N431 Care Plan 1

Lakeview College of Nursing

Brooke Valles

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
10/15/2022	B, S	88 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	No known allergies
Code Status	**Height**	**Weight**	
Full code	88.3 kg	182.2 cm	

Medical History (5 Points)

Past Medical History: The patient has a history of COPD, dementia, hypertension, hyperlipidemia, and acid reflux.

Past Surgical History: The patient underwent a cataract surgery in 2009, trigger point injections in 2015, and had a stent placed in 2019.

Family History: The patient's father has a history of Myocardial infarction, and his mother has a history of hypertension and hypothyroidism.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient denies any use of drugs or tobacco. The patient states he occasionally has one beer every other month or so at celebrations or holidays.

Assistive Devices: Walker, Oxygen, and CPAP.

Living Situation: The client is living at an assisted living facility in Oakland, IL.

Education Level: The client has completed some college but does not have a college degree.

Admission Assessment

Chief Complaint (2 points): Cough, shortness of breath, and increased work of breathing.

History of Present Illness – OLD CARTS (10 points): The patient is an 88-year-old Caucasian male that presented to the emergency department by emergency medical services after having a cough for several days, shortness of breath, and increased work of breathing. The patient has an

albuterol inhaler that he was using every four hours with no relief. The patient has a history of COPD, dementia, hypertension, hyperlipidemia, and acid reflux. During my shift the patient had continuous irritation during care and decreased mental orientation. The patient has a sitter present at bedside for around the clock supervision.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Bacterial pneumonia

Secondary Diagnosis (if applicable): N/A

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

Pneumonia is an acute inflammatory reaction due to lung infection (Alcón, 2018). Several infectious agents can cause pneumonia, such as bacteria, mycobacteria, a fungus, a virus, or a parasite (Alcón, 2018). This patient suffers from a bacterial infection that is causing the inflammatory process in the lungs. Pathogens continuously enter the airway, but the body's autoimmune defenses disrupt and prevent the colonization of the agent (Alcón, 2018). In pneumonia, the autoimmune defense mechanisms are overwhelmed, allowing the pathogen to reach the alveoli and colonize (Mayo Clinic, 2020). The alveoli fill with fluid or purulent fluid, which causes respiratory symptoms (Mayo Clinic, 2020). Pneumonia can range from a mild cough to a life-threatening infection (Mayo Clinic, 2020). The most at-risk populations are infants or younger children and adults over sixty-five (Mayo Clinic, 2020).

Symptoms for pneumonia range from mild to severe and can also differ on what type of pathogen is causing the infection. The most common symptoms include chest pain, confusion, productive cough, fatigue, fever, diaphoresis, chills, nausea, vomiting, and shortness of breath (Mayo Clinic, 2020). My patient has developed a productive cough, confusion, and shortness of

breath. Older adults and infants need to be seen by a physician or a care provider when increased work of breathing and shortness of breath is present (Mayo Clinic, 2020).

Pneumonia can be diagnosed in several ways, including a chest x-ray, blood tests, and a sputum culture (Mayo Clinic, 2020). The chest x-ray can view any abnormalities within the chest cavity (Mayo Clinic, 2020). Blood tests can determine the type of organism causing the infection, and a sputum culture will help pinpoint the source of the infection (Mayo Clinic, 2020). My patient received a chest x-ray for diagnostic purposes, which viewed opacities in the left lower lobe. My patient also received blood tests and a sputum culture that showed a diagnosis of bacterial pneumonia.

Treatment for pneumonia varies per source of infection. Most cases of pneumonia can be treated at home with over-the-counter antipyretics and cough suppressants (Mayo Clinic, 2020). More severe cases will be treated with antibiotics and albuterol breathing treatments (Mayo Clinic, 2020). My patient is being treated with levofloxacin to treat the bacterial infection in the lungs.

Pathophysiology References (2) (APA):

Alcón A, Fàbregas N, Torres A. Pathophysiology of pneumonia. *Clin Chest Med.* (2018). (1):39-46. doi: 10.1016/j.ccm.2004.10.013. PMID: 15802164.

