

Adult Health I Care Plan #1

Lakeview College of Nursing

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Date: 09-26-2022

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Demographics (5 points)

Date of Admission 09/18/2022	Client Initials C.F.	Age 69	Gender F
Race/Ethnicity African American	Occupation Retired	Marital Status Widowed	Allergies Lisinopril - Unsure of reaction Buprenorphine - unsure of reaction Mobic (Meloxicam) - unsure of reaction
Code Status Full Code	Height 163cm	Weight 121.3kg	

Medical History (5 Points)**Past Medical History:**

Hypertension (12/27/2018), GERD, Depression, Fibromyalgia, Asthma, hypercholesterolemia, H/O Seasonal Allergies, Degenerative Joint Disease, Chronic Obstructive Pulmonary Disease, Pneumonia due to infection (12/27/2018), Renal Insufficiency, Decreased Vitamin D, Cataract - Bilaterally, Arthritis, Primary Osteoarthritis in multiple joints (12/27/2018), Lupus, and Insomnia

Past Surgical History:

Tubal Ligation - Laterally (Date Unknown), Lap - Inguinal Hernia Repair, Cataract Removal with Implant (10/08/2018), Endoscopy - colon - Diagnosis (1986), Cataract Removal with implant - Left (09/16/2019), Upper Gastrointestinal Endoscopy with biopsy (06/29/21), Colonoscopy (06/29/21)

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Family History:

Both Father and Mother (did not assess if alive or deceased) has had arthritis and hypertension, paternal grandmother had cancer, maternal grandmother had breast cancer, Sister (Still living) has diabetes, all 3 daughters (Still living) have hypertension, the older daughter has had cancer and the 2nd oldest daughter had DVT.

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

- **Smoking:** is a current (use some days) smoker and used 0.25 packs/day (7.5 pack years) and used 4 cigarettes a day
- **Alcohol use:** Use alcohol (type: Liquor) occasionally
- **Drug use:** No drug use

Assistive Devices: Electrical Power Chair (mostly uses) , Assistive Cane (Rarely been used), 4-Wheeled Walker (mostly uses)

Living Situation: Lives with the oldest daughter

Education Level: Highest education level obtain is 1 year of college in accounting and nursing assistance.

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Admission Assessment

Chief Complaint (2 points): Shortness of Breath

Principal Problem: Pneumonia in Right Lower Lobe due to Infectious Organisms.

History of Present Illness – OLD CARTS (10 points - In Paragraph format):

Patient was admitted to the hospital with shortness of breath that occurred and progressively gotten worse til the point of admission. Patient stated that the the symptoms had been occurring from time to time 3 months prior but has progressively gotten worse before admission. The onset of symptoms is located in the chest area. The patient stated that new occurrence of symptoms felt like they could hardly breath and gasping for air. Patient stated that with activity and at rest the symptoms were the same and progressively gotten worst on it own. The patient stated that when the shortness of breath occur they felt dizzy and when they are on their feet they can feel unstable and less balance. Relieving techniques that the patient said they used to help try to occurrence of new symptoms are breathing techniques taught by her provider (deep breathing in the nose and slowly exhaling through the mouth). Pharmacological treatments that the patient stated to use is the albuterol inhaler (Short-acting nebulizer) (Accuneb) for 4 times a day as needed.

Primary Diagnosis

Primary Diagnosis on Admission (3 points):

- Pneumonia

Secondary Diagnosis (if applicable):

- None listed

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

Inhaling droplets with bacteria or other pathogens that pass through the upper airway and into the lung tissue is how pneumonia is contracted. As a result of this invasion, the epithelial cells undergo an acute inflammatory response that promotes vasodilation and the movement of neutrophils move into the air spaces (Capriotti, 2020) . As soon as the neutrophils arrive at the site of the inflammation, they begin a process known as phagocytosis that engulfs the infected microorganism to eliminate it using a reactive enzymes, an antimicrobial protein, and reactive oxygen species (Capriotti, 2020) . The resulting goblet cells secrete mucus, which subsequently builds up between the capillaries and alveoli (Capriotti, 2020). The alveoli makes a crackling sound as they try to open but are unsuccessful, which affects gas exchange at the capillary level (Capriotti, 2020).

The initial onset of symptoms presents a productive or nonproductive cough, fever, and chills (Mayo Clinic, 2020). Overtime symptoms such as dyspnea, hemoptysis (coughing up of blood), and decreased exercise tolerance becomes more apparent (Capriotti, 2020). In a physical exam symptoms maybe evident such as fever, tachypnea, use of accessory muscles for breathing, tachycardia, and cyanosis (Mayo Clinic, 2020). Dullness on percussion and increase fremitus over the lower lobes of pneumonia are evident along with poor cough and gag reflux increases risk of aspiration (Mayo Clinic, 2020). During the patient interview on the past medical history, it is very important to assess prior exposure to infection, immunosuppression factors and medical history such as asthma, COPD (Capriotti, 2020). It is also good to know social habits

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like smoking and the use of drugs/alcohol that may increase the risk of pneumonia (Capriotti, 2020).

