N441 Care Plan

Lakeview College of Nursing

Kaniqua Barnes-McMillian

Demographics (3 points)

Date of Admission 08/22/2022	**Client Initials** R.S.	**Age** 12/18/1957 (64)	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Unemployed	**Marital Status** Married	**Allergies** Penicillin
Code Status Full code	**Height** 168.4 cm	**Weight** 75.3 kg	

Medical History (5 Points)

Past Medical History: Bullous emphysema, cardiomyopathy, heart failure with reduced ejection fraction, and hypertension

Past Surgical History: N/A

Family History: N/A

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient drinks a beer 1- 2 times a week and smokes marijuana daily. I was unable to access how long the patient has been drinking due to being intubated and highly sedated. The patient is also a former smoker and smoked a pack a day for 37 years. He started smoking at 14 and quit at 51 years of age.

Assistive Devices: N/A

Living Situation: The patient lives at home with his wife.

Education Level: The patient highest level of education is high school.

Admission Assessment

Chief Complaint (2 points): Shortness of breath

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

The patient is a 64-year-old male who came to emergency with his wife on 08/22/2022 with shortness of breath and unable to talk. The wife mentioned that his shortness of breath started suddenly with his oxygen being in the low 80's and rushed him to the hospital. Before the patient came to the hospital, he complained of having sharp chest pain and difficulty breathing. The patient also has been complaining about a nonproductive cough for a week. The patient wife attempted to give him an albuterol breathing treatment and he felt better than after a while his chest started hurting again. There was nothing that helped or relieved the patients' symptoms after attempting to give him a breathing treatment. The wife was unsure what triggered his COPD exacerbation because he has not been sick recently or been around sick people.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute COPD exacerbation

Secondary Diagnosis (if applicable): Acute combined hypoxic and hypercapnic respiratory failure

Pathophysiology of the Disease, APA format (20 points): Chronic obstructive pulmonary disease (COPD) is a combination of chronic bronchitis, emphysema, and hyperactive airway disease (Capriotti, 2020). The patient has a past medical history of bullous emphysema. One of the major causes of COPD is smoking, 90% of patients with COPD are smokers, but can also be caused by occupational and environmental exposures to chemicals, dusts, and secondhand smoke (Capriotti, 2020). The patient is a former smoker and had been smoking for 37 years. The patient started to smoke at 14 years of age and quit at the age of 51. The patient is intubated and sedated so I was unable to ask if he still a former smoker. COPD is characterized by poorly reversible airflow limitation caused by a combination of disease which this patient has

been diagnosed with emphysema. Emphysema is when there is an overdistention of alveoli with trapped air, which creates obstruction to expiratory airflow, loss of elastic recoil of the alveoli, and high residual volume of carbon in the lungs (Capriotti, 2020). According to the patient labs on admission and present, he had levels of 32 and 34 which is high because normal levels are between 21-31. Some other labs that COPD affect are the neutrophils, T lymphocytes, and cytokines because of the constant inflammation of the lungs (Capriotti, 2020). The patient WBC were 19.5, neutrophils were 89.7 which are high due to the inflammation of the lungs. Some of the pathological changes leading to airflow limitation in COPD patients include narrowing, excessive mucus and fibrosis in the bronchioles, loss of alveolar elastic causes permanent remodeling of the pulmonary structure (Hinkle & Cheever, 2018). The patient required a lot of suctioning due to a lot of mucus build up inside of his lungs. When I observed the drainage system, there was about 80 ml of mucus that came out of him. When it comes to clinical presentation of COPD, the patient age and smoking history are important to establishing a pattern (Capriotti, 2020). The patient is a 64-year-old that has been smoking for 37 years although he has stopped for 13 years. The mean age of patient with emphysema is 65 years of age (Capriotti, 2020). The patient is 64 years of age which close to the average patient that has emphysema. Some common complaints for COPD patient are dyspnea and a cough (Capriotti, 2020). Before the patient was rushed to the hospital, he complained of a nonproductive cough for a week and was rush to the hospital because he could not talk due to not being able to breath. Wheezing is also a complaint of COPD patients, and I was able to hear wheezing, coarseness and crackles when I listened to the patients' lungs. Some additional signs and symptoms of COPD are barreled chest, cyanosis, clubbing of the fingers, and hypoxia (Hinkle & Cheever, 2018). Some ways to diagnosed COPD is the COPD Assessment Test (CAT) which is questionnaire to