Mayo Clinic. (2020). *Pneumonia- Symptoms, Causes, Diagnosis, and Treatment.* https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes/syc-20354204

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	3.8-5.41	3.96	N/A	N/A
Hgb	11.3-15.2	12.9	N/A	N/A
Hct	33.2-45.3	38.1	N/A	N/A
Platelets	149-393	67	N/A	The patient's platelet count is diminished due to the pneumonia infection. The patient is in the acute febrile stage of a pneumonia infection where it is common to see diminished platelet counts.
WBC	4-11.7	5.2	N/A	N/A
Neutrophils	45.3-79	70.2	N/A	N/A
Lymphocytes	11.8-45.9	12.1	N/A	N/A
Monocytes	4.4-12	13.6	N/A	Monocytes are known to be increased during the first infection stage of bacterial pneumonia (Hickling, 2022).
Eosinophils	0-6.3	4.6	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	138	N/A	N/A
K+	3.5-5.1	4.0	N/A	N/A
Cl-	98-107	107	N/A	N/A
CO2	21-31	24	N/A	N/A
Glucose	74-109	88	N/A	N/A
BUN	7-25	15	N/A	N/A

Creatinine	0.6-1.2	1.05	N/A	N/A
Albumin	3.5-5.2	N/A	N/A	N/A
Calcium	8.6-10.3	8.2	N/A	Heparin is linked to lowering serum calcium levels in acute use (Urban et al., 2019).
Mag	1.8-2.6	N/A	N/A	N/A
Phosphate	2.7-4.6	N/A	N/A	N/A
Bilirubin	0.3-1	N/A	N/A	N/A
Alk Phos	34-104	N/A	N/A	N/A
AST	13-39	N/A	N/A	N/A
ALT	7-52	N/A	N/A	N/A
Amylase	0-90	N/A	N/A	N/A
Lipase	0-70	N/A	N/A	N/A
Lactic Acid	4.5-19.8	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	1-2	N/A	N/A	N/A
PT	10-12	N/A	N/A	N/A

PTT	30-45	N/A	N/A	N/A
D-Dimer	Less than 0.5	N/A	N/A	N/A
BNP	Less than 100	N/A	N/A	N/A
HDL	60 and greater	N/A	N/A	N/A
LDL	Less than 100	N/A	N/A	N/A
Cholesterol	Less than 200	N/A	N/A	N/A
Triglycerides	Less than 150	N/A	N/A	N/A
Hgb A1c	Less than 5.7%	N/A	N/A	N/A
TSH	0.5-5	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	Clear to yellow	Yellow	N/A	N/A
pH	5-8	6.0	N/A	N/A
Specific Gravity	1.005-1.034	1.050	N/A	N/A
Glucose	Normal	Normal	N/A	N/A
Protein	Less than 150	Less than 150	N/A	N/A
Ketones	Negative	Negative	N/A	N/A
WBC	Less than 5	Less than 5	N/A	N/A
RBC	0-3	N/A	N/A	N/A
Leukoesterase	Negative	N/A	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	N/A	N/A	N/A
PaO2	75-100	N/A	N/A	N/A
PaCO2	35-45	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A
SaO2	95-100	N/A	N/A	N/A

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	Positive for bacteria nonspecific	N/A	The patient has an active infection of bacterial pneumonia
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Hickling, R. (2022). The Monocytes in Pneumonia: A Clinical and Hematologic Study. *Arch Intern Med (Chic).* 1927;40(5):594–604. doi:10.1001/archinte.1927.00130110022002

Urban P, Scheidegger D, Buchmann B, Skarvan K. (2019). The hemodynamic effects of heparin and their relation to ionized calcium levels. J Thorac Cardiovasc Surg. 1986 Feb;91(2):303-6. PMID: 3945097.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest x-ray, Chest CT

Diagnostic Test Correlation (5 points):

The chest x-ray was performed on the patient to visualize any possible lung infections or abnormalities. Chest x-rays attempt to visualize any cardiac or pulmonary dysfunction (Mayo clinic, 2022). The patient's chest x-ray showed left lower opacities which is congruent with the diagnosis of bacterial pneumonia.

Diagnostic Test Reference (1) (APA):

Mayo Foundation for Medical Education and Research. (2022, March 5). *Chest x-rays*. Mayo Clinic. Retrieved September 10, 2022, from https://www.mayoclinic.org/tests-procedures/chest-x-rays/about/pac-20393494

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

Home Medications (5 required)

