N431 Care Plan #2

Lakeview College of Nursing

Marianna Craighead

Demographics (3 points)

Date of Admission 10/22/22	**Client Initials** N.B	**Age** 73	**Gender** female
Race/Ethnicity White	**Occupation** NA	**Marital Status** Married	**Allergies** NKA
Code Status Full	**Height** 167.7 cm	**Weight** 70.6 kg	

Medical History (5 Points)

Past Medical History: Breast Cancer, Lymphoedema, hypertension, depression, COVID-19, Osteoporosis, Suicide attempts x 4, arrhythmias

Past Surgical History: Angioplasty, Bone biopsy, pacemaker, Hip surgery

Family History: Mother leukemia, father prostate cancer, Brother leukemia, Aunt Breast cancer

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

Denies any use

Assistive Devices: walker

Living Situation: Lives at home with husband

Education Level: High School

Admission Assessment

Chief Complaint (2 points): SOB with RUQ pain

History of Present Illness – OLD CARTS (10 points): The patient came into ER due the due to having RUQ pain with SOB. The patient was just discharged from the hospital on 10/21/22 with COVID-19. The patient had not tried anything to relieve pain. The husband was concerned with her SOB and thought it would be best to come in and get her checked out.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute Respiratory Failure

Secondary Diagnosis (if applicable): B/L PE

Pathophysiology of the Disease, APA format (20 points): Acute Respiratory Failure see page 4

Pathophysiology References (2) (APA):

Matthay, M. A., Zemans, R. L., Zimmerman, G. A., Arabi, Y. M., Beitler, J. R., Mercat, A., ... & Calfee, C. S. (2019). Acute respiratory distress syndrome. *Nature reviews Disease primers*, *5*(1), 1-22.

Mayo Foundation for Medical Education and Research. (2022, August 3). *Ards*. Mayo Clinic. Retrieved November 5, 2022, from https://www.mayoclinic.org/diseases-conditions/ards/symptoms-causes/syc-20355576

Acute Respiratory Failure

Acute respiratory failure is defined by the onset of noncardiogenic pulmonary edema, hypoxemia, and mechanical ventilation (Matthey et al., 2019). Acute respiratory failure is most common in the setting of pneumonia, sepsis, aspiration of gastric contents, or severe trauma (Matthey et al., 2019). The mortality rate remains high at 30-40% in most cases (Matthey et al., 2019).

Signs and symptoms of acute respiratory failure are the following, severe shortness of breath, Labored and unusually rapid breathing, low blood pressure, confusion, and fatigue (Mayo Clinic, 2022). Mrs. N.B. came into the emergency department with shortness of breath and hypoxemia. Complications of acute respiratory failure are the following, blood clots, pneumothorax, infections, and pulmonary fibrosis (Mayo Clinic, 2022). Mrs. N.B. also was diagnosed with bilateral pulmonary embolisms and infiltrates. Mrs. N.B. also is fatigued and is confused at times.

Diagnosis for respiratory failure is based on the physical examination, chest x-ray/CT, and oxygen level. Mrs. N.B. had a chest CT, physical examination, and monitoring of oxygen saturation to confirm her diagnosis of acute respiratory failure. Lab tests that are used to confirm the severity of respiratory failure are ABGs (Mayo Clinic, 2022).

There are many ways to treat acute respiratory failure. The first goal in treating is to improve the level of oxygen within the blood (Mayo Clinic, 2022). This is done with supplemental oxygen and mechanical ventilation. Mrs. N.B. is on 3L of oxygen continuously. There is a medication that can be used to help treat respiratory failure. Medications are used to prevent and treat infections, relieve pain and discomfort, and prevention of blood clots (Mayo Clinic, 2022). Mrs. N.B. is on antibiotics and uses morphine.