ask a patient, PFTs, CBC, ECG, and ABGs (Capriotti, 2020). Since patient was already diagnosed with COPD prior to his recent hospitalization, he did not have to undergo these tests to diagnose. Some treatments of COPD include bronchodilators, beta 2 adrenergic agonist inhalers, and many other drugs that helps improves the flow of oxygen (Capriotti, 2020). The patient had albuterol in his home medication and different nebulizer treatments. COPD is an irreversible condition but can be maintain if a patient stops smoking, get vaccines, pulmonary rehabilitation, and oxygen therapy. The patient has stopped smoking and has received his vaccines so this can help patient avoid COPD exacerbation.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Davis advantage for pathophysiology (2nd ed.). F. A. Davis.

Hinkle, J. L., & Cheever, K. H. (2018). Brunner & Suddarth's textbook of medical-surgical nursing (14th ed). Wolters Kluwer.

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	3.90-5.41	4.15	3.92	n/a
Hgb	11.0-15.2	12.9	11.8	n/a
Hct	33.2-45.3	38.3	33.2	n/a
Platelets	140-400	256	201	n/a
WBC	4.0-11.7	19.5	8.6	The patient WBC can be high due to poor circulation in the lungs from COPD (Pagana et al., 2021).
Neutrophils	45.3-79.0	89.7	n/a	The patient neutrophils are high due to the inflammation of the lungs

				(Capriotti, 2020).
Lymphocytes	11.8-45.9	3.6	n/a	The patient lymphocytes can be low due to having a bacterial infection in the lungs or due to the acute COPD exacerbation which causes stress on the immune system (Capriotti, 2020).
Monocytes	4.4 - 12.0	6.2	n/a	n/a
Eosinophils	0.0-6.3	.1	n/a	n/a
Bands	0.2-1.6	n/a	n/a	n/a

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	143	141	n/a
K+	3.5-5.1	5.1	4.2	n/a
Cl-	98-107	104	103	n/a
CO2	21-31	32	34	The patient co2 levels are high due to having a past medical history of emphysema which retains co2 due to lack of proper airflow (Capriotti, 2020).
Glucose	74-109	100	85	n/a
BUN	7-25	22	31	The patient has a past medical history of heart failure which can reduce the flow to the kidney and cause them to not work well (Capriotti, 2020).
Creatinine	0.6-1.2	.86	.73	n/a
Albumin	3.5-5.2	n/a	n/a	n/a
Calcium	8.6-10.3	n/a	n/a	n/a
Mag	1.6-2.1	n/a	n/a	n/a

Phosphate	45-117	n/a	n/a	n/a
Bilirubin	0.3-1.0	n/a	n/a	n/a
Alk Phos	7-52	n/a	n/a	n/a
AST	0.3-1.0	n/a	n/a	n/a
ALT	13-39	n/a	n/a	n/a
Amylase	30-110	n/a	n/a	n/a
Lipase	11-82	n/a	n/a	n/a
Lactic Acid	0.5-1.0	n/a	n/a	n/a
Troponin	0-0.04	n/a	n/a	n/a
CK-MB	3-5%	n/a	n/a	n/a
Total CK	22-198	n/a	n/a	n/a

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	Normal: 1 Therapeutic: 2-3	n/a	n/a	n/a
PT	10-12 seconds	n/a	n/a	n/a
PTT	30-45 seconds	n/a	n/a	n/a
D-Dimer	< 200	n/a	n/a	n/a
BNP	0-100	n/a	n/a	n/a
HDL	23-92	n/a	n/a	n/a
LDL	< 100	n/a	n/a	n/a

Cholesterol	< 199	n/a	n/a	n/a
Triglycerides	0-149	n/a	n/a	n/a
Hgb A1c	< 6.4	n/a	n/a	n/a
TSH	0.45-5.33	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	Pale yellow/ clear	Yellow/ clear	n/a	n/a
pH	5-8	5.0	n/a	n/a
Specific Gravity	1.005-1.030	1.023	n/a	n/a
Glucose	Negative	Negative	n/a	n/a
Protein	Negative	Trace	n/a	The patient has a past medical history of heart failure which can reduce the flow to the kidney and cause them to not work well (Capriotti, 2020).
Ketones	Negative	2 +	n/a	The patient has a past medical history of heart failure which can reduce the flow to the kidney and cause them to not work well (Capriotti, 2020).
WBC	Negative	2	n/a	The patient has WBC in the urine because it is sign of infection which the patient also was diagnosed with pneumonia (Pagana et al., 2021).
RBC	Negative	Negative	n/a	
Leukoesterase	Negative	Negative	n/a	n/a