A chest exay is the the most definitive/important diagnostic test for the diagnosis of pneumonia (Capriotti, 2020). CBC with differential can tell if a infection is present from a bacterial or viral standpoint (Capriotti, 2020). Pulse oximetry can show any presence of low oxygenation (Capriotti, 2020). Sputum culture/sensitivity can identify the causative organism and assess its antibiotic susceptibility (Capriotti, 2020).

The primary treatment options for pneumonia include the use of antibiotic therapy and oxygenation (Capriotti, 2020). Supportive interventions include the use of fowlers positioning, supplemental oxygen, IV fluid may be administered for dehydration, and the use of bronchodilators to dilate the airway (Capriotti, 2020). Other Pharmacologic interventions include the use of analgesia for pain and antipyretics for fevers (Mayo Clinic, 2020). In older adults over the age of 65, the population is the most at risked for pneumonia in a hospital setting, therefore the pneumococcal vaccine is highly recommended (Mayo Clinic, 2020).

This is relevant to the patient data because the patient has had a lot of commonalities that connects with the pathophysiology of pneumonia. Her past medical history connects with the pathophysiology because she has medical diagnosis of asthma, COPD, and past pneumonia infection. She has a social history of currently smoking cigarettes (4 cigs/day), and a use of alcohol occasionally on special events. During the admission she stated that she felt chest tightness, shortness of breath, along with dizziness. Labs that were done at admission revealed that her neutrophils were high (76.1%) with the normal range of 47 - 73.0%. Initial diagnostic imaging that were done at admission was a chest x-ray that reveled that infiltration was present

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in the right lower lung section meaning pneumonia was confirmed. The patient hospital medication that she takes is a nebulizer for bronchodilation of the lungs. Four days after the initial treatment of antibiotics had started, the patient was coughing up thick green mucus during clinical hours. Upon auscultation in the head to toe assessment, the lung sounds were congested.

Pathophysiology References (2) (APA):

- **Reference:**

Capriotti, T. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives*. F. A. Davis Company.

Mayo Clinic. (2020, June 13). *Pneumonia - Symptoms and Causes*. Retrieved September 26, 2022, from <https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes>

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Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

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	3.80 - 5.30 10 ⁶ cells/mcL	3.76	3.77	infected alveoli become inflamed and filled with WBC, RBC, and fluid. (Pagana, 2018)
Hgb	12.0 - 15.8 g/dL	11.6	11.7	Acts as a Risk indicator for pneumonia. (Pagana, 2018)
Hct	36.0 - 47.0%	34.6	34.5	Theres a difference between oxygen demand in the body versus the red blood cells availability to transport oxygen to the body. (Pagana, 2018)
Platelets	140 - 440 10 ⁶ cells/mcL	395	423	
WBC	4.00 - 12.00 10 ⁶ cells/mcL	10.9	11.4	
Neutrophils	47.0 - 73.0%	76.1	55.3	Infection in the lungs (Pagana, 2018)
Lymphocytes	18.0 - 42.0%	15.8	33.6	Infection in the lungs (Pagana, 2018)
Monocytes	4.0 - 12.0%	6.9	10.6	
Eosinophils	0.0 - 5.0%	0.2	0.3	

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Bands	50 - 65%	Not tested	N/A	
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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 - 144mmol/L	141	140	
K+	3.5 - 5.1mmol/L	3.4	3.8	relates to the pneumonia because the lungs muscles are not resting due to the impairment of oxygenation. (Pagana, 2018)
Cl-	98 - 107mmol/L	104	101	
CO2	21 - 31mmol/L	26	29	
Glucose	70 - 99mg/dL	97	97	
BUN	7 - 25mg/dL	21	24	
Creatinine	0.5-1.00 mg/dL	0.94	1.01	it is high due to the initial start of pneumonia (Pagana, 2018)
Albumin	3.5 - 5.7 g/dL	3.8	Not tested	
Calcium	8.6 - 10.3 mg/dL	9.1	9.9	
Mag	1.6 - 2.6 mg/dL	Not Tested	N/A	
Phosphate	3.0 - 4.5 mg/dL	Not Tested	N/A	
Bilirubin	0.2 - 0.8 mg/dL	0.5	Not Tested	
Alk Phos	34 - 104 U/L	30	Not Tested	