Brand/Generic	Atorvastatin/ Lipitor	Pantoprazole / Protonix	Acetylsalicylic acid/ Aspirin	Centrum Multivitamin	Amlodipine/ Norvasc
Dose	40 mg	40 mg	81 mg	1 tablet	10 mg
Frequency	QD	QD	QD	QD	QD
Route	PO	PO	PO	PO	PO
Classification	Therapeutic class: Antilipemic Pharmacological class: HMG-CoA reductase inhibitors	Therapeutic: Antiulcer drug Pharmacological: PPI	Therapeutic: NSAID Pharmacologic: Salicylates	Therapeutic: Multivitamin Pharmacological: Multivitamin and iron product	Therapeutic: Antihypertensive Pharmacologic: Calcium channel blocker
Mechanism of Action	This drug inhibits HMG-CoA reductase in cholesterol biosynthesis.	Inhibits proton pump activity to inhibit gastric acid secretion.	The drug in low doses interferes with clotting by keeping a platelet	This drug binds vitamins and minerals to the body's natural supplementat	This drug inhibits calcium ion influx across cardiac and smooth muscle cells.

			aggregating substance from forming.	ion to prevent vitamin deficiency.	
Reason Client Taking	Hyperlipidemia	Acid reflux	Prophylactic use for prevention of clotting or myocardial infarction.	Prophylactic use to prevent vitamin deficiency in older age.	Hypertension
Contraindications (2)	A patient with hepatic impairment or renal failure should not take this medication.	This drug is contraindicated in patients with osteoporosis. The nurse should caution administration in patients with an autoimmune disorder.	This drug should not be taken by a patient with bleeding disorders or a patient with severe hepatic impairment.	A patient with increased iron storage should not take this medication. A patient with hemolytic anemia should not take this medication.	A patient with severe hepatic impairment should use caution with this drug. A patient already receiving therapy from a peripheral vasodilator should take caution with this drug.
Side Effects/Adverse Reactions (2)	Insomnia, dyspepsia, and muscle spasms.	Anxiety, dizziness, blurred vision, and abdominal pain.	Cerebral edema, headache, lethargy, gastrointestinal bleeding, and renal failure.	Constipation, diarrhea, and abdominal pain.	Headache, fatigue, palpitations, and abdominal pain.
Nursing Considerations (2)	The nurse should watch for myositis which includes monitoring for unexplained muscle pain,	The nurse should discontinue use of the drug if symptoms of SLE start to develop. The nurse should caution this	The nurse should monitor the patient closely due to the increased risk of toxicity in elderly	The nurse should assess for hepatic impairment before administration of this medication. The nurse should assess	The nurse should monitor for severe angina and signs of heart failure with this medication.

	dark urine, and fever. The nurse should also follow a standard lowering cholesterol diet for the patient.	drug due to the look alike sound alike drug Prilosec.	patients. The nurse monitor for gastrointestinal bleeding in the client.	for renal impairment before administration of this medication.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	The nurse should monitor ALT, AST, and CK levels prior to administration of the drug.	This medication may increase glucose and lipid levels.	The nurse should monitor hematocrit, PT, INR, BUN, creatinine, platelet, and WBC count.	The nurse should monitor ALT, AST, BUN, and creatinine.	The nurse should monitor blood pressure frequently with this medication because it induces vasodilation.
Client Teaching Needs (2)	The nurse should educate the client on proper dietary management and weight control. The nurse should also educate the patient that the drug can be taken at any time of the day with or without food.	The nurse should educate the patient to take this medication exactly as prescribed and at the same time very day. The nurse should educate the patient to take this medication whole.	The nurse should educate the client to maintain a low sodium diet since aspirin contains 553 mg of sodium. The nurse should educate the client not to crush or chew the tablet while taking this medication.	The nurse should educate the client not to take more than the daily allotted amount. The nurse should educate the client to monitor for nausea, vomiting, or abdominal pain as these are symptoms of iron overload.	The nurse should educate the patient on signs and symptoms of heart failure such as swelling of hands or shortness of breath. The nurse should educate the patient to continue medication therapy even if the patient's symptoms decrease.

Hospital Medications (5 required)