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	7.43	7.42	n/a
PaO2	80-100	70.8	67.5	The patient has a past medical history of emphysema and in acute COPD exacerbation (Pagana et al., 2021).
PaCO2	35-45	49.9	56.6	The patient has a past medical history of emphysema and in acute COPD exacerbation (Pagana et al., 2021).
HCO3	22-26	30.9	34.1	The HC03 is high because the body is trying to compensate for the paC02 (Pagana et al., 2021).
SaO2	92-100	95.2	94.5	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):

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest x ray (08/22/2022)- A chest x ray was done to check the placement of the tube. The heart was normal but severe emphysematous changes, improved aeration of both lungs with mild residual in airspace disease.

Electrocardiogram (ECG) (08/22/2022)- Left ventricle had moderate ventricular hypertrophy, it was normal size and estimated ejection fraction is 40-45 %, and there is grade 1 diastolic dysfunction. The right ventricle and aorta were normal. The mitral had a trace amount of mitral regurgitation.

Diagnostic Test Correlation (5 points):

1.) A chest x ray is a film that produces images of your heart, lungs, blood vessels, airways, and the bones of your chest and spine (Hinkle & Cheever, 2018). The patient was getting a chest x ray to see images of her heart. The patient was given this test to check the placement of the ET tube.

2.) Electrocardiogram is a graph that shows electric activity of the heart. An electrocardiogram is used to measure time and velocity (Hinkle & Cheever, 2018). The patient will have electrodes that placed throughout the body specific parts to measure the heart. The patient was given this test to see changes in his cardiac health due to coming in for shortness of breath.

Diagnostic Test Reference (1) (APA):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed). Wolters Kluwer.

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

Home Medications (5 required)

Brand/Generic	Albuterol/ ProAir HFA	Furosemide/ Lasix	Lisinopril, Prinivil	Cymba Dulox
Dose	90mcg	40 mg	20mg	60 mg
Frequency	Three times a day (TID)	Daily	Once daily	Once
Route	Inhaled	Oral	PO	PO
Classification	Inhaled beta 2 agonist	Loop diuretic/ antihypertensive	ACE inhibitor/ antihypertensive	Antide muscu 2020).
Mechanism of Action	Albuterol acts on beta 2 adrenergic receptors to relax the bronchial smooth muscles (Jones, 2021).	Inhibits sodium and water reabsorption in the loop pf Henle and increase urine formation (Jones, 2021).	May reduce blood pressure by inhibiting conversion of angiotensin1 to angiotensin 2 (Jones, 2021).	Inhibit and Norep elevate (Jones
Reason Client Taking	The patient has a history of COPD.	The patient has history of hypertension.	To treat hypertension	To trea
Contraindications (2)	Diabetes, high blood pressure (Jones, 2021).	Anuria, hypersensitivity to furosemide components (Jones, 2021).	Diabetes and hereditary or idiopathic angioedema (Jones, 2021).	Chron impair (Jones
Side Effects/Adverse Reactions (2)	Nervousness, tachycardia (Jones, 2021).	Arrhythmias, pancreatitis (Jones, 2021).	Arrhythmias and hypotension (Jones, 2021).	Anger (Jones
Nursing Considerations (2)	The nurse should monitor respiration and oxygen saturation	Use cautiously with patients with advanced	Concurrent aliskiren use in patients with diabetes and hereditary or idiopathic	Should renal i

