

N431 Care Plan #1

Lakeview College of Nursing

Noredia Asia

N431 CARE PLAN

Demographics (3 points)

| | | | |
|--------------------------------------|--------------------------------|-----------------------------------|--|
| Date of Admission 08/11/22 | Client Initials W.M. | Age 83 years old | Gender Male |
| Race/Ethnicity White | Occupation Retired | Marital Status Divorced | Allergies No known allergies |
| Code Status FULL | Height 182.9 cm | Weight 89 kg | |

Medical History (5 Points)

Past Medical History: Atrial fibrillation, Hyperlipidemia, Hypertension, Dementia

Past Surgical History: Cardioversion; EGD with PEG

Family History: No family history on file.

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

Never smoked or used tobacco or nicotine products. Never vaped. Never used alcohol or other forms of drugs.

Assistive Devices: Glasses

Living Situation: Lives in a nursing home.

Education Level: High school diploma; some college completed; intermittent confusion

Admission Assessment

Chief Complaint (2 points): Weakness, confusion, decreased oral intake, back pain

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

The patient was admitted here 8/1 to 8/4/22 after presenting to the ED with complaints of palpitations, found to be in rapid AFib. He was treated with IV diltiazem. He was seen by Cardiology. He received beta-blockers. His heart rate improved, and he was subsequently discharged home. The patient's son stated that the patient had not been doing well since then and returned with the patient to the ED. The son stated he had “low oral intake, increased confusion,

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and increased weakness”. He reported low, constant back/flank pain, worse on the left. Patient himself stated ” he feels fine”, denied any issues, but was clearly confused. The patient physically was guarding the area and grimacing upon palpation showing some severity. Accurate aggravating and alleviating factors were not able to be given by the patient. There was no treatment given prior to presenting to the ED. He was admitted.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Severe Sepsis

Secondary Diagnosis (if applicable):

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

Septicemia, or sepsis, affects many people worldwide daily. Sepsis is a leading cause of death in the United States. Gram-positive organisms have increased in being the cause of sepsis. Over time, the more frequent use of broad antibiotics in increasingly sick patients has resulted in increased bacterial resistance. Respiratory tract infections, specifically pneumonia, are the most common site of infection and are associated with the highest mortality (Mayr et al, 2019). Immunosuppressed persons, older adults, and infants are most susceptible to sepsis. Infection usually begins in one organ system and then spreads into the bloodstream, leading to sepsis (Capriotti, 2020).

Signs and symptoms of sepsis can look different in all patients. Some signs include the source of infection, which could be a cough, abdominal pain, or a sore throat with a fever adjacent. Some other symptoms include tachycardia, shortness of breath, confusion or disorientation, low blood pressure, and decreased urine output (Yale Medicine, 2019). Physicians may also diagnose sepsis by looking at abnormal white blood cells, lactic acid, and markers of

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organ dysfunction. Abnormally high white blood cells can indicate a current infection in the body, and deficient white blood cells indicate a person at a greater risk of getting an infection. Lactic acid is secreted from organs and muscles when they do not receive enough oxygen, which means a condition (Yale Medicine, 2019). A urinalysis can also give physicians more information about a urinary tract infection or kidney dysfunction. Some diagnostic tests that can be ordered are chest x-rays to view the lungs, a CT scan to view conditions in the liver, pancreas, and other susceptible organs, and an MRI which can help identify soft tissue or bone infections (Mayo Clinic, 2021). The client had a chest x-ray, a CT scan, and abnormal labs that included WBCs, lactic acid, and urine-filled with ketones, WBC, and protein.

Sepsis is severe, and patients must be treated to prevent death. Sepsis is primarily treated with medications and under close surveillance in hospital intensive care units to prevent septic shock and rapid decline. Intensive antibiotic medication helps treat the specific bacteria that is afflicting the patient. Intravenous fluids help supply the body back with lost electrolytes and nutrients that the body typically gives itself to help the healing process further. Vasopressors are also used if the blood pressure remains too low after intravenous fluids and other interventions, constrict the blood vessels, increase the blood pressure, and keep blood flowing to insufficient organs (Mayo Clinic, 2021). The client receives antibiotic treatment, blood pressure medications, and continuous intravenous fluids to promote health restoration.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

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Mayo Clinic. (2021, January 19). *Sepsis - Diagnosis and treatment*.

