N321 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 05/17/22	**Client Initials** EM	**Age** 67	**Gender** Male
Race/Ethnicity White	**Occupation** Retired	**Marital Status** Married	**Allergies** Bee stings
Code Status Full	**Height** 5'8"	**Weight** 253 lbs	

Medical History (5 Points)

Past Medical History: Chronic respiratory failure (2/13/2018), COPD, history of cardiac arrest, hypertension, hypercholesterolemia, hyperlipidemia, traumatic brain injury.

Past Surgical History: Cerebral four vessel angiogram (11/21/16), colonoscopy (1/4/17), hernia repair, tracheostomy (1/4/17), cardio catheterization (11/18/16), endobronchial ultrasound (5/17/2022).

Family History: Father: Sudden cardiac death and Hypertension; Mother: Cerebral aneurysm and hypertension

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): History of smoking 1 Pack/day for 40years, no history of drugs or alcohol.

Assistive Devices: Glasses and Dentures

Living Situation: Lives in a two-story home with his wife, patient states that he only stays on the first floor of the home, which takes 3 steps to enter from outside.

Education Level: Completed Highschool

Admission Assessment

Chief Complaint (2 points): Chills and diaphoresis

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

Patients' wife found him on the floor around 1730 after coming home from work. Patient was found **passed out** without his oxygen and is unsure of how long he had been without it. When the patient woke up, he complained of chills and diaphoresis. The patient was then brought to the ER by ambulance. The patient has no complaints of pain, he states his chills and diaphoresis where constant, but they didn't last long, he thinks it was approximately 45 minutes after the onset. Upon interview the patient denies having chills or diaphoresis before. The patient did not take anything to get rid of the symptoms and has never been treated for chills or diaphoresis before.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute on chronic respiratory failure with hypoxia

Secondary Diagnosis (if applicable): COPD

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

Upon admission the patient was diagnosed with acute on chronic respiratory failure with hypoxia. The acute on chronic respiratory failure with hypoxia is an exacerbation of the client's pervious diagnosis of COPD. Patients with a history of smoking, as well as a COPD diagnosis are at risk for respiratory failure. Respiratory failure can happen when there is fluid buildup in the lung (Capriotti, 2020). This causes the capillaries in the alveoli of the lung to be unable to perform gas exchange (Macon, 2018). When there is fluid buildup in the lung the pulmonary system can respond in two ways, one is our pulmonary system will be unable to oxygenate our blood, we see this in hypoxemic respiratory failure (Capriotti, 2020). However, hypercapnic respiratory failure the body is unable to expel the carbon dioxide in the blood. A patient who is experiencing hypoxemic respiratory failure may have, a loss of consciousness, diaphoresis, rapid

and shallow breathing, and bluish discoloration (Macon, 2018). One way to identify respiratory failure in a patient is by taking an arterial blood gas (ABG) (Macon, 2018). A patient who is in hypoxemic respiratory failure, will have a PaO2 that is lower than 60 mmHg along with a normal PaCo2. When diagnosing respiratory typically a series of ABGS is done to observe the patients PaO2 and PaCo2 (Capriotti, 2020). In addition to the ABG tests a patient who is suspected to have respiratory failure will typically have a chest x-ray (Macon, 2018). The chest x-ray used to detect any obstructions, such as cancer, as well as to see if fluid is collecting. When treating a patient with respiratory failure oxygen therapy is necessary. Many patients who have respiratory failure will wear oxygen full time (Macon, 2018).

Pathophysiology References (2) (APA):

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

Macon, B. L. (2018, September 17). *Acute Respiratory Failure.* Healthline. Retrieved May 27, 2022, from https://www.healthline.com/health/acute-respiratory-failure#symptoms

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	**4.2-5.4**	**4.78**	**4.72**	**N/A**
Hgb	**12-16**	**13.4**	**12.1**	**N/A**