	(Jones, 2021).	cirrhosis and monitor for hypokalemia (Jones, 2021).	angioedema (Jones, 2021).	behavi
Key Nursing Assessment(s)/Lab(s) Prior to Administration	The nurse should measure the client blood pressure and heart prior and during the administration of this medication (Jones, 2021).	Ask the patient is they are allergic to sulfonamides because they may also be allergic to this medication (Jones, 2021).	The nurse should assess the patient blood pressure before given this medication (Jones, 2021).	The nu suicida
Client Teaching needs (2)	The patient should follow the directions on prescription label carefully and know that the medication can cause tachycardia and jittery feeling so do not be alarmed (Jones, 2021).	Make sure client takes medication the same time each day and it should be taken several hours before bedtime to avoid nocturia (Jones, 2021).	The patient should know that the medication helps control but not treat hypertension and should be taken at the same time everyday (Jones, 2021).	The ca not cru stoppe

Hospital Medications (5 required)

Brand/Generic	Enoxaparin/ Lovenox	Acetaminophen / Tylenol	Midazolam/ Versed	Formoterol/ performist	Pantoprazo Protonix
Dose	40mg	650mg	4 mg	20 mcg	40 mg
Frequency	Daily	O6=4H PRN	Q4H continuous	Twice a day	Daily
Route	Subcutaneous	IV push	IV drip	NEB	IV push
Classification	Low molecular weight and Anticoagulant	Analgesics and antipyretics	Benzodiazepine and sedative - hypnotic	Selective beta-adrenergic and bronchodilator	Proton pur inhibitor a Antiulcer
Mechanism of Action	Potentiates the action of	Block prostaglandin	The medication increases	Attaches to beta receptors	Effectively blocks gas

	antithrombin and without thrombin, fibrinogen can't convert to fibrin and clots cant form (Jones, 2021).	production and interferes with pain impulse generation in the peripheral nervous system (Jones, 2021).	activity of gamma-aminobutyric acid, a major inhibitory neurotransmitter in the brain (Jones, 2021).	on bronchial membranes to increase in the intracellular cAMP level inhibits histamine release. This than relaxes the bronchial smooth muscles (Jones, 2021).	acid secret irreversibly binding to inhibiting t hydrogen-potassium pump (Jon 2021).
Reason Client Taking	The patient is taking this medication due the hospital policy which indicates it should be taken as precautions to avoid blood clots.	The patient takes this medication as needed for pain.	The patient is taking this medication to keep sedated while on the ventilator.	The patient is taking this medication to help clear up secretions during his acute COPD exacerbation.	The patien medication to hospital of trying to prevent sto ulcers.
Contraindications (2)	Active major bleeding, hypersensitivity to pork products or their components (Jones, 2021).	Severe hepatic impairment, severe active liver disease (Jones, 2021).	Acute angle-closure glaucoma, acute pulmonary insufficiency (Jones, 2021).	Patient that has asthma and not taking inhaled corticosteroid and hypersensitivity to formoterol fumarate (Jones, 2021).	Concurren therapy wi rilpivirine containing products a hypersensi to pantopra (Jones, 202
Side Effects/Adverse Reactions (2)	Pulmonary edema, hemorrhage (Jones, 2021).	Hypotension, angioedema (Jones, 2021).	Cardiac arrect, hypotension (Jones, 2021).	Angioedema, bronchospasm (Jones, 2021).	Rhabdomy , hepatic fa (Jones, 202
Nursing Considerations (2)	Use cation with patient with heparin-induced thrombocytopenia and hepatic impairment (Jones, 2021).	Use cautiously in patients with hepatic impairment and monitor renal impairment (Jones, 2021).	The nurse should know if the patient takes antihypertensive medications and should assess level of consciousness frequently (Jones, 2021).	Should not be used in patient with acute deteriorating COPD and caution should be taking with patients with cardiovascular disorder (Jones, 2021).	Monitor pa for diarrhe C. diff and should not given long than medic necessary 2021).

Key Nursing Assessment(s)/Lab(s) Prior to Administration	The nurse should assess for active bleeding and look at platelet's labs.	The key assessments that are renal and liver labs.	The patient blood pressure should be checked prior to administration.	The nurse should know the status of the patients COPD progression and heart diseases.	Platelets sh be looked before givi this medica
Client Teaching needs (2)	Teach patient how to give this medication at home and know the signs of bleeding (Jones, 2021).	The patient can crush or take whole and learn signs of hepatic toxicity (Jones, 2021).	The patient should be informed that they might not remember procedure and to avoid alcohol (Jones, 2021).	The patient should tell provider of any medications taking prior and instruct patient to notify if any chest pain (Jones, 2021).	Bleeding precautiou should be i place and decrease in output sho noted (Jon 2021).