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AST	13 - 39 U/L	9	Not Tested	
ALT	7 - 52 U/L	12	Not Tested	
Amylase	40 - 140 U/L	Not Tested	N/A	
Lipase	11 - 82 U/L	Not Tested	N/A	
Lactic Acid	0.5 - 2.0 mmol/L	Not Tested	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 sec	Not Tested	N/A	
PT	10.1-13.1 sec	Not Tested	N/A	
PTT	25-36 sec	Not Tested	N/A	
D-Dimer	No labs available	Not Tested	N/A	
BNP	0 - 100 pg/mL	33	Not Tested	
HDL	No labs available	N/A	N/A	
LDL	No labs available	N/A	N/A	
Cholesterol	No labs available	N/A	N/A	
Triglycerides	No labs available	N/A	N/A	
Hgb A1c	No labs available	N/A	N/A	
TSH	No labs available	N/A	N/A	

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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	Bright Yellow/Clear	Yellow/Clear	Not Tested	
pH	5.0 - 9.0	6.0	Not Tested	
Specific Gravity	1.003 - 1.030	1.013	Not Tested	
Glucose	Negative	Negative	Not Tested	
Protein	Negative	Negative	Not Tested	
Ketones	Negative	Negative	Not Tested	
WBC	Negative 0-5/hpf	6 -10	Not Tested	Infection in the urine (Pagana, 2018)
RBC	Negative Ery/uL	Negative	Not Tested	
Leukoesterase	Negative	+2	Not Tested	Infection in the urine (Pagana, 2018)

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	Not Tested	N/A	
Blood Culture	Negative	Not Tested	N/A	
Sputum Culture	Negative	Pending Results	N/A	
Stool Culture	Negative	Not Tested	N/A	

Lab Correlations Reference (1) (APA):

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Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

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Diagnostic Imaging**All Other Diagnostic Tests (10 points):**

- **X-Ray Chest 2 views (09/18/2022):** indicated Infiltrate noted in Right Lower Lobe
- **X-Ray Lumbar Spine 2 or 3 View (09/10/2022):** Views indicated that no fractures are present, arthritic changes in both ST Joint - Degenerative, Degenerative disc disease is present at the L5-S1 section, and gas was noted without narrowing of the intervertebral space.

Diagnostic Imaging Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

Capriotti, T. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives*. F. A. Davis Company.

Current Medications (10 points, 2 points per completed med)***5 different medications must be completed*****Home Medications (5 required)**

Brand/ Generic	Hydrocodone- Acetaminophen (Norco) - <u>Schedule II Controlled Substance</u>	Celecoxib (Celebrex)	Alprazolam (Xanax) - <u>Schedule IV Controlled Substance</u>	Duloxetine Hydrochloride (Cymbalta)	Pregabalin (Lyrica) - <u>Schedule V Controlled Substance</u>
Dose	325mg Tab	200mg Cap	1mg Tab	60mg Cap	150mg Cap
Frequency	Every 8 hours/PRN	Daily	Daily	Daily	BID
Route	Oral	Oral	Oral	Oral	Oral
Classification	Pharmacologic Class: Narcotics	Pharmacologic Class: NSAID	Pharmacologic Class: Benzodiazepine	Pharmacologic Class: Selective serotonin	Pharmacologic Class: Gamma-Aminobutyric

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	Therapeutic Class: Analgesics (Opioid-Combinations)	Therapeutic Class: Analgesic, Anti-Inflammatory/Antirheumatics	Therapeutic Class: Anxiolytic/Anipanic	and norepinephrine reuptake Therapeutic Class: Antidepressant/Neuropathic and Musculoskeletal pain reliever	Acid (GABA) Analogue Therapeutic Class: Analgesics/Anticonvulsant
Mechanism of Action	It interacts with the mu-receptors and delta receptors in the body. The interaction leads to inhibition of the nociceptive pain reflexes and induce analgesic effects without affecting sensory receptors (Jones & Bartlett, 2021).	It inhibits the enzymatic activity of the COX-2 (an enzyme needed to convert arachidonic acid to prostaglandin (is needed to mediate the inflammatory response/vasodilation). By inhibiting the COX-2 activity and prostaglandin, it reduces the inflammatory symptoms and relieves pain (Jones & Bartlett, 2021).	It increases effects of Gamma-aminobutyric acid and other neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of the CNS. This interaction inhibits the excitatory stimulation and control emotional behavior (Jones & Bartlett, 2021).	It inhibits dopamine, neuronal serotonin, and norepinephrine reuptake to potentiate noradrenergic and serotonergic activity in the CNS. It elevate mood and inhibit pain signals stemming from peripheral nerves adversely affected by chronically elevated serum glucose level (Jones & Bartlett, 2021).	It binds to alpha ₂ -delta site in CNS tissue where it may reduce calcium-dependent release of several neurotransmitters that affect the calcium channel function which lead to the decrease of pain sensation and seizure activity (Jones & Bartlett, 2021).