Hct	**37-47**	**42.5**	**38.0**	**N/A**
Platelets	**150-440**	**315**	**368**	**N/A**
WBC	**4.50-11.00**	**32.17**	**12.2**	**Elevated WBC levels can indicate an infections, or high levels of inflammation (Pagana, 2019)**
Neutrophils	**55-70**	**N/A**	**N/A**	**N/A**
Lymphocytes	**18-42%**	**N/A**	**N/A**	**N/A**
Monocytes	**4-12%**	**5.5**	**N/A**	**N/A**
Eosinophils	**0.0-5.0%**	**0.0**	**N/A**	**N/A**
Bands	**50-65%**	**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-	**133-144**	**142**	**140**	**N/A**
K+	**3.5-5.1**	**4.0**	**4.0**	**N/A**
Cl-	**98-107**	**97**	**91**	**A low level of chloride can be related to lung disease which is possible in the case of this patient (Pagana, 2019).**
CO2	**21-31**	**31**	**29**	**N/A**
Glucose	**70-99**	**138**	**91**	**High glucose levels upon admission could be related to the patients last meal (Pagana, 2019).**
BUN	**7-25**	**16**	**10**	**N/A**
Creatinine	**0.50-1.00**	**0.58**	**0.66**	**N/A**
Albumin	**3.5-5.7**	**N/A**	**N/A**	**N/A**
Calcium	**8.8-10.2**	**9.2**	**9.2**	**N/A**
Mag	**1.6-2.6**	**2.0**	**2.1**	**N/A**

Phosphate	**1.0-4.5**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.3-1.0**	**N/A**	**N/A**	**N/A**
Alk Phos	**34-104**	**N/A**	**N/A**	**N/A**
AST	**5-34**	**N/A**	**N/A**	**N/A**
ALT	**0-55**	**N/A**	**N/A**	**N/A**
Amylase	**40-140**	**N/A**	**N/A**	**N/A**
Lipase	**0-160**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.5-2.2**	**1.54**	**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	**1**	**1**	**N/A**	**N/A**
PT	**9.5-11.8**	**10.6**	**N/A**	**N/A**
PTT	**30-40 sec**	**37.4**	**N/A**	**N/A**
D-Dimer	**<250**	**N/A**	**N/A**	**N/A**
BNP	**<100**	**24.0**	**N/A**	**N/A**
HDL	**<60**	**N/A**	**N/A**	**N/A**
LDL	**<130**	**N/A**	**N/A**	**N/A**
Cholesterol	**<200**	**N/A**	**N/A**	**N/A**
Triglycerides	**<150**	**N/A**	**N/A**	**N/A**
Hgb A1c	**4-5.6%**	**N/A**	**N/A**	**N/A**

TSH		**N/A**	**N/A**	**N/A**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Amber yellow & clear**	**Yellow and clear**	**N/A**	**N/A**
pH	**4.6-8.0**	**5.0**	**N/A**	**N/A**
Specific Gravity	**1.005-1.030**	**1.010**	**N/A**	**N/A**
Glucose	**Negative**	**neg**	**N/A**	**N/A**
Protein	**0-8**	**neg**	**N/A**	**N/A**
Ketones	**Negative**	**neg**	**N/A**	**N/A**
WBC	**0-4**	**neg**	**N/A**	**N/A**
RBC	**<2**	**0**	**N/A**	**N/A**
Leukoesterase	**Negative**	**neg**	**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):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

X-ray, CT, endobronchial ultrasound

Diagnostic Test Correlation (5 points):

Chest X-ray

The patient received a chest x-ray upon admission to the hospital. The purpose of giving this patient a chest x-ray was most likely to visualize what was happening in the patient's lungs. The chest x-ray can help us identify if there is an infection or any abnormalities in the chest. During the patient's chest x-ray they found what appears to be an infection in the lower right lung zone. In addition to this they were unable to rule our superimposed vascular congestion and the potential for developing pulmonary edema.

CT

In addition to the chest x-ray the patient also had a CT. The patient has had pervious CT scans in the past which identified a mass in the patients' lungs. The early on the same day the patient came to the ER he had a endobronchial ultrasound to help identify the mass. The CT that was taken when the patient was admitted identifies and infiltrative masslike consolidation that was in the right hilum extending into the portions of the right upper, right middle and right lower lobes of the lung. No new finds were found in this CT.