Medications Reference (1) (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:**	I was unable to access the alert and oriented of the patient due to him being intubated and highly

Orientation: **Distress:** **Overall appearance:**	sedated. Overall, the patient appeared to be well groomed.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient skin was kind of pale and dry to appearance and touch. The patient skin was warm to touch on all extremities bilaterally. The patient had no rashes or bruises. There were no wounds present. The patient Braden score is 11.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head and neck appeared to be midline with no deviation, and his ears were intact and symmetrical. There was currently no drainage present. The client's eyes appeared to be symmetrical with no drainage. The sclera was white, and conjunctiva was pink. The patient had only one tooth in his mouth, and it appear to be rotten. .
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:**	.S1 and S2 heard. No murmur or gallop present when listening to the aortic, pulmonic, Erb's point, tricuspid, and mitral locations. Pulses 2+ bilaterally in the carotid arteries, radial arteries, and dorsalis pedis arteries. All locations were easily palpable. Capillary refill was less than 3 seconds in all extremities. The patient had nonpitting edema is his hands.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** 8.0 **Placement (cm to lip):** 24 cm **Respiration rate:** 16 **FiO2:** 60 **Total volume (TV):**360 **PEEP:**5.0	The patient lung sounds were coarse everywhere and heard wheezing in the lower left lobe with some crackles. The patient was not using accessory muscles and I did not see any chest deformities.

VAP prevention measures: Some measure we took to avoid VAP is by recapping the tubes in between given medication and doing oral care. We also practiced proper hand hygiene and used glove while doing any type of care.	
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:** Orogastric tube and size is 16 **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	I am unsure of the patients' diet at home due to no family at bedside and him being intubated and sedated. The patient current diet consists of Glucerna 1.2 and getting 70 cc an hour. The patient height is 168.4 cm and weight is 75.3 kg. The patient bowel sounds were active in all four quadrants. The patient last bowel movement was the night of 08/29/2022. The patient had no pain or masses preset during palpation. There appear to be no distention, wounds, incisions, or drains. The patient did not have an ostomy but had an orogastric tube.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** Foley catheter (indwelling) **Size:**16 **CAUTI prevention measures:**	The patient urine was yellow and clear. The patient voided 95 mL of urine while I was present. I wasn't sure if the patient was in pain due to being intubated and sedated. The patient was not on dialysis but did have a catheter. The genitals were pink and dry. Some measure that was taking to prevent CAUTI were proper hand hygiene and frequent cleaning of the genital area. We also kept the drainage bag lower than bladder and empty the drainage container before it was full.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** 50	Neurovascular status was unable to be determined due to the patient being intubated and sedated. I also unable to do ROM or test the strengths of the extremities. The client does not assistive devices to get around because he is currently on bedrest due to be heavily sedated and ventilated. The patient needs total

Activity/Mobility Status: **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	dependence with activities of daily living. The patient fall risk score is 50
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	I was unable to access the alert and oriented of the patient due to him being intubated and highly sedated. I was unable to test the patient strength in extremities due to being sedated. I am also unable to access that patient mental status, speech, sensory or LOC due to being heavily sedated.
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 is intubated and heavily sedated with no family at bedside, so I was not able to find out much. I do know the patient has a good support system from his wife and daughter because they visit frequently. According to the patient charts before he was intubated, religion did not play a big part in his life.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1000	109	135/77	18	37.4	100
1200	98	130/70	16	37.6	100

Vital Sign Trends/Correlation: The patient vital signs are stable and there are no major difference in the two vital signs.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	FLACC	n/a	n/a	n/a	n/a
1200	FLACC	n/a	n/a	n/a	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:**	The patient has an 18-gauge IV in the left forearm. The IV was placed on 08/22/2022. IV site is dry, and intact. IV is patent. No Drainage, erythema, swelling, inflammation, or warmth. IV dressing was clear and intact. The patient has a saline lock
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	The patient has an 18-gauge midline in the right forearm. The IV was placed on 08/22/2022. The site is dry, and intact. IV is patent. No Drainage, erythema, swelling, inflammation, or warmth. IV dressing was clear and intact. The patient has a saline lock. Aspirated and flushed , needless connection change.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
150 ml of water **131 ml of fentanyl** **15 ml of midazolam** **121.5 ml of propofol**	**95 ml of urine**

Nursing Care

Summary of Care (2 points)

Overview of care: While I was taking care of the patient, I was able to reposition him every 2 hours, do oral care and give medication.