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	3.5-5.2	2.74	2.53	This lab could be abnormal due to anemia (Hinkle & Cheever, 2022).
Hgb	12-18	9.2	7.54	This lab could be abnormal due to anemia (Hinkle & Cheever, 2022).
Hct	37-51%	28%	24.2%	This lab could be abnormal due to anemia (Hinkle & Cheever, 2022).
Platelets	140-400	355	150	This value is within normal limits
WBC	4-11	8.76	5.9	This value is within normal limits
Neutrophils	1.6-7.7	7.59	4.18	This value is within normal limits
Lymphocytes	1.0-4.90	1.61	1.23	This value is within normal limits
Monocytes	0-1.0	0.49	0.46	This value is within normal limits
Eosinophils	0-0.50	0.02	0.01	This value is within normal limits
Bands	0.01-0.20	0.02	0.01	This value is within normal limits

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-	135-145	135	138	This value is within normal limits
K+	3.5-5.1	4.7	4.0	This value is within normal limits
Cl-	98-107	102	106	This value is within normal limits
CO2	22-29	22	23	This value is within normal limits
Glucose	74-100	143	76	This lab value could be abnormal related to malnutrition (Hinkle & Cheever, 2022).
BUN	0.2-1.2	0.4	1.3	This value is within normal limits

Creatinine	0.55-1.30	1.30	1.05	This value is within normal limits
Albumin	3.5-5.5	2.4	1.7	This lab value could be abnormal related to malnutrition (Hinkle & Cheever, 2022).
Calcium	8.9-10.6	9.9	9.1	This value is within normal limits
Mag	1.6-2.6	NA	NA	This value is within normal limits
Phosphate	2.5	NA	NA	This value is within normal limits
Bilirubin	0.2-1.6	0.4	NA	This value is within normal limits
Alk Phos	40-150	112	118	This value is within normal limits
AST	5-34	33	19	This value is within normal limits
ALT	0-55	44	10	This value is within normal limits
Amylase	22-1125	NA	NA	There was no lab value on this patient
Lipase	<140	NA	NA	There was no lab value on this patient
Lactic Acid	Venous:0.5-1.7	NA	NA	There was no lab value on this patient
Troponin	0.001-0.12	1.06	Pending	This lab value is abnormal due to muscle damage. (Hinkle & Cheever, 2022).
CK-MB	5-25 IU/L	NA	NA	There was no lab value on this patient
Total CK	22-198	NA	NA	There was no lab value on this patient

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	0.8-1.2	3.1	1.3	This lab value is high related to the treatment of PE (Hinkle & Cheever, 2022). Patient is currently not on treatment due to surgery

PT	11-13 seconds	31.5	16.2	This lab value is high related to the treatment of PE (Hinkle & Cheever, 2022). Patient is currently not on treatment due to surgery
PTT	21-35 seconds	42.8	41.6	This lab value is high related to the treatment of PE (Hinkle & Cheever, 2022). Patient is currently no on treatment due to surgery
D-Dimer	<250	NA	NA	There was no lab value on this patient
BNP	<100	NA	NA	There was no lab value on this patient
HDL	35-65	NA	NA	There was no lab value on this patient
LDL	<160	NA	NA	There was no lab value on this patient
Cholesterol	<205	NA	NA	There was no lab value on this patient
Triglycerides	44-180	NA	NA	There was no lab value on this patient
Hgb A1c	4.4-6.4%	5.6%	NA	This lab value is normal
TSH	0-15	NA	NA	There was no lab value on this patient

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 to amber Clear	Yellow and clear	NA	This lab value is normal
pH	5.0-9.0	5.5	NA	This lab value is normal
Specific Gravity	1.003-1.030	1.015	NA	This lab value is normal
Glucose	Negative	Negative	NA	This lab value is normal
Protein	Negative	30	NA	The patient could be dehydrated at the time of the urine test (Hinkle & Cheever, 2022).
Ketones	Negative	Negative	NA	This lab value is normal
WBC	0-5	4	NA	This lab value is normal