Endobronchial ultrasound

Before the patient came to the ER, he had an endobronchial ultrasound where they used a camera attached to a bronchoscope to look at patients' lungs. During this procedure a piece of the mass in the client's lung was taken to be further tested. These results are not yet available.

Diagnostic Test Reference (1) (APA):

Mayo Foundation for Medical Education and Research. (2020, June 13). *Ards*. Mayo Clinic. Retrieved May 27, 2022, from https://www.mayoclinic.org/diseases-conditions/ards/diagnosis-treatment/drc-20355581

Sheski, F. D., & Mathur, P. N. (2008). Endobronchial ultrasound. *Chest*, *133*(1), 264-270.

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

Home Medications (5 required)

Brand/Generic	**Aspirin/acetylsalicylic acid**	**Acetaminophen**	**Carbamazepine/ Tegretol**	**Losartan/ Cozaar**	**Spironolactone/ Aldactone**
Dose	**81mg**	**325mg**	**200mg**	**100mg**	**25mg**
Frequency	**PRN**	**PRN**	**BID**	**Daily**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacologic: Salicylate** **Therapeutic: NSAID**	**Pharmacologic: Nonsalicylate, parapaminophenol derivative.**	**Pharmacologic: Iminostilbene derivative**	**Pharmacologic: angiotensin II receptor blocker**	**Pharmacologic: potassium-sparing diuretic**

		Therapeutic: antipyretic, nonopioid analgesic.	**Therapeutic: Analgesic, anticonvulsant**	**Therapeutic: Antihypertensive**	**Therapeutic: diuretic**
Mechanism of Action	**Bocks the activity of cyclooxygenases, the enzymes needed for prostaglandin synthesis/ Prostaglandins, important mediators in the inflammatory response cause local vasodilation with swelling and pain. With blocking of cyclooxygenases and symptoms subside. Pain is also relieved because prostaglandins play a role in pain transmission from the periphery to the spinal cord. Aspiring inhibits platelet aggregation by A2, a substance that stimulates platelet regulating center in the hypothalamus**	**Inhibits the enzymes cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generating in the peripheral nervous system. Acetaminophen also acts directly on temperature-regulating venter in the hypothalamus by inhibiting synthesis of prostaglandin E2.**	**Normally, sodium moves into a neuronal cell by passing through a gated sodium channel in the cell membrane. Carbamazepine may prevent or halt seizures by closing or blocking sodium channels, as shown here, thus preventing sodium from entering the cell. Keeping sodium out of the cell may slow nerve impulse transmission, thus slowing the rate at which the**	**Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle. Angiotensin II is a potent vasoconstrictor that also stimulates the adrenal cortex to secrete aldosterone. The inhibiting effect of angiotensin II reduce blood pressure.**	**Normally, aldosterone attaches to receptors on the walls of distal convoluted tubule cells causing sodium and water reabsorption in the blood, as shown at left. Spironolactone competes with aldosterone for these receptors, thereby preventing sodium and water reabsorption and causing their excretion through the distal convoluted tubules. Increased urinary excretion of**

	and causes peripheral vasodilation, diaphoresis, and heath loss.		**neurons fire.**		**sodium and water reduces blood volume and blood pressure.**
Reason Client Taking	**To relieve mild to moderate pain from inflammation, as in rheumatoid arthritis and osteoarthritis.**	**To relieve mild to moderate pain.**	**To relieve pain in trigeminal neuralgia.**	**To manage hypertension**	**To treat hypertension**
Contraindications (2)	**Coagulation disorders and fever**	**Hypersensitivity to acetaminophen and severe active liver disease**	**MAO inhibitor therapy within 14 days and concurrent therapy with boceprevir**	**Concurrent aliskiren therapy and hypersensitivity to losartan or its components**	**Addison's disease, and hyperkalemia**
Side Effects/Adverse Reactions (2)	**Confusion and tinnitus**	**Anxiety and peripheral edema.**	**Blurred vision and eosinophilia**	**Dizziness and nasal congestion.**	**Ataxia and irregular menses.**
Nursing Considerations (2)	**To be aware that elderly patients and dehydrates febrile children are at high risk for toxicity and Except aspirin therapy to be temporarily halted 5 to 7 days before elective surgery to reduce risk of bleeding.**	**Calculate total daily intake of acetaminophen including other products that may contain acetaminophen so maximum daily dosage is not exceeded and monitor the end of a**	**Monitor patient closely for other adverse reactions because many of them are serious and some can become life-threatening, such as DRESS**	**Want patient to tell all prescribers of losartan therapy and monitor blood pressure and renal function studies, as ordered, to evaluate drug**	**Evaluate spironolactone's effectiveness by assessing blood pressure and presence and degree of edema and caution patient that he may experience**