Procedures/testing done: N/A

Complaints/Issues: N/A

Vital signs (stable/unstable): The patient vital signs were stable the entire time I took care of him.

Tolerating diet, activity, etc.: I was able to perform oral care on the patient and suctioning to help get rid of build up secretions.

Physician notifications: N/A

Future plans for client: The future plans for the client was unknown due to the family not sure if they wanted him to have trach put in or keep him ventilated for a little longer.

Discharge Planning (2 points)

Discharge location: The patient will be discharged to a nursing home to get some physical therapy help.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: The doctor and the family are unsure of the follow up plan on the patient but going to wait a day or so more to make decisions.

Education needs: The patient and the family will need to be educated on ways to avoid COPD exacerbation.

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

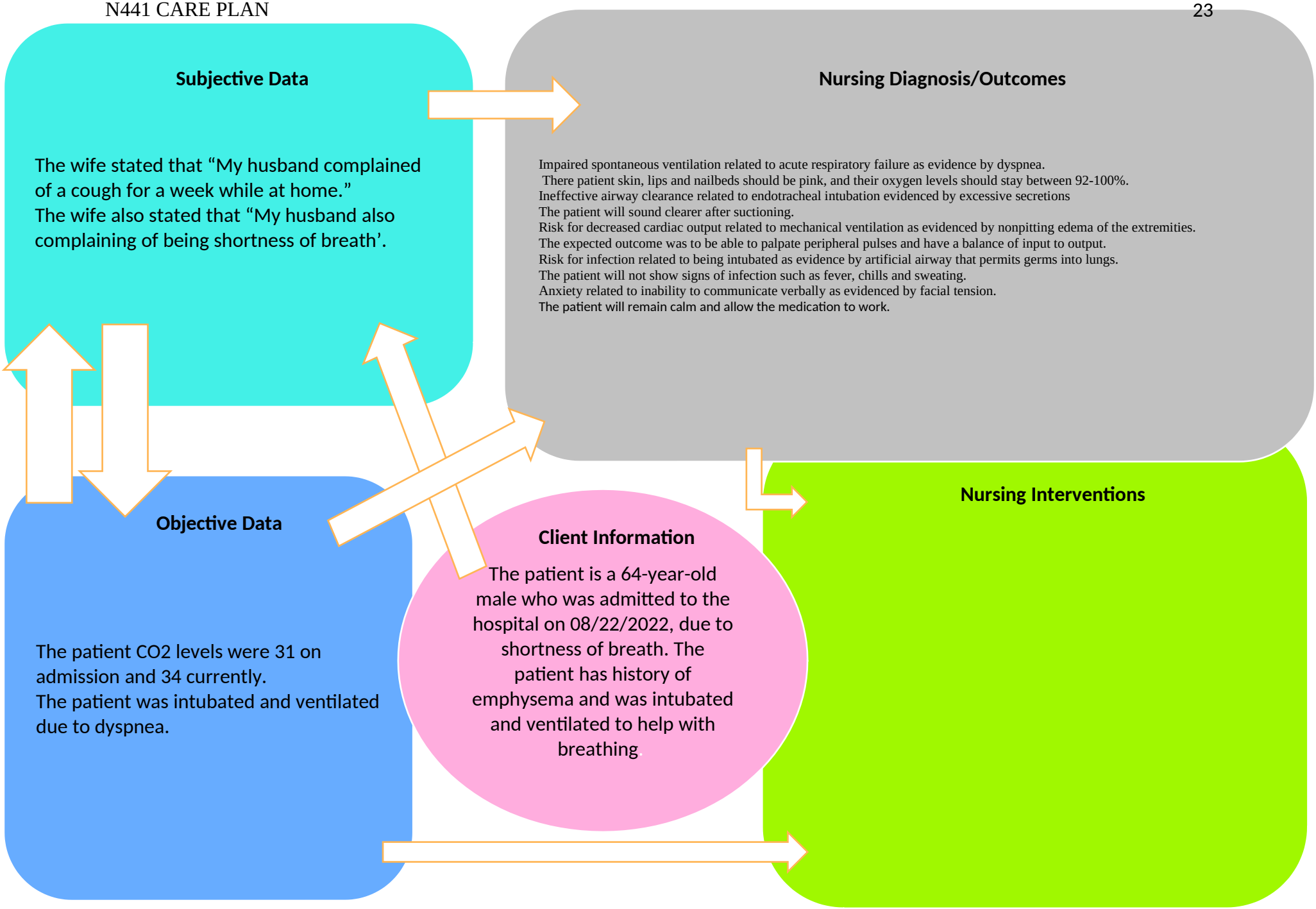
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 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 spontaneous ventilation related to acute respiratory	The patient came into the hospital not being able to talk due to	**1.** The patient skin color, lips and nailbeds should be assessed for cyanosis. **2.** The patient	**1.** There patient skin, lips and nailbeds should be pink, and	The patient goals were met because their oxygen levels were at 98% and his skin