<https://www.mayoclinic.org/diseases-conditions/sepsis/diagnosis-treatment/drc-20351219>

Mayr, F. B., Yende, S., & Angus, D. C. (2019). Epidemiology of severe sepsis. *Virulence*, 5(1),

4–11. <https://doi.org/10.4161/viru.27372>

Yale Medicine. (2019, December 10). *Sepsis: Symptoms, diagnosis & treatment*.

<https://www.yalemedicine.org/conditions/sepsis>

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 | 4.40-5.80 | 4.57 | 2.88 | The systemic inflammatory response to sepsis due to hemolysis and bleeding. |
| Hgb | 13.0-16.5 | 13.6 | 8.5 | This is abnormal due to bleeding and hemolysis. |
| Hct | 38.0-50.0 | 40.9 | 25.7 | This is abnormal due to bleeding and hemolysis. |
| Platelets | 140-440 | 137 | 240 | Severe infection can lead to the destruction of platelets. |
| WBC | 4-12 | 18.30 | 6.70 | This was abnormally high because of the infection in the patient causing sepsis. |
| Neutrophils | 40-68 | 90.3 | 69.1 | The infection in the patient's body. |
| Lymphocytes | 19-49 | 1.1 | 9.4 | The infection in the patient's body. |
| Monocytes | 3-13 | 8.5 | 19.0 | The infection in the patient's body affects the tissues as well. |
| Eosinophils | 0-8 | 0.0 | 1.9 | N/A |
| Bands | 0-10 | 26 | 2.0 | High bands is an indicator of sepsis and infection due to increased need of neutrophil, the body will produce |

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|--|--|--|--|---|
| | | | | more immature neutrophils (bands). |
|--|--|--|--|---|

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 | 135 | 140 | N/A |
| K+ | 3.5-5.1 | 4.1 | 4.6 | N/A |
| Cl- | 98-107 | 99 | 107 | N/A |
| CO2 | 21-31 | 21 | 26 | N/A |
| Glucose | 70-99 | 136 | 111 | There is reduced blood flow that leaves glucose to accumulate more. |
| BUN | 6-20 | 39 | 29 | There is kidney dysfunction. |
| Creatinine | 0.50-1.20 | 3.56 | 1.26 | There is kidney dysfunction. |
| Albumin | 3.5-5.7 | 3.8 | 2.5 | There is kidney dysfunction. |
| Calcium | 8.8-10.2 | 8.8 | 8.9 | N/A |
| Mag | 1.6-2.6 | 1.6 | 2.2 | N/A |
| Phosphate | 2.5-4.5 | 2.5 | 3.5 | N/A |
| Bilirubin | 0.2-0.8 | 0.4 | 0.5 | N/A |
| Alk Phos | 34-104 | 50 | 101 | N/A |
| AST | 13-39 | 27 | 13 | N/A |
| ALT | 7-52 | 19 | 13 | N/A |
| Amylase | 25-115 | N/A | N/A | N/A |

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|--------------------|--------------------|--------------|--------------|---|
| Lipase | 11-82 | N/A | N/A | N/A |
| Lactic Acid | 0.5-2.0 | 4.2 | 2.3 | The body's organs are not receiving enough oxygen. |
| Troponin | 0.000-0.040 | 0.268 | 0.130 | There was damage to the heart. |
| CK-MB | 3-5 | N/A | N/A | N/A |
| Total CK | 30-223 | 34 | 34 | 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 | 0.8-1.1 | 4.0 | 1.7 | The blood is taking longer to clot |
| PT | 10.1-13.1 | 46.3 | 18.5 | The blood is taking longer to clot. |
| PTT | 25-36 | 36 | 57 | The proteins that control blood clotting has become over active. |
| D-Dimer | <500 | N/A | N/A | N/A |
| BNP | 0-100 | 976 | 617 | The heart is having difficulty pumping. |
| HDL | 40-60 | N/A | N/A | N/A |
| LDL | <100 | N/A | N/A | N/A |
| Cholesterol | 0-200 | N/A | N/A | N/A |
| Triglycerides | <150 | N/A | N/A | N/A |
| Hgb A1c | 4-6 | N/A | N/A | N/A |
| TSH | 0.350-4.940 | 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 | Yellow & | Orange & | Yellow & | This is a sign of infection. |