		parenteral infusion to prevent possibility of air embolism.	**multiorgan hypersensitivity. And use carbamazepine cautiously in patients with impaired hepatic function because it's mainly metabolized in the liver. Monitor liver function tests, as directed.**	**effectiveness**	**dizziness during spironolactone therapy if fluid imbalance is altered**

Hospital Medications (5 required)

Brand/Generic	**Atropine/ atropen**	**Furosemide / lasix**	**Carvedilol/ Coreg**	**Atorvastatin/ Zithromax**	**Atorvastatin/ Lipitor**
Dose	**1 mg**	**20 mg**	**6.25 mg**	**500 mg**	**40 mg**
Frequency	**PRN**	**Daily**	**BID with meals**	**BID**	**At bedtime**
Route	**Injection**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacologic: anticholinergic** **Therapeutic: Antiarrhythmic,**	**Pharmacologic: Loop diuretic** **Therapeutic: Antihypertensive diuretic**	**Pharmacologic: Nonselective beta blocker and alpha-1 blocker**	**Pharmacologic: HMG-CoA reductase inhibitor** **Therapeutic: Antihyperlipidemic**	**Pharmacologic: HMG-CoA reductase inhibitor** **Therapeutic: Antihyperlipidemic**

	antimuscarinic		**Therapeutic: antihypertensive, heart failure treatment adjust**		
Mechanism of Action	**Inhibits acetylcholine's muscarinic action at the neuroeffector junction of smooth muscles, cardiac muscles, exocrine glands, SA AV modes, and the urinary bladder. In small doses, atropine inhibits salivary and bronchial secretions and diaphoresis.**	**Inhibits sodium and water reabsorption in the loop of Henle and increases your information. As the body's plasma volume decreases, aldosterone production increases, which promotes sodium reabsorption in the loss of potassium and hydrogen ions. By reducing intracellular fluid volume, the drug reduces blood pressure and decreases**	**Reduces cardiac output and tachycardia. Causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload, When given for at least 4 weeks, carvedilol reduces plasma renin activity**	**Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown.**	**Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells enhance LDL uptake and breakdown.**

		cardiac output. Overtime, cardiac output returns to normal.			
Reason Client Taking	**To reduce secretions and block vagal effect preoperatively.**	**To reduce edema caused by cirrhosis, heart failure, and renal disease, including nephrotic syndrome**	**To control hypertension**	**To control lipid levels as adjunct to diet in primary hypercholesterolemia and mixed dyslipidemia**	**To control lipid levels as adjunct to diet in primary hypercholesterolemia and mixed dyslipidemia.**
Contraindications (2)	**Hypersensitivity to atropine or other belladonna alkaloids or their component**	**Anuria and hypersensitivity to furosemide.**	**Severe brady cardia and second- or their-degree AV block**	**Active hepatic disease and unexplained persistent rise in serum transaminases level**	**Active hepatic disease and Breastfeeding**
Side Effects/Adverse Reactions (2)	**Cold skin and rash**	**Arrhythmias and anaphylaxis**	**Asthenia and abdominal pain**	**Amnesia and fatigue**	**Abnormal dreams and orthostatic hypertension**
Nursing Considerations (2)	**Inform patient that atropine may inhibit sweating. Advise patient to avoid excessive exercise or heart exposure, which can**	**Advise patient to change position slowly to minimize effect or orthostatic hypotension and Expect patient to have periodic**	**Tell patient to notify prescriber of all medications taken, including OTC preparation, before using them.**	**Monitor diabetic patient's blood glucose levels because atorvastatin therapy can affect blood glucose control and use atorvastatin cautiously in patients who consume**	**Monitor diabetic patien''s blood glucose levels because atorvastatin therapy can affect blood glucose control and expect to measure lipid levels 2 to 4 weeks after therapy starts,**