Brand/Generic	Levofloxacin / Levaquin	Risperidone/ Risperidal	Heparin	Docusate sodium/ Colace	Polyethylene Glycol/ Miralax
Dose	500 mg	0.5 mg	5,000 units in 5 ml	50 mg	17 grams
Frequency	QD	BID	QAM	QD	BID
Route	PO	PO	SQ	PO	PO
Classification	Therapeutic: Antibiotic Pharmacological: Fluroquinolone	Therapeutic: Antipsychotic Pharmacological: Benzisoxazole derivative	Therapeutic: Anticoagulant Pharmacological: Anticoagulant	Therapeutic: Laxative Pharmacological: Sulfonic acid	Therapeutic: Laxative Pharmacologic: Osmotic laxative
Mechanism of Action	Inhibits bacterial DNA replication, transcription, repair, and recombination.	This drug blocks dopamine and alpha-1/ alpha-2 receptors in the brain.	This drug accelerates the formation of antithrombin complex and prevents conversion of fibrinogen to fibrin.	This drug increases the amount of water in the stool which makes the stool softer and easier to pass.	This drug draws water into the colon and softens the stool. This drug also may cause the colon to naturally contract.
Reason Client Taking	Bacterial pneumonia	Dementia related behaviors.	Prevention of clotting or deep vein thrombosis while in the hospital.	Constipation	Constipation
Contraindications (2)	This drug has a black box warning for increased risk of tendinitis		This medication should not be taken in clients who are allergic to	A patient with severe abdominal pain or a blockage in the intestines	A patient with an intestinal blockage or a known allergy to

	and tendon rupture. This drug has a black box warning for increased exacerbation of muscle weakness.		pork. The nurse should use caution in administration in patients with thrombocytopenia.	should not take this medication.	polyethylene glycol should not take this medication.
Side Effects/Adverse Reactions (2)	Encephalopathy, dizziness, headache, edema, and chest pain.	Agitation, anxiety, parkinsonism, hallucination, and impaired concentration.	Fever, rhinitis, osteoporosis, hematoma, and urticaria.	Abdominal pain, abdominal cramping, nausea, and vomiting.	Severe abdominal pain, nausea, vomiting, and stomach cramping.
Nursing Considerations (2)	The nurse needs to monitor the patient for increased muscle weakness or fatigue. The nurse should monitor the patient for signs and symptoms of peripheral neuropathy.	The nurse should caution administration with a sedative medication. The nurse caution administration with antiarrhythmic medications.	The nurse should monitor for hyperkalemia during therapy. The nurse should inspect the client for gum bleeding, bruising, and hematuria.	The nurse should monitor for diarrhea in the patient taking this medication. The nurse should caution administration with this medication with magnesium sulfate.	The nurse should monitor intake and output closely in a client taking this medication. The nurse should monitor increased frequency of loose stools occurring more than a couple days.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	This medication can increase glucose and eosinophil counts.	There are no labs or vital signs to monitor with this medication.	The nurse needs to monitor INR, PT, and aPTT during heparin therapy.	The nurse should monitor electrolyte and fluid imbalances with this medication.	The nurse should monitor electrolyte and fluid imbalances with this medication.

Client Teaching Needs (2)		The nurse should educate the patient and family on signs and symptoms of decreased mental cognition. The nurse should educate the signs and symptoms of decreased urine output or pain with urination.	The nurse should educate the patient in signs and symptoms of abnormal bleeding. The nurse should educate the client to avoid taking over the counter medications containing aspirin.	The nurse should educate the patient to monitor for diarrhea or frequent loose stools lasting more than a couple days.	The nurse should educate the patient to monitor for diarrhea or frequent loose stools lasting more than a couple days.

Medications Reference (1) (APA):

Cleveland Clinic. (2019). Stool softener: Uses and side effects.

https://my.clevelandclinic.org/health/drugs/23274-stool-softener

Jones & Bartlett Learning. (2021). *2022 Nurse's Drug Handbook.* Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was alert, awake, and oriented to person and time. The patient was not oriented to time, place, or situation. The patient did not display any form of distress. The patient is well developed, hydrated, and nourished.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:**	The patient's skin color was appropriate for ethnicity. The patient's skin was warm and dry upon palpitation. The patient had no rashes, bruises, or wounds present upon inspection. The patient's skin turgor was loose. The patient's nails showed no cyanosis, and the capillary refill was less than 3 seconds in the fingers and toes