RBC	0-2	Trace	NA	The kidneys could have damage to them causing blood (Hinkle & Cheever, 2022).
Leukoesterase	Negative	Negative	NA	This lab value is normal

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	NA	NA	There was no lab value on this patient
PaO2	80-100	NA	NA	There was no lab value on this patient
PaCO2	35-45	NA	NA	There was no lab value on this patient
HCO3	22-26	NA	NA	There was no lab value on this patient
SaO2	92-100%	NA	NA	There was no lab value on this patient

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	NA	NA	There was no lab value on this patient
Blood Culture	Negative	NA	NA	There was no lab value on this patient
Sputum Culture	Negative	NA	NA	There was no lab value on this

				patient
Stool Culture	Negative	Pending results	NA	Pending results

Lab Correlations Reference (1) (APA):

Carle Database (2022)

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner suddarth's textbook of medical-surgical nursing* (15 th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

CT scan of the chest- B/L PE, Ultrasound RUQ- normal, CT of Spine- Stimulator in T 10-L1, with Severe disc height loss in the lumbar section of the spine

Diagnostic Test Correlation (5 points):

CT of the chest is performed with contrast to be able to see any abnormalities within the chest (Hinkle & Cheever, 2022). With N.B having a CT performed related to her SOB it showed she had bilateral pulmonary embolisms in the right lower lob and upper left lob with both right and left lungs having pleural effusions. An abdominal ultrasound is performed on any abnormalities within the abdomen (Hinkle & Cheever, 2022). The patient's abdominal ultrasound showed no abnormalities. The CY of the Spine is performed with contrast to show any abnormalities of the spine (Hinkle & Cheever, 2022). The patient's spine CT showed the location of the spine stimulator and degeneration of the disc in the lumbar section.

Diagnostic Test Reference (1) (APA):

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner suddarth's textbook of medical-surgical nursing* (15 th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

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

Home Medications (5 required)

Brand/Generic	Aripiprazole Abilify	Carbamazepine Tegretol	Vit. D	Atorvastatin Lipitor	Clonazepam Clozapine
Dose	10mg	20mg	25mcg	20mg	1mg
Frequency	Q hs	BID	Daily	Daily q evening	Q hs
Route	PO	PO	PO	PO	PO
Classification	antipsychotic	Anticonvulsant	Vitamin	HMG-CoA Reductase inhibitor	anticonvulsant
Mechanism of Action	Quinolinone	Iminostilbene derivative	Parathyroid agent	Antihyperlipidemic	Benzodiazepine
Reason Client Taking	Depression	Pain management	Vit D hormone	Hyperlipidemia	Insomnia
Contraindications (2)	Hypersensitivity Seizure disorders	Hypersensitivity MAOI therapy	Hypersensitivity Hypercalcemia	Hepatic disease Hypersensitivity to atorvastatin	Hypersensitivity Acute closed-angle glaucoma
Side Effects/Adverse Reactions (2)	Drowsiness Orthostatic hypotension	Drowsiness Hypertension	Drowsiness Dysrhythmias	Abnormal dreams Hypoglycemia	Drowsiness Suicidal tendencies

Nursing Considerations (2)	Mental status Monitor ECG changes	Seizures Bone marrow depression	Vitamin D deficiency Hypercalcemia	Avoid the use in renal failure patients Use cautiously in diabetic patients	Monitor for seizures Assess mental status
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Mental status B/P standing and lying	Assess mood Assess for suicidal ideation	Vitamin D levels Vitamin C levels	Liver function panel Cholesterol levels 2-4 weeks	Assess for suicidal thoughts Therapeutic level 20-80 ng/mL
Client Teaching Needs (2)	Stand up slowly to avoid dizziness Avoid driving or walking due to drowsiness	Carry emergency ID Immediately report flu-like symptoms	Follow prescribed diet Monitor weight	Not a substrate for a low-cholesterol diet Take in the evening at the same every day	Carry emergency ID Education on withdrawal symptoms