	lead to heat injury and Advise patient to notify prescriber if he has constipation, difficulty urinating, or persistent or severe diarrhea.	**hearing tests during prolonged or high-dose I.V. therapy**		**substantial quantities of alcohol or have a history of liver disease because atorvastatin uses increases risk of liver dysfunction**	**to adjust dosage as directed, and to repeat periodically until lipid levels are within desired range.**

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2022). *2021 Nurse's Drug Handbook* (21st ed.).

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:** 18	Patients skin is pink, warm and dry upon palpation. No rashes or lesions. Bruising present on the left hand and right A/C. Normal quantity, distribution, and texture of hair. Nails without clubbing or cyanosis. Skin turgor normal mobility. Capillary refill less than 3 seconds fingers and toes bilaterally.

Drains present: Y☐ N ☒ **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical, trachea is midline without deviation, Bilateral carotid pulses are palpable and 2+. 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 and EOMs intact bilaterally. Bilateral auricles no visible or palpable deformities, lumps, or lesions. Septum is midline, no visible bleeding or polyps. Posterior pharynx and tonsils are moist and pink without exudate noted. Tonsils are 2+, Uvula is midline; soft palate rises and falls symmetrically. Hard palate intact. Top and bottom dentures present, 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:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	Clear S1 and S2 without murmurs gallops or rubs. PMI palpable at 5th intercostal space at MCL. Normal rate and rhythm. 2+ edema present in ankles and feet.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal rate and pattern of respirations, respirations non-symmetrical and labored, lung sounds diminished throughout anterior/posterior bilaterally, no crackles or rhonci noted. Wheezing present exhalation

GASTROINTESTINAL: **Diet at home:** Regular diet **Current Diet:** Clear liquid diet **Height: 5' 8"** **Weight: 253 lbs** **Auscultation Bowel sounds:** **Last BM: 5/22/22** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention: No** **Incisions: No** **Scars: Yes** **Drains: No** **Wounds: No** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Abdomen is soft, nontender, no organomegaly or masses notes upon palpation of all four quadrants. Bowel sounds are normoactive in all four quadrants. No CVA tenderness noted bilaterally.
GENITOURINARY: **Color: Yellow** **Character: Clear** **Quantity of urine: 375 ml** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score:** 11 **Activity/Mobility Status:** **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	All extremities have full range of motion (ROM). Hand grips and pedal pushes and pulls demonstrate normal and equal strength. Patient wears glasses and dentures.

NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient alert and oriented to person, place, and time. Patient has no difficulty speaking. All cranial nerves are intact. PERRLA.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient is an adult who lives with his wife in a two-story home. The patient remains on the first floor of the home. He has 3 children and 6 grandchild who all live in the area. Patient states that he believes in a God but that is all he thinks about religion. Spending time with his family and thinking about them helps him cope with his medical problems. The patient states "I want to be around for my family as long as I can be."

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0820	**87**	**142/55**	**18**	**98.8**	**93%**
1100	**74**	**136/61**	**18**	**98.2**	**94%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0820	**0/10**	**N/A**	**N/A**	**N/A**	**N/A**
1100	**0/10**	**N/A**	**N/A**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20g
Location of IV:	Left AC
Date on IV:	5/17/2022
Patency of IV:	Patent, flushes well
Signs of erythema, drainage, etc.:	None
IV dressing assessment:	Changed 5/22/2022

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
480 mL	**375 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: Work on lower oxygen therapy need

Procedures/testing done: Chest x-ray, labs, CT

Complaints/Issues: The patient has no complaints as long as he is connected to his oxygen.

Vital signs (stable/unstable): Unstable O2, Bp, and Respiratory rate

Tolerating diet, activity, etc.: The patient is tolerating his clear liquid diet. Patient is also, able to walk without assistance to the bathroom.