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Reason Client Taking	To manage moderate to severe pain.	To relieve signs/symptoms of osteoarthritis	Used to control anxiety disorders or treat anxiety related to depression	To treat depressive disorder and neuropathic pain.	To relieve neuropathic pain or manage fibromyalgia
Contraindications (2)	<ul style="list-style-type: none"> ● Hydrocodone/acetaminophen given with diuretics may reduce efficacy of diuretics. ● Hydrocodone/acetaminophen given with an anticholinergic drug may increase the risk of urinary retention. 	<ul style="list-style-type: none"> ● If patient has hypertension then the use of celebrex can cause the high blood to worsen. ● Hypersensitivity to aspirin or other NSAIDs. 	<ul style="list-style-type: none"> ● If the patient uses an opioid and is given an anxiolytic then it could result in a depression in respirations. ● Hypersensitivity to Alazopram or its components 	<ul style="list-style-type: none"> ● Hypertension ● Hypersensitivity to duloxetine or its components. 	<ul style="list-style-type: none"> ● Hypersensitivity to pregabalin or its components ● its contraindicated with the use of alcohol due to leading to additive effects on the cognition and gross motor function.
Side Effects/ Adverse Reactions (2)	<ul style="list-style-type: none"> ● Respiratory depression ● Drowsiness 	<ul style="list-style-type: none"> ● Hypertension ● Decreased Hematocrit and Hemoglobin. 	<ul style="list-style-type: none"> ● Depression ● Nervousness 	<ul style="list-style-type: none"> ● Myocardial infarction ● Suicidal Ideation 	<ul style="list-style-type: none"> ● Suicidal Ideation ● Depression
Nursing Considerations (2)	<ul style="list-style-type: none"> ● Pain relief and adverse effects should be an ongoing 	<ul style="list-style-type: none"> ● Celebrex should be used cautiously in patients 	<ul style="list-style-type: none"> ● Opioid should only be used concurrently with 	<ul style="list-style-type: none"> ● Obtain a baseline blood pressure before therapy 	<ul style="list-style-type: none"> ● Pregabalin therapy should be stopped

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	<p>frequent assessment due to the possibility for signs of toxicity.</p> <ul style="list-style-type: none"> • Opioid/Acetaminophen Toxicity can happen with 24 - 72 hours of the initial treatment or after a dose increase. Opioid toxicity assessments should include respiratory, neurological, and cardiovascular. Acetaminophen levels should be monitored due to the association of severe renal disease, which means liver/renal test and labs should be assessed due to 	<p>with hypertension because it can worsen the high blood hypertension.</p> <ul style="list-style-type: none"> • Celebrex can reduce inflammation and fever but if infection is present then celebrex can mask signs of infections. 	<p>alprazolam when other treatment options are inadequate; assessments include s/s of decreased consciousness, and respiratory status. (death can occur if prolonged)</p> <ul style="list-style-type: none"> • Plan to reduce dosage when discontinuing due to effects that can lead to dependency. 	<p>initiates and assess it periodically for changes, report any signs of orthostatic hypotension.</p> <ul style="list-style-type: none"> • Watch closely for evidence of suicidal thinking when therapy starts or when dose changes. 	<p>gradually over at least 1 week to decrease the risk of seizure activity</p> <ul style="list-style-type: none"> • Monitor Patient for any evidence of suicidal behavior or thinking when therapy starts or when dosage change.
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	possible toxicity.				
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Hospital Medications (5 required)

Brand/Generic	Amlodipine Besylate (Norvasc)	Cyclobenzaprine Hydrochloride (Flexeril)	Furosemide (Lasix)	Ipratropium Bromide - Albuterol (Duo-Neb)	Enoxaparin Sodium (Lovenox)
Dose	10mg Tab	10mg Tab	600mg Tab	0.5 -2.3 (3)mg/(3)mL	40 mg
Frequency	Daily	TID	BID	4x a day	Every 12 hours
Route	Oral	Oral	Oral	Nebulization	Subcutaneous Injections
Classification	Pharmacologic Class: Calcium-Channel Blocker Therapeutic Class: Antianginal/Antihypertensive	Pharmacologic Class: Tricyclic Antidepressant-like Agent (TCA) Therapeutic Class: Skeletal Muscle Relaxant.	Pharmacologic Class: Loop Diuretic Therapeutic Class: Antihypertensives/Diuretics	Pharmacologic Class: Anticholinergic Therapeutic Class: Bronchodilator	Pharmacologic Class: Low-molecular Weight Heparin Therapeutic Class: Anticoagulant
Mechanism of Action	Binds to dihydropyridine and nondihydropyridine cell membrane receptor sites on myocardial and vascular smooth-muscle cells and inhibits influx of extracellular calcium	Acts in the brain stem to reduce or abolish tonic muscle hyperactivity which relieves muscle spasm without disrupting muscle function (Jones &	Inhibits sodium and water reabsorption in the loop of henle and increases urine formation. The body's plasma volume decreases and aldosterone increases	Ipratropium prevents acetylcholine to attach to muscarinic receptors on membranes of smooth-muscle cells, which induces relaxation for the smooth muscles and causes	it lowers the action of antithrombin III which binds with and inactivates clotting factors (primarily factor Xa and thrombin). Clot