Brand/Generic	Amiodarone Pacerone	Ceftriaxone NA	Levofloxacin Levaquin	Morphine Arymo ER	Furosemide Lasix
Dose	AM=200mg PM=400mg	500mg	300mg	15mg	20mg
Frequency	BID	Every other day	Daily	Daily	Daily
Route	PO	IVBP	PO	PO	PO
Classification	Antidysrhythmic	cephalosporine	Fluoroquinolone	Alkaloid	Diuretic
Mechanism of Action	Iodinated benzofuran	Broad-spectrum anti-infective	Anti-infective	Opioid analgesic	Loop diuretics
Reason Client Taking	Antiarrhythmics	Possible infection	Possible infection	Pain management	Hypertension
Contraindications (2)	Sinus node dysfunction Hypersensitivity	Hypersensitivity to cephalosporins Penicillin's	Hypersensitivity Acute MI	Hypersensitivity CNC changes	Diabetes mellitus Severe renal disease
Side Effects/Adverse Reactions (2)	Headache Hypotension	Headache Thrombocytopenia	Headache Chest pain	Drowsiness Bradycardia	Headache Orthostatic hypotension
Nursing Considerations (2)	Cardiac dysrhythmias Stevens-Johnson syndrome	Infection Blood studies	Assess sensitivity reaction Signs of infection	Bowel status Respiratory status	Monitor hypertension Hypokalemia
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess heart rhythm CMP	Assess for signs of infection Vital signs daily	WBC Temperature	Pain Vital signs	Daily weight I & O
Client Teaching Needs (2)	Avoid grapefruit juice Use sunscreen and avoid the sun	Report flu-like symptoms Take full treatment	Report superinfection Monitor blood glucose	Avoid driving Report any signs of CNS depression	Discuss the need for high potassium diet Take with food to avoid GI upsets

Hospital medications (5 required)

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's Drug Handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** Yes **Orientation:** x4 **Distress:** No acute distress **Overall appearance:** Groomed and awake	Msr. N is a 73-year-old male. The client is groomed and awake. The client weighs 70.6kg and is 167.6 cm in height. The client is pleasant when speaking and is in no acute distress.
INTEGUMENTARY: **Skin color:** pink **Character:** dry **Temperature:** warm **Turgor:** less than two seconds **Rashes:** none **Bruises:** Yes **Wounds:** Yes **Braden Score:** 12 **Drains present: Y☐ N ☒** **Type:**	Skin is warm and dry upon palpation. Skin turgor is less than two seconds, normal mobility. Nails are without clubbing. The client's capillary refill is less than 3 seconds between fingers and toes bilaterally. Braden score of 12, indicating high risk. A 18 g IV is in place in the right forearm and a 18 g IV is in place in the left forearm. Two wounds present coccyx stage 4 with tunneling which is 6x5cm and a r heel wound stage 2 with 3cmx4cm.
HEENT: **Head/Neck:** Skull is normocephalic, neck is midline with body **Ears:** hard of hearing **Eyes:** WNL **Nose:** WNL **Teeth:** Poor dentition	The client's head and neck are symmetrical and there are non-palpable lymph nodes and lobes. There is no visible abnormality of ears or palpable deformities. The client has difficultly hearing and has no hearing aids.The sclera is white bilaterally. The client's cornea is clear b/l. Their conjunctiva is pink b/l with no mucus. Their EOMs are intact b/l and PERRLA b/l. The client's septum is midline. The client has no dentition. The client does has dentures. .
CARDIOVASCULAR: **Heart sounds:** Clear S1 and S2 without murmur **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Normal sinus rhythm **Peripheral Pulses:** + 2 **Capillary refill:** Less than 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	. Upon auscultation, there are clear S1 and S2 without murmurs. The client's PMI is palpable at the 5th intercostal space at the MCL. There is a normal rate and rhythm. Mrs. N. extremities are pink, warm, and dry. There is no edema, palpated in all extremities. The epitrochlear lymph nodes are nonpalpable b/l. The client's pulses are 2+ b/l. Their capillary refill is less than 3 seconds between fingers and toes b/l.