Physician notifications: No

Future plans for client: Stabilize the patient on 5L O2

Discharge Planning (2 points)

Discharge location: His 2-story home

Home health needs (if applicable): Patient should remain on 1st floor of home, and not

exert himself by walking up stairs

Equipment needs (if applicable): Patient need to have O2 tanks and access at home.

Follow up plan: Patient will be following up with his cardiologist

Education needs: Diet and activity

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 a diagnosis of acute on chronic respiratory failure with hypoxia as evidence by the patient being hypoxic.	**This nursing diagnosis was chosen due to the patient's respiratory failure diagnosis. The respiratory failure causes fluid build in the lungs which impairs**	**1. Administer oxygen therapy and monitor the patient's oxygen levels.** **2.Turn the patient every 2 hours**	**1. Administering oxygen will help to enhance the patient's oxygen levels. Monitoring the patient's oxygen levels will allow us to observe how the oxygen therapy is working and in**	**The client responded well to the actions being taken. He understands why it is necessary to wear oxygen. The patient's goal is to be on 5L oxygen, so he can go home.**

	the patients gas exchange.		**changes need to be made.** **2. Turning the patient every two hours will help secretions clear.**	
2. Ineffective breathing pattern related to COPD as evidence by the patient wheezing on exhalation.		**1. Access and record the patient's respiratory rate and depth every 4 hours.** **2.Ausculate breath sounds every 4 hours**	**1. Accessing the patient's respiratory rate will help to observe early signs of respiratory compromise.** **2. Accessing the patient's breath sounds every 4 hours will help to notice changes in the patients breath sounds. Both good and bad changes.**	**The patient understands the actions being taken and knows it is for his health. Accessing his respiratory rate and breath sounds help to monitor his progress.**
3. Risk for activity intolerance related to a diagnosis of acute on chronic	**The nursing diagnosis was chosen due to the patients' diagnosis**	**1. Teach the patient symptoms of overexertion, such as dyspnea**	**1. Teaching the patient what to look for when overexerting themselves**	**The patient has difficulty understand why he not able to do as much activity as he was use to however, he**

respiratory failure with hypoxia as evidence by, the patient experiencing shortness of breath when doing too much activity.	**of respiratory failure and COPD. The patient's lungs are not working as well as they should which means; the patient should limit his activity to ensure he does not strain his lungs any more.**	**and chest pain.** **2. To establish realistic goals to improve the patient's activity levels.**	**will help the patient take responsibility for monitory their activity level.** **2. This will help improve the patient's quality of life as well as helping them understand their limits.**	**agreed that doing too much activity "makes me feel sick" and because of this he wants to understand his limits.**

Other References (APA):

Phelps, L. L. (2021). *Sparks & Taylor's nursing diagnosis pocket guide*. Wolters Kluwer.

Concept Map (20 Points):

N321 CARE PLAN

Subjective Data

Smoked 1 pack/day for 40 years
No alcohol/ drug usage
Medical hisoty.

Nursing Diagnosis/Outcomes

1. **Impaired gas exchange related to a diagnosis of acute on chronic respiratory failure with hypoxia as evidence by the patient being hypoxic.**
2. **Ineffective breathing pattern related to COPD as evidence by the patient wheezing on exhalation.**
3. **Risk for activity intolerance related to a diagnosis of acute on chronic respiratory failure with hypoxia as evidence by, the patient experiencing shortness of breath when doing too much activity.**

Objective Data

0820 vitals:
Pulse: 87
B/P: 142/55
RR: 18
Temp: 98.8
O2: 93%
Pain: 0/10

Client Information

67 Y/O male admitted with chills and diaphoresis.

Nursing Interventions

1a. **Administer oxygen therapy and monitor the patient's oxygen levels.**
1b. **Turn the patient every 2 hours**

2a. Access and record the patient's respiratory rate and depth every 4 hours.
2b. Auscultate breath sounds every 4 hours

3a. Teach the patient symptoms of overexertion, such as dyspnea and chest pain.

3b. To establish realistic goals to improve the patient's activity levels.