Wounds: . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	bilaterally. The patient's Braden score was 18. The patient had no drains present upon inspection.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patients head and neck are symmetrical at midline. The patient's sclera was white bilaterally. The patient's conjunctiva was pink and moist bilaterally with no drainage present. PERRLA was intact bilaterally. The eyelids displayed no wounds or bruises bilaterally. Extraocular movement was intact bilaterally. The patient's septum was symmetrical at midline with no deviation. The auricles displayed no lesions, bruises, or wounds bilaterally. The nares show no signs of epistaxis bilaterally. The patient's uvula was at midline and the soft palate rose and fell symmetrically. The patient's oral mucosa was pink and moist. The hard palate was intact. The patient has no teeth, but gums were intact and well cared for displaying no lesions, wounds, or ulcers in the mouth. The patient's dentures were also well cared for.
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:**	The patient had clear S1 and S2 heart sounds with a normal rate and rhythm. No murmurs, gallops, or rubs were present, and the patient does not complain of chest pain or syncopal episodes. The patient had palpable +2 pulses at the carotid, brachial, radial, popliteal, and dorsalis pedis locations. The patient displayed no edema or neck vein distention. The patient had a capillary refill of less than 3.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient has normal rate and rhythm of respirations with no accessory muscle use. The patient had coarse crackles in the anterior and posterior lower lobes bilaterally.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:**	The patient is on a heart healthy diet at home and at the hospital. The abdomen is soft and nontender upon palpitation in all four quadrants with no organomegaly present. Bowel sounds are active in all four quadrants. The patient has no abdominal wounds, scars, distention, incisions, or wounds present. The patient has no ostomy, nasogastric, or PEG tube present. The patient's last bowel movement was 10/15/22. The patient

Distention: **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	is 88.3 kg and is 182.2 cm tall.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient's urine is clear and yellow with no sediments. The patient does not complain of pain, frequency, or urgency with urination. The patient is not on dialysis. The genitals presented no abnormalities upon inspection. The genitals were clean and intact with no lesions, wounds, or scars present. The patient did not have a catheter placed.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	All of the patient's extremities have full range of motion with no motor deficits noted. The patient's muscle strength was 5/5 bilaterally in all extremities. Deep tendon reflexes are 2+ in all extremities bilaterally. The patient is a one assist with a slow unstable gait. The patient utilizes a walker for assistance during movement. The patient is not up independently and requires assistance with ADL's. The patient needs assistance with equipment and support to stand and walk. The patient is a fall risk with a fall score of 60.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	All of the patient's extremities move well with PERLA intact bilaterally. The patient's strength is equal in all extremities bilaterally. The patient is oriented to person and time (x2). The patient has clear speech but suffers from continuous memory loss due to dementia. The patient felt sensation is all extremities bilaterally and was completely conscious.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):**	The patient states that he watches television or speaks with his family often as a coping method.

Developmental level: **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient's development is adequate for age. The patient states that he is Christian but does not practice in the religion heavily. The patient expresses the strong bond between him and his wife and son.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0857	77 bpm	105/78 mmHg	16 breaths per minute	36.4 Celsius	95% on 2L of oxygen via nasal cannula
1130	78 bpm	116/82 mmHg	18 breaths per minute	36.2 Celsius	97% on 2L of oxygen via nasal cannula

Vital Sign Trends:

The patient's vital signs remain stable with an increase of oxygen saturation.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0857	Numeric	N/A	0/10	N/A	N/A
1100	Numeric	N/A	0/10	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 did not have an IV placed.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
720	800

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was admitted to the hospital 3 days ago due to shortness of breath, coughing, and increased work of breathing. During my shift, the patient had a consistent, productive cough with no relief from pharmacological treatment. The patient did not have enough strength to cough the sputum from the airway, resulting in consistent shortness of breath. The patient had a sitter present at the bedside self-injuring instances such as pulling out his IV. The patient was compliant with all care and assessments but seemed increasingly agitated during these times. The patient ordered breakfast and ate 80% of his meal, so he tolerated his diet well. The patient remains inpatient but plans to be discharged to an assisted living facility for continued care.

Procedures/testing done: The patient did not have any procedures or testing done during my shift.

Complaints/Issues: The patient had no complaints during my shift but continued to verbalize needs such as going to the bathroom or when he needed assistance changing position.

Vital signs (stable/unstable): The patient's vital signs remained stable throughout my shift, with increased oxygen saturation after a respiratory therapy session.

Tolerating diet, activity, etc.: My patient ordered breakfast at 0750 and ate 80% of his meal. Therefore, he tolerated her diet well. The patient got out of bed several times with assistance and sat in his chair for 2 hours before requesting to be put back into bed. The patient's strength remained strong in all extremities bilaterally during my shift.

Physician notifications: No physicians were notified during my shift.

Future plans for client: The patient will set up appointments with his primary care physician to check in after discharge. These appointments have still not been made.

Discharge Planning (2 points)

Discharge location: My patient will be discharged to Oak's manor assisted living facility in Oakland, IL for further assistance and care.

Home health needs (if applicable): N/A

Equipment needs (if applicable): The patient utilizes a daily walker but does not need further assistive devices.