RESPIRATORY: **Accessory muscle use:** Y☐ N ☒ **Breath Sounds: Location, character**	. Upon auscultation, the client's lungs are Sounds are diminished posterior and anterior. Respirations are unlabored and no history of illicit drug use. Client is on 3L of oxygen via nasal canula.
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet** Regular **Height:** 160.7 cm **Weight:** 70.6 kg **Auscultation Bowel sounds:** active in all quadrants **Last BM:** 11/1/22 **Palpation: Pain, Mass etc.:** No palpable mass or pain **Inspection:** **Distention:** None **Incisions:** None **Scars:** None **Drains:** None **Wounds:** None **Ostomy:** Y ☐ N ☒ **Nasogastric:** Y ☐ N ☒ **Size:** **Feeding tubes/PEG tube** Y ☐ N ☒ **Type:**	. Upon inspection, the client's abdomen flat. There are active and normal bowel sounds and no tenderness after palpation of all four quadrants. The clients last BM was 11/1/22. The client is on a regular diet. The client denies nausea, pain, and vomiting. There is no pain with defecation. There is no distention, incisions, scars, or wounds visible on the abdomen.
GENITOURINARY: **Color:** Yellow **Character:** Clear **Quantity of urine:** 460 **Pain with urination:** Y ☐ N ☒ **Dialysis:** Y ☐ N ☒ **Inspection of genitals:** No abnormalities **Catheter:** Y ☒ N ☐ **Type:** foley **Size:** 14fr	The client urinal had 460mL of urine that was yellow and clear. The client has no complaints of urinary system. The clients' genitals have no abnormalities. The client has a coley catheter in place that is a 14 fr.
MUSCULOSKELETAL: **Neurovascular status:** Normal **ROM:** Active **Supportive devices:** **Strength:** 5/5 b/L throughout **ADL Assistance:** Y☐ N ☒ **Fall Risk:** Y ☒ N☐	. The client shows no signs of muscular atrophy in limbs. The client's arm muscle strength is rated at a 3/5. The right lower leg muscle strength is 1/5 and the left is 3/5.The client fall score is 23. The client is currently on bedrest. Client does not use assistive devices to get around.

Fall Score: 23 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** yes **Mental Status:** Alert **Speech:** organized **Sensory:** intact **LOC:** None	. The patient is alert and restless. The client-oriented x3; to person, place, and situation. Upon assessment, PERRLA b/l. The client's strength is equal in the arms. The client leg strength is equal the right weaker than the left from previous lymphedema. The client was able to perform hand grips without difficulty. The client is unable to do pedal pushers and pulls on the right leg.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** Husband **Developmental level:** Intellectually delayed **Religion & what it means to pt.:** NA **Personal/Family Data (Think about home environment, family structure, and available family support):** Has support from family	. The client is alert and oriented x3 (to person, place, and situation). The clients' thoughts process is organized. The client lives at home with her husband.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	60	101/54	18	97.1	99% on 3L
1030	65	112/54	18	97.8	98% on 3L

Vital Sign Trends: Stable

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0830	1-10	NA	0	NA	NA

1030	1-10	NA	0	NA	NA

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18g **Location of IV:** RFA and LFA **Date on IV:** 10/31/22 on both **Patency of IV:** excellent **Signs of erythema, drainage, etc.:** No **IV dressing assessment:** dry clean intact	Saline Lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
NPO	460 (urine)

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was calm and cooperative during assessments. Client was sent down for surgery at 1030.