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|------------------|-------------|----------|----------|--|
| | clear | turbid | clear | |
| pH | 5.0-9.0 | 5.5 | 8.0 | N/A |
| Specific Gravity | 1.003-1.030 | 1.023 | 1.011 | N/A |
| Glucose | Negative | Negative | Negative | N/A |
| Protein | Negative | 4+ | 2+ | The kidneys aren't functioning properly. |
| Ketones | Negative | Traced | Negative | The body has become too acidic. |
| WBC | 0-5 | 11-20 | 51-150 | There is an infection in the body present. |
| RBC | 0-2 | 11-20 | 21-50 | There is a possible urinary tract infection. |
| Leukoesterase | Negative | 3+ | 3+ | There is an infection in the body. |

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 | 7.36 | 7.42 | N/A |
| PaO ₂ | 80-100 | 50 | 61 | There is a decrease in gas exchange in the patient's lungs due to the bacteria. |
| PaCO ₂ | 35-45 | 48 | 34 | There is a decrease in gas exchange in the patient's lungs due to the bacteria. |
| HCO ₃ | 22-26 | 27 | 21.7 | The body is having trouble removing CO ₂ through lungs and kidneys. |
| SaO ₂ | 95-100 | 81 | 90 | There is not enough oxygen reaching the body's tissues. |

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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 | Methicillin Resistant Staph aureus | No growth within 1 day | This could indicate a urinary tract infection. |
| Blood Culture | Negative | Methicillin Resistant Staph aureus | No growth within 5 days | The indicates bacteria in the blood. |
| Sputum Culture | Negative | Few candida albicans; scant mixed flora | Mixed flora | This indicates bacteria has entered the respiratory system. |
| Stool Culture | Negative | Negative for C Diff; Positive for occult blood | Negative for C Diff; Positive for occult blood | Bacteria has entered the blood and presents in the stool which could indicate a GI bleed. |

Lab Correlations Reference (1) (APA):

Van, A. M. (2021). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications* (9th ed.). F. A Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT Abdomen/Pelvis; CT Chest; Chest XRay

Diagnostic Test Correlation (5 points):

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A CT scan of the abdomen and pelvis was performed to view any affliction to the area that was initially causing the patient abdominal pain. Diverticulosis and small stones were found in the CT scan that could explain the pain and possible harboring of foreign bacteria causing sepsis. A CT of the chest was completed to view the lungs for infection or foreign particles causing an illness. Small pleural effusions with finding representative of CHF with pulmonary edema found in the CT of the chest explain the patient's respiratory decline and impaired exchange of gas due to the infection restricting adequate blood flow. A chest X-ray was completed to view the lungs for possible conditions like pneumonia that are congruent to the patient's laboratory results. The chest x-ray confirmed lung opacities in the client which could progressively worsen the patient's status if lung capacities are impaired.

Diagnostic Test Reference (1) (APA):

Van, A. M. (2021). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications* (9th ed.). F. A Davis Company.

Current Medications (10 points, 1 point per completed med) *10 different medications must be completed*

Home Medications (5 required)

| Brand/Generic | Apixaban/ Eliquis | Diltiazem/ Cardizem CD | Lisinopril/ Prinivil | Nitroglycer in/ Nitrostat | Bisacodyl EC/ Dulcolax |
|---------------|----------------------|------------------------------|-------------------------|---------------------------------|---------------------------|
| Dose | 5 mg | 180 mg | 2.5 mg | 0.4 mg | 10 mg |
| Frequency | Bid | Once daily | Once daily | Every 5 minutes | Tid |

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| | | | | PRN | |
| Route | PO | PO | PO | Sublingual | PO |
| Classification | Pharm:Factor Xa inhibitor Therapeutic: Anticoagulant | Pharm: Ca+ Channel blocker Therapeutic: Antianginal | Pharm: ACE inhibitor Therapeutic : Antihypertensive | Pharm: Nitrate Therapeutic : Antianginal | Pharm: Therapeutic: |
| Mechanism of Action | Inhibits free and clot-bound factor Xa and prothrombinase activity which decreases thrombin generation and thrombus development. | Inhibits calcium movement into coronary and vascular smooth muscle cells which decreases myocardial oxygen demand and slow AV conduction time. | May reduce blood pressure by inhibiting conversion of angiotensin 1 to angiotensin 2. Decreased release of aldosterone reduces sodium and water reabsorption and reduces blood pressure. | Dilates coronary arteries increasing blood flow to ischemic myocardial tissue and provides analgesic effects. | |
| Reason Client Taking | Atrial fibrillation | Atrial arrhythmias; angina; hypertension | Hypertension | Chest pain | Constipation |
| Contraindications (2) | Bleeding; hypersensitivity to apixaban | Systolic blood pressure below 90; ventricular tachycardia | Concurrent aliskiren use; Hypersensitivity to lisinopril | Severe anemia; orthostatic hypotension | Appendicitis; gastroenteritis |
| Side Effects/Adverse Reactions (2) | GI bleeding; Hypotension | Atrial flutter; Heart failure | Arrhythmias; pulmonary embolism | Arrhythmias; hypotension | Diarrhea; abdominal discomfort |
| Nursing Considerations (2) | Monitor closely for bleeding; Expect to be | Monitor blood pressure, | Monitor for angioedema ; monitor | Check vital signs prior; monitor | |

