Medications

Allopurinol, 200mg, Daily

Amlodipine, 10mg, Daily

Arformoterol tartrate, 15mcg, BID

Aspirin, 81mg, Daily

Atenolol, 25mg, Daily

Atorvastatin, 40mg, Nightly

Azithromycin, 500mg, Daily

Budesonide, 500mg, BID

Calcitriol, 0.25mcg, Daily

Ceftriaxone IV, 2g, Q24H

Clonidine, 0.2 mg, BID

Enoxaparin, 1mg/kg, Daily

Ferrous Sulfate, 325mg, Daily

Finasteride, 5mg, Daily

Furosemide, 40mg, Daily

Hydralazine, 50mg, BID

Insulin Lispro Injection, 2-12 units, 4x Daily WC

Ipratropium-albuterol, 3mL, 4x Daily

Levothyroxine, 50 mcg, QAM AC

Methylprednisolone, 40mg, Q24H

Pantoprazole, 40mg, Daily

Lab Values/Diagnostics

RBC 4.2-5.4 → 3.38 (Respiratory Hypoxia)

Hgb 12-16→10.1 (Respiratory Hypoxia)

Hct 37%-47%→ 30.8% (Respiratory Hypoxia)

Neutrophils 55-70→ 90.6 (Infection)

Lymphocytes 20-40→ 5.2 (Immunosuppress)

Glucose 74-106→ 217 (Diabetes Mellitus)

BUN 10-20→ 76 (Urine retention)

Creatinine 0.5-0.8→ 2.93 (Urine retention)

Demographic Data

Date of Admission:
Admission Diagnosis/Chief Complaint: Acute on chronic respiratory failure with hypoxia
Age: 81 y/o
Gender: Male
Race/Ethnicity: White
Allergies: N/A
Code Status: Full Code
Height in cm: 182.9 cm
Weight in kg: 110.9 kg
Psychosocial Developmental Stage: Normal
Cognitive Developmental Stage: Normal
Braden Score: 22
Morse Fall Score: 10
Infection Control Precautions: Standard/ N/A

Admission History

81 y/o male, presented to ED with shortness of breath. The patient states shortness of breath started the night before and gradually got worst. The patient reports a cough that has not progressed since the onset. The patient presents with bilateral swelling in lower extremities.

Medical History

Previous Medical History: Aphakia of the left eye, Benign localized hyperplasia of prostate, blind one eye, COPD (Chronic obstructive pulmonary disease), Diabetes mellitus, GERD (Gastroesophageal reflux disease), Gout, Hyperlipidemia, hypertension, hypothyroid, meralgia paresthetica, peripheral vascular disease
Prior Hospitalizations: N/A
Previous Surgical History:
Tonsillectomy (No date)
Cholecystectomy (No date)
Nasal Fracture Surgery (No date)
Social History: Former smoker, former smokeless tobacco use, previous use of alcohol and drugs.

Pathophysiology

Disease process: Patient experienced shortness of breath the night before seeking medical attention. Shortness of breath continued to the following day; patient has been experiencing a mild cough that has not progressed since onset. The patient also is experiencing edema in lower extremities.
S/S of disease:

- Shortness of breath
- Use of accessory respiratory muscles
- Distress
- Elevated ABGs
- Abnormal respiratory rate

Method of Diagnosis:

- ABGs
- Pulmonary Function Tests
- Culture and Sensitivity testing

Treatment of disease:

- Nebulizer treatments
- Broncho dilaters
- Antiviral drugs

Active Orders

- Diet consistent medium calorie
- IP consult to pharmacy
- Basic metabolic panel/ calcium total
- Complete blood count with Diff
- Culture respiratory lower
- Streptococcus pneumoniae antigen, urine
- Nebulizer treatment
- Daily weight
- Bladder Scan (pt has history of urine retention)
- For blood sugar 70mg/dL or less feed patient 15g of carbs or liquids
- Insert or maintain peripheral IV
- Intake and output every 8 hours (Strict to limit pts body ability to retain fluids)
- PT/OT for deconditioning since admissions (to get pt to start moving more since hospitalization)
- Perform POC blood glucose very 6 hours (Due to pts diabetes)
- Post hypoglycemia treatment greater than or equal 8-mg/dL
- Reason for No DVT/VTE pharmacologic prophylaxis (Pt is already on Antithrombotic medicine)
- Telemetry monitoring (Pt has high risk for cardiac/respiratory arrest)
- Vitals (Routine)

Physical Exam/Assessment

General: Patient was alert and oriented x person, place, time, and situation. Seemed to be in no distress and good overall appearance.

Integument: Skin is white, intact, and warm to the touch. Skin is dry to touch, skin turgor is elastic, no rashes, minimal bruises, and no wounds are present. Nails without clubbing or cyanosis and no drains present.

HEENT: Head is symmetrical, unable to see from one eye, dentation is good pink, moist, and no bleeding. No drainage from the nose. Hearing is intact no signs of hearing impairment.

Cardiovascular: Clear S1 and S2 sounds. No gallops or murmurs. Normal rate and rhythms bilaterally 2+ radial pulse. Dependent edema in lower extremities.

Respiratory: Unlabored respirations, regular respiration patterns, equal lung aeration. Clear breath sounds.

Genitourinary: Patient urine is yellow and clear. Patient presented with an indwelling catheter with 500cc of urine. The patients catheter was removed at 0950.

Gastrointestinal: Diabetic diet, patient presents with a hernia bulging out from the umbilicus area. Bowel sounds are active, and the abdomen is nontender.

Musculoskeletal: Patient has active ROM and uses a walker as a supportive device. Patient strength ranked at a 4 with active motion against some resistance and slight weakness. Patient is a fall risk because of blood thinner medication and has a fall score of 10.

Neurological: Normal cognition, clear speech, the patient is alert can answer questions appropriately.

Most recent VS (include date/time and highlight if abnormal): 09/08/22 1045 T: 97.7 P: 65 R:20 BP:140/53 Oxygen: 96

Pain and pain scale used: 0 pain on pain scale 0-10**,** patient denies pain/ discomfort.

Nursing Diagnosis 1 Impaired Gas Exchange	**Nursing Diagnosis 2** Impaired Urinary Elimination	**Nursing Diagnosis 3** Risk for Imbalanced Fluid Volume
Rationale Related to the diagnosis of acute chronic respiratory failure with hypoxia due to the body not receiving enough oxygen, evidenced by shortness of breath.	**Rationale** Related to the indwelling catheter placed due to retention of urine, evidenced by the inability of producing urine sample by self.	**Rationale** Related to dependent edema in lower extremities due to the body not exerting excess fluid correctly, evidenced by edema in lower extremities.
Interventions **Intervention 1:** Assess and record pulmonary status every 4 hours. **Intervention 2:** Have patient turn, cough, and deep breath every 4 hours to prevent atelectasis or fluid build-up.	**Interventions** **Intervention 1:** Use clean or sterile technique every 2 hours for catheterization. **Intervention 2:**Monitor patency, keep tubing kink free, and maintain a drainage bag below the bladder.	**Interventions** **Intervention 1**: Administer intravenous fluids as indicated **Intervention 2:** Collect and evaluate urine output frequently
Evaluation of Interventions • Patient’s oxygen levels are in normal range • Patient is routinely assessed	**Evaluation of Interventions** • Patient received catheter care • Patient’s catheter was removed • Patient was able to void 500cc	**Evaluation of Interventions** • Patient voided often • Patient was ordered Lasix’s • Patient urine was clear and yellow

References (3) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company

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