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	ions. This inhibits smooth-muscle cell contractions and relaxing coronary/vascular smooth muscles, decreases peripheral vascular resistance, and reducing systolic and diastolic blood pressure. It also inhibits coronary artery muscle cell contractions and restoring blood flow, drug may relieve angina (Jones & Bartlett, 2021).	Bartlett, 2021).	which prompts sodium reabsorption and encourages the loss of hydrogen ions (Acidic waste). This action reduces the body's blood pressure and decreases cardiac output (Jones & Bartlett, 2021).	bronchodilation (Jones & Bartlett, 2021).	cannot fully form (Jones & Bartlett, 2021).
Reason Client Taking	Hypertension	Muscle Spasms	Hypertension/Edema	Asthma	Postoperative prophylaxis DTV in Arthroplasty of the knee
Contraindications (2)	<ul style="list-style-type: none"> Hypersensitivity to amlodipine and its components 	<ul style="list-style-type: none"> Acute Recovery Phase of Myocardial Infarction 	<ul style="list-style-type: none"> Hypersensitivity to furosemide or its components 	<ul style="list-style-type: none"> Concurrent use of other anticholinergics may increase 	<ul style="list-style-type: none"> Use of NSAIDs concurrently can increase

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	<ul style="list-style-type: none"> No other contraindication is listed that is evident to the patients data. 	<ul style="list-style-type: none"> Hypersensitivity to cyclobenzaprine or its components. 	<ul style="list-style-type: none"> No other contraindication is listed that is evident to the patients data. 	<ul style="list-style-type: none"> anticholinergics effects such as dry mouth, dizziness, and tachycardia. Hypersensitivity of atropine, ipratropium bromide, and its components. 	<ul style="list-style-type: none"> the risk of bleeding Hypersensitivity to enoxaparin or heparin, or pork products
Side Effects/Adverse Reactions (2)	<ul style="list-style-type: none"> Arrhythmias Chest pain 	<ul style="list-style-type: none"> Dizziness Dysarthria 	<ul style="list-style-type: none"> Hyperuricemia Hypovolemia 	<ul style="list-style-type: none"> Dry Mouth Dizziness 	<ul style="list-style-type: none"> Hemorrhage Atrial fibrillation
Nursing Considerations (2)	<ul style="list-style-type: none"> Monitor blood pressure while adjusting dosage Assess the patient frequently for chest pain when starting therapy or after dose 	<ul style="list-style-type: none"> Monitor patient closely if been given cyclobenzaprine with a serotonergic drug due to a potential risk of developing life-threatening serotonin syndrome 	<ul style="list-style-type: none"> Be aware that patients who are allergic to furosemide may also be allergic to sulfonamide. Obtain patients weight before and 	<ul style="list-style-type: none"> When using a nebulizer, apply a mouthpiece to prevent drug from leaking out around the mask and causing blurred vision or eye pain. 	<ul style="list-style-type: none"> Use extreme precaution in patients with increased risk of hemorrhage, notify provider if platelet count is

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	<p>change, because worsening of angina can cause acute myocardial infarction to occur.</p>	<p>e. assess patient for mental status changes and nervous system abnormalities</p> <ul style="list-style-type: none"> • Take safety precautions to prevent falls if patient is confused, dizzy, or weak. 	<p>periodically to monitor fluid loss.</p>	<ul style="list-style-type: none"> • Monitor patient for hypersensitivity reactions that could be life-threatening. if present stop drug immediately and notify physician and provide supportive care. 	<p>below 100,000/mm³.</p> <ul style="list-style-type: none"> • Do not give this drug intramuscularly injection.
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Medications Reference (1) (APA):

- Jones & Bartlett. (2021). *Nurse's Drug Handbook* (12th ed.). Jones & Bartlett Learning.

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

GENERAL: Alertness: Orientation: Distress: Overall appearance:	<ul style="list-style-type: none"> - Patient is alert and oriented X4 to person, place, time, and situation. - No distress appearance at the moment and was resting/laying in bed with HOB elevated at 30 degrees. - Patient is alert and responsive to verbal and painful stimuli - Overall appearance was appropriate for the setting/situation
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 20 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	<p>Skin color is brown</p> <p>Skin was also dry/warm upon palpation.</p> <p>Skin turgor was retractable almost immediate.</p> <p>No signs of contusions or rashes in the trunk areas and upper/lower extremities.</p> <ul style="list-style-type: none"> - Cervical area had a slight redness in the front forehead section on the left side <p>A wound with a bandage is apparent in the right antecubital area from a previous IV insertion.</p> <ul style="list-style-type: none"> - No drainage is present <p>Braden Score is 20 (no risk - no need for pressure ulcer prevention)</p>
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	<p><u>Head/Neck:</u> Skull and face are symmetrical. Trachea is midline with no deviations. Upon palpation trachea movement is present when patient swallows. Carotid artery is palpable and is +2 bilaterally. All cervical lymph nodes are nonpalpable bilaterally. Eyelids have no visible discoloration, lesions, or swelling bilaterally.</p> <p><u>Eyes:</u> Sclera is white and clear bilaterally. Conjunctiva is pink and moist bilaterally. Pupils (PERRLA) are round and equal, reactive to light, and are able to accommodate</p>