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| | discontinued 48 hours before an invasive procedure | heart rate and rhythm continuously; monitor for digitalis toxicity | for dehydration | heart and breath sounds | |
| Key Nursing Assessment(s)/Lab(s) Prior to Administration | D-dimer; Risk of stroke | Blood pressure; Digoxin level | Blood pressure; creatinine level | Pain level; blood pressure | |
| Client Teaching Needs (2) | Report any unusual bleeding or bruising; Avoid the use of a razor | Report chest pain; Maintain good oral care | Seek emergency treatment if there is difficulty breathing or swallowing; do not use salt substitutes that contain potassium | Teach signs of angina; Tell patient of headaches | Report any rectal bleeding or failure; expect to have a bowel movement 15-30 minutes after taking |

Hospital Medications (5 required)

| Brand/Generic | Digoxin/ Lanoxin | Pravastatin / Pravachol | Guaifenesin/ Robitussin | Omeprazole | Metoprolol tartrate/ Lopressor |
|-----------------------|--|--|------------------------------------|----------------------------|---|
| Dose | 125 mcg | 20 mg | 10 mL | 20 mL | 50 mg |
| Frequency | Once daily | Once daily | q4h | Once daily | Bid |
| Route | Per G Tube | PO | PO | Per G Tube | Per G Tube |
| Classification | Pharn: Cardiac glycoside Therapeutic : | Pharn: HMG-CoA reductase Therapeutic : | Pharn: Therapeutic : | Pharn: Therapeutic : | Pharn: Therapeutic: |

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| | Antiarrhythmic | Antilipemic | | | |
| Mechanism of Action | Increases the force and velocity of myocardial contraction. It decreases the conduction rate and increases the refractory period of the AV node. | Inhibits cholesterol synthesis in the liver by blocking the enzyme needed to convert HMG-CoA to mevalonate. When cholesterol synthesis is blocked the liver increases breakdown of LDL cholesterol | | | |
| Reason Client Taking | Atrial fibrillation | Hyperlipoproteinemia | Clear sputum and thin secretions | Peptic ulcer | Angina; cardiac dysrhythmias |
| Contraindications (2) | Hypersensitivity to digoxin; ventricular tachycardia | Active hepatic disease; hypersensitivity to pravastatin | | | |
| Side Effects/Adverse Reactions (2) | Arrhythmias; Heart block | Hepatic failure; Hemolytic anemia | | | |
| Nursing Considerations (2) | Monitor for digitalis toxicity; Obtain frequent ECG tracings | Monitor liver enzymes; Monitor BUN and serum creatinine | | | |
| Key Nursing Assessment(s)/Lab(s) Prior | Serum digoxin; | Liver enzymes; | | | |

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| to Administration | Apical heart rate | Lipoprotein level | | | |
| Client Teaching Needs (2) | Teach how to take pulse; Teach and report signs of toxicity | Caution from performing hazardous activities; notify provider about muscle pain and tenderness | | | |

Medications Reference (1) (APA):**Assessment****Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS**

| | |
|--|--|
| GENERAL: Alertness: Orientation: Distress: Overall appearance: | Alert and disoriented Confused Ill-appearing Patient in no apparent distress |
| INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: | Right heel pressure injury Warm and dry Skin turgor weak elasticity; slow to return to original state Skin red tinged and blanchable No rashes Skin bruised all around; 2 presentable wounds; |

