask and increase the volume of airflow**
- **Raise the head of the bed**
- **Call the provider to get an order for and administer an albuterol nebulizer to dilate the bronchioles as needed.**
- The patient should wear a yellow fall risk bracelet and no-slip socks.
- A nurse should assist the patient when moving at all times and a gait belt should be placed on the patient to reduce the risk of falls