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	<p>bilaterally. 6 Extraocular movements are present in both eyes with no deviations bilaterally.</p> <p><u>Ears:</u> No present ear tenderness upon palpation with no visible drainage or discoloration bilaterally. No visible impaction in ears bilaterally.</p> <p><u>Nose:</u> Nose septum is midline. Turbinates are moist and pink in nose bilaterally with no visible signs of bleeding. Frontal sinuses are nontender to palpation bilaterally.</p> <p><u>Teeth:</u> Uvula is midline. Soft palate and hard palate are present. Swallow reflex is present with a soft palate able to move upward. Buccal mucosa is moist. Teeth are present and are a yellow/white color and is consistent in the top section and bottom section of the mouth. Patient does cough up green thick mucus</p>
<p>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:</p>	<p>Sinus Rhythm is present along with S1 and S2 sound present. No signs of S3, S4, or murmurs.</p> <p>Heart rhythm is regular.</p> <p>Upper and lower peripheral pulses were +2 bilaterally.</p> <ul style="list-style-type: none"> - Apical pulse auscultated at the midclavicular line at the 5th intercostal space (rhythm/rate is regular). - ***<u>Could not palpate apical pulse</u>*** <p>Cap refill is less than 3 seconds.</p> <p>No signs of neck vein distention or edema in the upper/lower extremities.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>No use of accessory muscles during respiration</p> <p>Normal rate and regular pattern of respirations.</p> <p>Respirations are symmetrical and non-labored.</p> <p>Lung sounds clear throughout anterior/posterior in the upper section bilaterally.</p>

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	<p>- Lungs are congested in the lower section anteriorly/posteriorly bilaterally.</p> <p>No wheezes, crackles, or rhonchi present</p> <p>No use of accessory muscle or signs of breathing distress.</p> <p>Lung aeration is equal bilaterally.</p> <p>Patient does cough up green thick mucus</p>
<p>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 <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 type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Diet at home is regular</p> <p>Current Diet is regular</p> <p>Height is 5'4" (163 cm) and Current Weight is 267 lbs (121 kg).</p> <p>Normoactive bowel sounds in all 4 quadrants.</p> <p>Last BM was the day prior in the evening.</p> <p>No signs of pain/tenderness or mass upon palpation in all 4 quadrants.</p> <p>No signs of distention, incisions, scars, drains, or wounds upon inspection.</p> <p>No ostomy or nasogastric tube present.</p>
<p>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 type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Urine is yellow and clear.</p> <p>Urine output was 300mL (on 1x occurrence - measurable and 1x occurrence - unmeasurable) with patient denying pain when voiding.</p> <p>- Patient does use a bedside commode (due to fall risk safety precaution)</p> <p>Genitals are clean (By patient statement).</p>

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	Patient is not on dialysis and has not catheter in place for voiding.
<p>MUSCULOSKELETAL: Neurovascular status:</p> <p>ROM:</p> <p>Supportive devices:</p> <p>Strength:</p> <p>ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score: 70 (High Risk)</p> <p>Activity/Mobility Status:</p> <p>Independent (up ad lib) <input type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input checked="" type="checkbox"/></p>	<p>Neurovascular is intact with no impaired blood flow or damage to the peripheral nerves in the extremities bilaterally.</p> <p>Patient is able to perform all ROM actively in upper and lower extremities bilaterally.</p> <p>- able to do so in bed or in a chair but not standing (due to fall risk safety precautions)</p> <p>Patient uses cane, 4-wheeled walker, and a mobile electric chair.</p> <p>Muscle strength is 4/5 in upper and lower bilaterally.</p> <p>No need of ADL assistance except for toileting (assisting to bedside commode and monitoring only)</p> <p>Client is able to ambulate with the assistive devices in the hospital settings and at home.</p> <p>Fall Risk score is 70 (High Risk - recommend that the implementation of High Risk Fall Prevention Measures)</p> <p>Patient need support with ambulating to stand/walk and to a chair or bed.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p> <p>Sensory:</p> <p>LOC:</p>	<p>MAEW is intact</p> <p>PERRLA is equal, round and reactive.</p> <p>Muscle Strength in both upper and lower extremity is equal bilaterally.</p> <p>Orientated x4 to person,place, time, and situation.</p> <p>Mental status is normal with behavior appropriate to their responses.</p> <p>Speech and sensory is normal.</p>