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| Wounds: . Braden Score: 18 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: | PEG tube inserted in abdominal region |
| HEENT: Head/Neck: Ears: Eyes: Nose: Teeth: | head symmetrical at rest and with movement expression; no swelling; no tenderness Scratchy throat Dry oral mucosa No teeth ; gums moist; palate intact, pink, and moist Patient glasses at bedside |
| CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema: | S1 and S2 sounds heart; murmur present Apical pulse irregular Peripheral pulses Capillary refill less than 3 seconds |
| RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character | Barrel chest Frequent cough; congested; loose; productive Anterior and posterior coarse crackles auscultated; diminished breath sounds in all lung fields |
| GASTROINTESTINAL: Diet at home: Current Diet Height: 182.9 cm Weight: 89 kg Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: 1 Scars: Drains: Wounds: 2 Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: 20 Fr | Regular diet at home NPO currently Gastrostomy/Enterostomy Percutaneous endoscopic gastrostomy - 20 Fr. LUQ abdominal incision - endoscopic puncture for PEG Audible bowel sounds; normoactive Last BM 9/4/22 Deep tissue pressure injury on right heel covered with scab; area clean with barrier cream and covered No abdominal tenderness, pain, or mass |

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| GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Urethral catheter double- lumen Size: 16 Fr. | Urethral catheter Double-lumen 16 Fr. 08/14/22 Urine tea colored Catheter site intact, clean, dry Genitals warm, without lesion and bruising |
| MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 24 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/> | Posterior gluteal pressure injury- stage 2; area cleaned and barrier cream applied and covered No supportive devices Upper extremities 4 out of 5 strength bilaterally Lower extremities 2 out of 5 bilaterally Bed rest No supportive devices Needs support to stand and walk High fall risk; fall risk precautions of keeping the bed low, bed alarm on, fall risk wrist band, closely supervised |
| NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> if no - Legs <input checked="" type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC: | Alert; Disoriented and confused Moves upper extremities well; Demonstrates equal strength in upper extremities; limited movement in lower extremities with unequal strength Altered mental status Speech spontaneous and illogical Senses intact |
| 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): | Calm and cooperative; patient is self-caring and without reliable external support; patient is cared for in nursing home; patient is developmental appropriate for age; patient does not participate in any religion |

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

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|------|-------|---------------|-----------|------|--------|
| 1300 | 97 | 137/71 | 18 | 98 F | 91% |

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| | | | | | |
| 1546 | 96 | 117/69 | 19 | 98.1 F | 95% |

Vital Sign Trends: The patient's vitals were relatively stable throughout the clinical day. The patient's blood pressure decreased and oxygen saturation increased during the second vital set.

Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|------|-------|-------------|----------|--------------------|-------------------------|
| 1300 | 0-10 | No location | 0 | No characteristics | No interventions needed |
| 1546 | 0-10 | No location | 0 | No characteristics | No interventions needed |

IV Assessment (2 Points)

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|--------------------------------|
| Size of IV: 20 G Location of IV: Right distal posterior forearm Date on IV: 9/14/22 Patency of IV: Patent Signs of erythema, drainage, etc.: None IV dressing assessment: Clean; Dry; Intact | 0.9% NaCl at 50mL/hr |

Intake and Output (2 points)

| Intake (in mL) | Output (in mL) |
|--|----------------|
| Tube feeding - 70mL/hr - 620mL total IV 0.9% NaCl - 219mL | Urine - 546mL |

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Nursing Care

Summary of Care (2 points)

Overview of care: There was not much care provided other than suctioning, adjusting the oxygen saturation, vital signs, and an assessment. The nurse administered Guaifenesin through the PEG tube.

Procedures/testing done: Suctioning; medication given through G tube

Complaints/Issues: No complaints or issues

Vital signs (stable/unstable): Vital signs were stable throughout clinical day

Tolerating diet, activity, etc.: NPO and on bed rest and fall precautions

Physician notifications: No physician notification

Future plans for client: Monitor the patient

Discharge Planning (2 points)

Discharge location: To nursing home

Home health needs (if applicable): Nutritional assistance to feed; close to nurses station as risk for falls;

Equipment needs (if applicable): Low bed; walking assistance devices; bed floating devices to prevent skin breakdown; floor mats

Follow up plan: Follow up with provider a week after successfully following medication regimen, safety guidelines, and appropriate nutrition interventions

Education needs: Education on nutrition, safety, dysrhythmias signs and symptoms, pulse monitoring