Follow up plan: The patient will follow up with his primary care provider following discharge.

Education needs: The patient requires further education on personal limitations. The patient attempts to get up by himself and needs to be educated about the danger of this action. The patient also needs further education on medication compliance since he voiced that he does not remain compliant with his meds at home.

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

Nursing Diagnosis	Rationale	Interventions	Outcome	Evaluation

• 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	• Explain why the nursing diagnosis was chosen	**(2 per dx)**	**Goal (1 per dx)**	• 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 increased sputum production as evidenced by abnormal breath sounds.	This diagnosis was chosen due to the patient not having enough strength to clear his own airway by coughing.	**1.**Raise the head of the bed to 30 degrees. **2.** Frequent respiratory therapy sessions to obtain a clear and continuous airway for the patient.	**1.** The patient will obtain and maintain an adequate airway to ensure optimal gas exchange.	The patient responded well to all interventions. The patient has begun to use the incentive spirometer more often and shows interest in continuing care to increase airway capabilities.
2. Ineffective breathing pattern related to increased work of breathing as evidenced by diminished oxygen saturation while on oxygen therapy.	This diagnosis was chosen due to the patient having an inconsistent airway and a decreased oxygen saturation while being on 2 liters of oxygen via nasal cannula continuously.	**1.** Assist the patient into fowlers position. **2.** Titrate oxygen therapy as needed to maintain an optimal oxygen saturation.	**1.** The patient's work of breathing will decrease, and the patient's oxygen saturation will increase.	The patient responded well to all interventions. The patient's oxygen saturation has trended upwards, and the patient expresses easier breathing.
3. Fluctuation in cognition related to acute infection as evidenced	This diagnosis was chosen due to the apparent decrease in cognition of	**1.** Frequent neurological assessments to ensure the patients condition is not	**1.** The patient's cognition and orientation will increase to person,	The patient has responded well to all interventions. The patient is able to identify everyone in the room, where

by alertness and orientation to person and place.	the patient related to the infection he is suffering from.	declining. **2** Frequently orient the client to person, place, situation, and time.	place, situation, and time. The patient will be able to communicate these back to me.	he is, and why he is in the hospital.
4. Disturbed sleep pattern related to interruptions as evidenced by the change of normal routine.	This diagnosis was chosen due to the decreased amount of sleep the patient is getting due to frequent assessments.	**1.** Decrease the patient's intake of caffeinated beverages. **2.** Cluster care and assessments to give the patient elongated periods of rest.	**1.** The patient's rest will increase which will increase optimal healing of the acute bacterial infection.	The patient responded well to all interventions. The patient has had increased rest since new interventions have been in place.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient shows decreased ability and strength to clear his own airway of sputum production.
The patient displays increased levels of irritability.
The patient displays coarse crackles in lower lobes bilaterally.

Nursing Diagnosis/Outcomes

Ineffective airway clearance related to increased sputum production as evidenced by abnormal breath sounds.
Ineffective breathing pattern related to increased work of breathing as evidenced by diminished oxygen saturation while on oxygen therapy.
Fluctuation in cognition related to acute infection as evidenced by alertness and orientation to person and place.
Disturbed sleep pattern related to interruptions as evidenced by the change of normal routine.

Objective Data

Vital signs: 0857: Pulse- 77 bpm, BP- 105/78 mmHg, RR- 16 breaths per minute, Oxygen: 95% on 2L O2 vis nasal cannula, Temperature: 36.4 Celsius.
Chest x-ray: Left lower opacities present
Sputum culture: Bacteria present in sputum expelled from the lungs
Increased work of breathing
Lab values: Platelets: 67 (decreased), Monocytes: 13.6 (increased)

Client Information

The client is an 88-year-old Caucasian male with a history of COPD, dementia, hypertension, hyperlipidemia, and acid reflux. The patient presented to the emergency department with shortness of breath and increased work of breathing.

Raise the head of the bed to 30 degrees.

Nursing Interventions

2. Frequent respiratory therapy sessions to obtain a clear and continuous airway for the patient.
1. Assist the patient into fowlers position.

2. Titrate oxygen therapy as needed to maintain an optimal oxygen saturation.
1. Frequent neurological assessments to ensure the patient's condition is not declining.

2 Frequently orient the client to person, place, situation, and time.
1Decrease the patient's intake of caffeinated beverages.

2. Cluster care and assessments to give the patient elongated periods of rest.