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	LOC is 15 with patient alert and awake to question and answers appropriately.
<p>PSYCHOSOCIAL/CULTURAL:</p> <p>Coping method(s):</p> <p>Developmental level:</p> <p>Religion & what it means to pt.:</p> <p>Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Method of coping is to talk to the most their daughter and some family and letting them know of their situation.</p> <p>No deficit noted in development level.</p> <p>Patient stated that they have no religion but does believe in an certain higher power of spirituality.</p> <p>Patient is widow but has been living the oldest daughter and is really close to them along with the rest of the family. Support system is good because their family keeps calling the patients phone.</p>

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

Time	Pulse	B/P (list position)	Resp Rate	Temp	Oxygen
0735	96 Automatic Machine	144/92 - HOB elevated @ 30° - Left Brachial Artery	16 Unlabored	97.7°F Temporal	100% - Pulse Ox - On Room Air
1030	99 Automatic Machine	138/81 - HOB elevated @ 30° - Left Brachial Artery	20 Unlabored	97.5°F Temporal	95% - Pulse Ox - On Room Air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0735	1-10	Abdominal - genalized	10 - severe	Burning/Grueling	Given pharmacologic interventions Omeprazole

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0912	1-10	Lower Back	10 - Severe	Sharp/Throbbing	Given pharmacological interventions - Flexeril
1030	1-10	Lower Back	5 - Mild	Throbbing	No Interventions needed at this time.

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:	No fluid was given (it was disconnected) IV Saline Lock was in place Size of IV is 22g IV Saline Lock is located in the right upper arm (where the bicep and shoulder muscle meet) Date: 09/21/2022 Patency of IV is able to flush without difficulties No signs of erythemas, drainage, and ect. IV Dressing is clean, neat, dry, and intact.

Intake and Output (2 points)

Intake (in mL) (Make a list of what was eaten)	Output (in mL)
120 mL - snack (Granola bar and crackers)	1x occurrence - Bedside commode (unmeasurable)

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	1x Occurrence - Bedside Commode - 300 mL
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Nursing Care**Summary of Care (2 points)**

Overview of care: The patient woke up at 7000 with vitals taken at 0735. She did not ordered breakfast in the morning. Patient did not wanted breakfast from the hospital. Patient did take all morning medication but did had a problem with one medication due to the size and almost choked on it. Patient had needed assistance to void (urinate) in the bedside commode but was unable to measure the amount. At 0912, the patient reported that the pain level was at 10/10 in the lower back area. Pharmacological interventions was given (Flexeril) to relieve pain. At 1030 the patient stated that the pain level was at 5/10 and verbalized to be feeling better.

Procedures/testing done: The patient had occupational therapy visit to work on active range of motions. No other tests was performed

Complaints/Issues: The patient was upset with the food that the hospital provide and stated that it was not to their liking. The patient asked the nurse if they could order food outside of the facility to be brought to her.

Vital signs (stable/unstable): All vital signs were stable except for the Blood pressure. The blood pressure at 0735 was 144/92 and at 1030 it was 138/81. The patients primary RN Nurse was notified of blood pressure findings on both occurrences.

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Tolerating diet, activity, etc.: Patient did not want the food at the hospital and wanted outside food. Patient requested assistance to ambulate to the bedside commode. The patient tolerated active range of motion exercises very well.

Physician notifications: No notification

Future plans for client: Needs to evaluate on patients strength, to be later discharge and return home.

Discharge Planning (2 points)

Discharge location: The patients home with her daughter

Home health needs (if applicable): None required

Equipment needs (if applicable): No additional equipment needed

Follow up plan: Follow up with the primary provider to discuss the recent pneumonia infection.

Education needs: The patient needs education on how to stay healthy and prevent infections that can cause respiratory illness.

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Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

(3) Nursing Diagnosis <ul style="list-style-type: none"> ● Include full nursing diagnosis with “related to” and “as evidence 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. ● Is the Goal met or unmet?
1.) Ineffective airway clearance related to excess mucus in the lungs as evidence by alteration of breath sounds (congestive sounds), excessive sputum (thick and green) coughed up, and neutrophil count at 76.1% (High) that means infection.	This is relates to the patient due to the recent diagnosis of the principle problem is pneumonia.	1.) Avoid placing patient in supine position, encourage lateral or sitting positions as much as possible to enhance lung expansion and ventilation (Phelps, 2020). 2.) Encourage Patient to increase	The patient will be able to cough up the sputum as much as possible within a days time Patient will also able to drink 2 bottles (32oz) of water or other clear liquids per meal within a 24hr period to ensure hydration and to loosen secretions.	Response to actions: not sure, did not stay long to implement and evaluate. Response to goal: Not sure did not assess due to time restraints. Goal unmet: due to inability to implement and evaluate.