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Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

| Nursing Diagnosis <ul style="list-style-type: none"> ● 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 <ul style="list-style-type: none"> ● Explain why the nursing diagnosis was chosen | Interventions (2 per dx) | Outcome Goal (1 per dx) | Evaluation <ul style="list-style-type: none"> ● How did the client/family respond to the nurse’s actions? ● Client response, status of goals and outcomes, modifications to plan. |
|--|--|---|---|--|
| 1. Ineffective airway clearance related to excess mucous evidenced by persistent cough. | The nursing diagnosis was chosen because the patient was persistently coughing to remove the mucus secretions and had to be suctioning frequently. This is a major issue. | 1. Teach the patient to deep breathe and cough frequently. 2. Perform suctioning as necessary. | 1. The patient’s airway will clear of excess mucous and reduce coughing for longer periods in an hour. | The patient was able to breathe better and handled the suctioning well. Suctioning may not work if the patient is confused so it should only be utilized when the patient is alert and oriented x4. |
| 2. Impaired gas exchange related to lung tissues as evidenced by nasal cannula | This nursing diagnosis was chosen because the patient’s need for oxygen was increasing and critical to | 1. Position the head of the bed in a semi-fowler position. 2. Keep the patient on continuous oxygen as | 1. The patient’s oxygen saturation will remain above a 95% for at least an hour. | The patient responded well to the interventions. The patient will need tape to secure the nasal cannula in place in periods of confusion. |

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| <p>for low oxygen saturation and high carbon dioxide in body.</p> | <p>keep the organs and tissue functioning.</p> | <p>needed.</p> | | |
| <p>3. Imbalanced nutrition related to confusion as evidenced by placement of G tube and intravenous fluids.</p> | <p>This nursing diagnosis was chosen because the patient couldn't keep his NG tube due to his confusion and need a different route to receive his nutrients. Without proper nutrients, the patient's body cannot heal well.</p> | <p>1. Supply the patient with protein in meals.</p> <p>2. Take daily weights for the patient.</p> | <p>1. The patient's protein level will increase and gain strength in his legs. The patient will be able to ambulate at least 10 feet through the halls.</p> | <p>The patient is responding well to the interventions. The patient needed a PEG tube inserted due to repeated removal of the NG tube and this has improved the nutrients.</p> |
| <p>4. Risk for skin integrity breakdown related to lack of perfusion to tissues as evidenced by pressure injuries.</p> | <p>This nursing diagnosis was chosen because the patient had 2 pressure sores that were both stage 2 and needed to be turned frequently.</p> | <p>1. Turn the patient every 2 hours.</p> <p>2. Use pillows or foam wedges to keep bony prominences from direct contact.</p> | <p>1. The patient will no obtain any more pressure sores from hospitalization until discharge.</p> | <p>The patient was understanding of these interventions and tolerated the frequent movement. The patient will need to continue these measure and possible increase turning dependent on the increasing strength in skin elasticity.</p> |

Other References (APA):

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Concept Map (20 Points):

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Subjective Data

- "low oral intake, increased confusion, and increased weakness"
 - "he feels fine"
 - No pain given

Objective Data

- Abnormal lactic acid, WBC
- CT scan of abdomen and chest
- Chest x-ray
- Pressure sores
- Crackles in lung
- PEG tube

Client Information

- 83 yrs old male
- Lives in nursing home
 - Never smoked
 - Uses glasses

ND #1: **Ineffective airway clearance related to excess mucous evidenced by persistent cough.**
Outcome #1: **The patient's airway will clear of excess mucous and reduce coughing for longer periods in an hour.**

ND #2: **Impaired gas exchange related to lung tissues as evidenced by nasal cannula for low oxygen saturation and high carbon dioxide in body.**
Outcome #2: **The patient's oxygen saturation will remain above a 95% for at least an hour.**

ND #3: **Imbalanced nutrition related to confusion as evidenced by placement of G tube and intravenous fluids.**
Outcome #3: **The patient's protein level will increase and gain strength in his legs. The patient will be able to ambulate at least 10 feet through the halls.**

ND #4: **Risk for skin integrity breakdown related to lack of perfusion to tissues as evidenced by pressure injuries.**
Outcome #4: **The patient will not obtain any more pressure sores from hospitalization until discharge.**

Nursing Diagnosis/Outcomes

Nursing Interventions

- 1: Teach the patient to deep breathe and cough frequently. Perform suctioning as necessary.**
- 2: Position the head of the bed in a semi-fowler position. Keep the patient on continuous oxygen as needed.**
- 3: Supply the patient with protein in meals. Take daily weights for the patient.**
- 4: Turn the patient every 2 hours.**
- 2. Use pillows or foam wedges to keep bony prominences from direct contact.**