failure as evidence by dyspnea.	having trouble breathing.	oxygen saturation should be monitor using pulse oximetry.	their oxygen levels should stay between 92-100%.	remained pink.
1. Ineffective airway clearance related to endotracheal intubation evidenced by excessive secretions	As I excess the patient, I heard a lot of coarseness, crackles and wheezing.	**1.** Suctioning will be done as needed to prevent secretions from building up. **2.** Monitoring oxygen saturation prior to and after suctioning.	**1.** The patient will sound clearer after suctioning.	When I assessed the patient again, he still had a lot of crackling in his lungs. The patient did not tolerate suctioning well as evidenced by oxygen levels dropping and become tachycardic after suctioning.
2. Risk for decreased cardiac output related to mechanical ventilation as evidenced by nonpitting edema of the extremities.	As I excess the patient, he had edema in all of his extremities and had a foley catheter to keep up with his input and output. The patient also had heart failure.	**1.** The capillary refill, skin temperature, and peripheral pulsed were assessed. **2.** Monitored fluid balance and urine output.	**1.** The expected outcome was to be able to palpate peripheral pulses and have a balance of input to output.	The patient peripheral pulses were faint, but I was able to feel them, and the input compared to the output were not balanced. The patient was heavily sedated so there was no response from him.
3. Risk for infection related to being intubated as evidence by artificial airway that permits germs into lungs.	The patient has a high risk of getting ventilated associated pneumonia because he has been ventilated for 8 days.	**1.** I performed proper oral care. 2. I used proper hand hygiene while giving care to the patient.	**1.** The patient will not show signs of infection such as fever, chills and sweating.	There were no signs of infection seen in the patient.
4. Anxiety	The patient	**1.** The patient	**1.** The patient	The patient

	related to inability to communicate verbally as evidenced by facial tension.	was ventilated for the first time and has been on ventilation for a long time.	remained heavily sedated. **2.** Use a soothing touch and tone while caring for the patient.	will remain calm and allow the medication to work.	seems to be calm and was not combative.

Other References (APA):

Concept Map (20 Points):


Subjective Data
The wife stated that “My husband complained of a cough for a week while at home.”
The wife also stated that “My husband also complaining of being shortness of breath’.
Nursing Diagnosis/Outcomes
Impaired spontaneous ventilation related to acute respiratory failure as evidence by dyspnea.
There patient skin, lips and nailbeds should be pink, and their oxygen levels should stay between 92-100%.
Ineffective airway clearance related to endotracheal intubation evidenced by excessive secretions
The patient will sound clearer after suctioning.
Risk for decreased cardiac output related to mechanical ventilation as evidenced by nonpitting edema of the extremities.
The expected outcome was to be able to palpate peripheral pulses and have a balance of input to output.
Risk for infection related to being intubated as evidence by artificial airway that permits germs into lungs.
The patient will not show signs of infection such as fever, chills and sweating.
Anxiety related to inability to communicate verbally as evidenced by facial tension.
The patient will remain calm and allow the medication to work.
Objective Data
The patient CO2 levels were 31 on admission and 34 currently.
The patient was intubated and ventilated due to dyspnea.
Client Information
The patient is a 64-year-old male who was admitted to the hospital on 08/22/2022, due to shortness of breath. The patient has history of emphysema and was intubated and ventilated to help with breathing.
Nursing Interventions