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		adequate intake of water (3 - 4 L/day) to ensure optimal hydration and loosening of secretions (Phelps, 2020).		
2.) Impaired Physical Mobility related to alteration in gait as evidence by up and assist to use bedside commode, uses assistive devices such as cane and electrical mobile chair, and having ¼ muscle strength in all extremities.	The nursing diagnosis relates to the patient because of the a slight weakness is noted in muscle strength and patient needed to use a assistive device to move.	1.) Perform range of motion exercises actively at least once per shift and able to maintain muscle contraction for long periods of times (Phelps, 2020). 2.) Provide progressive mobilization to the limits of patients capabilities to prevent immobility (Phelps, 2020).	Within 2 weeks, the patient will be able to perform active range of motion exercises 2 per shift and maintain strength for a 30 second hold Within 7 days, the patient will be able to achieve a higher level of mobility such as being able to stand up without assistance.	Response to actions: not sure, did not stay long to implement and evaluate. Response to goal: Not sure did not assess due to time restraints. Goal unmet: due to inability to implement and evaluate.
3.) Risk for infection related to insufficient knowledge to avoid exposure to pathogen as evidence by the provider	This is relevant because of the recent diagnosis of pneumonia.	1.) Minimized patient's risk of infection by following standard precautions such as washing	During the entire shift(s), the patient will remain free from signs/symptoms of infection. At the point of discharge, the	Response to actions: not sure, did not stay long to implement and evaluate. Response to goal: Not sure did not

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<p>stating that later for discharge the patient will need to know ways to prevent respiratory infection, patient cough up greenish sputum, lung sounds are congestive, and neutrophil count at 76.1%</p>		<p>hands and wearing gloves and mask to maintain asepsis when carrying out certain procedures (Phelps, 2020).</p> <p>2.) Teach the patient about good hand washing, factors that increase infection risk, and signs and symptoms of respiratory infection (Phelps, 2020).</p>	<p>patient will be taught and be able to state measures to prevent infection such as knowing how to wash hands, relevant factors that increases the patients risk of infection, and state sign/symptoms of respiratory infection.</p>	<p>assess due to time restraints.</p> <p>Goal unmet: due to inability to implement and evaluate.</p>
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Other References (APA):

- Phelps, L. (2020). *Sparks & Taylor's nursing diagnosis reference manual* (11th ed.). LWW.

Concept Map (20 Points):

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Subjective Data

- Patient stated that they felt weak and had a hard time catching their breath.
- Patient also stated that they felt dizzy that gotten progressively worse with a loss of balance.
- Patient states that his pain during the time was a 5 on a 1-10 scale

Objective Data

- Blood pressure at 1030 was 138/81 sitting with the head of the bed elevated at 30°.
- Able to perform ROM actively
- Neutrophil count is 76.1 (which is high) = infection.
- Leukoesterase on urinalysis lab is a +2
- Fall risk score is 70 (High Risk)

Nursing Diagnosis/Outcomes

- Nursing diagnosis: Ineffective airway clearance related to excess mucus in the lungs as evidence by alteration of breath sounds (congestive sounds), excessive sputum (thick and green) coughed up, and neutrophil count at 76.1% (High) that means infection.
 - Goal: Keep airways clear from mucus during intervention for 2 days.
- Nursing Diagnosis: Impaired Physical Mobility related to alteration in gait as evidence by up and assist to use bedside commode, uses assistive devices such as cane and electrical mobile chair, and having % muscle strength in all extremities.
 - Goal: it to improve muscle strength or achieve a new level of mobility within 1 week.
- Nursing Diagnosis: Risk for infection related to insufficient knowledge to avoid exposure to pathogen as evidence by the provider stating that later for discharge the patient will need to know ways to prevent respiratory infection, patient cough up greenish sputum, lung sounds are congestive, and neutrophil count at 76.1%
 - Goal: At the end of discharge, the patient will state how to keep themselves safe from respiratory infections and factors to increases risk of infection.

Nursing Interventions

- Avoid placing patient in supine position, encourage lateral or sitting positions as much as possible to enhance lung expansion and ventilation.
- Encourage Patient to increase adequate intake of water (3 - 4 L/day) to ensure optimal hydration and loosening of secretions
- Perform range of motion exercises actively at least once per shift and able to maintain muscle contraction for long periods of times
- Teach the patient about good hand washing, factors that increase infection risk, and signs and symptoms of respiratory infection.

Client Information

69 year old female admitted with shortness of breath. Has history of Hypertension, Asthma, COPD, Past pneumonia infection prior, renal insufficiency, Lupus, fibromyalgia, GERD, and depression.

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