Procedures/testing done: The client had few labs drawn at 0415 without complications

Complaints/Issues: Client has b/l PE and two wounds of concern

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Client is being compliant with diet and is currently on bed rest pending surgery

Physician notifications: Any abnormalities related to the patient

Future plans for client: Has scheduled surgery for 11/3/22 to remove pacemaker leads

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
Impaired gas exchange related to fluid in the lungs as evidenced by CT infiltrates	This diagnosis was chosen because of b/ l pulmonary infiltrates	Oxygen at 3L continuous Turn, deep breathing and coughing q 2 hrs with the nursing staff	The client will have an oxygenation saturation greater than 95%	The client was willing to wear the oxygenation and practice turns, deep breathing, and coughing. Client oxygen saturation reminds above 95%.
Ineffective breathing pattern related to SOB as evidenced by respiratory distress	This diagnosis was chosen because of Pulmonary embolism	Oxygen at 3L continuous Monitor ABG labs	The client will have an oxygenation saturation greater than 95%	Client oxygen saturation reminds above 95%.
Impaired skin integrity related to pressure ulcers as evidenced by coccyx wound and heel wound.	This diagnosis was chosen due to the wounds on the client	Coccyx wound dressing wet to dry q 3 days Heel wound dressing wet to dry q 3 days	Client will remain absent of new wounds.	Client does not have any current new wounds. Client also understands the importance of dressing changes
At risk for edema related to the previous lymphoedema in the past	This diagnosis was chosen related to previous lymphoedem a flare-ups in the past	Limb alert band is in place on the right leg Active range of motion and passive range of motion	The client will not have any flare-ups of lymphoedema	The client understands the importance of a limb alert band. Client participates in active range of motion and passive range of

				motion.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): Wound care

Equipment needs (if applicable):NA

Follow up plan: Follow up with PCP

Education needs: Prevention of pressurthe e ulcers

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

Other References (APA):

Phelps, L.L. (2020). Sparks and Taylor's Nursing Diagnosis Reference Manual (11th ed.). Wolters Kluwer.

Concept Map (20 Points) See page 21

Subjective Data

The patient came into ER due to having RUQ pain with an SOB. The patient was just discharged from the hospital on 10/21/22 with COVID-19. The patient had not tried anything to relieve pain. The husband was concerned with her SOB and thought it would be best to come in and get her checked out. The patient denies having any pain currently.

Nursing Diagnosis/Outcomes

Impaired gas exchange related to fluid in the lungs as evidenced by CT infiltrates
The client will have an oxygenation saturation greater than 95%
Ineffective breathing pattern related to SOB as evidenced by respiratory distress
The client will have an oxygenation saturation greater than 95%
Impaired skin integrity related to pressure ulcers as evidenced by coccyx wound and heel wound.
Client will remain absent of new wounds.
At risk for edema related to the previous lymphoedema in the past
The client will not have any flare-ups of lymphoedema

Objective Data

Weight: 70.6kg
Height 160.7cm
Vitals: B/P 112/54, P 60, R 18, T 97.7, O2 99% on 3 L.
Wounds: Coccyx and R Heel
Respiratory: Lungs are diminished posterior and anterior throughout
Muscle: Weakness in lower extremities. Right leg is absent on pedal pushes and pulls

Client Information

rs. N.B is a 73-year-old female. Admitted on 10/22/22 with a diagnosis of acute respiratory failure. The client is a full code.
PMH: Breast Cancer, Lymphoedema, hypertension, depression, COVID-19, Osteoporosis, Suicide attempts x 4, arrhythmias
PSH: Angioplasty, Bone biopsy, pacemaker, Hip surgery
Family History: Mother leukemia, father prostate cancer, Brother leukemia, Aunt Breast cancer

Nursing Interventions

A limb alert band is in place on the right leg
Active range of motion and passive range of motion
Coccyx wound dressing wet to dry q 3 days
Heel wound dressing wet to dry q 3 days
Oxygen at 3L continuous
Monitor ABG labs
Oxygen at 3L continuous
Turn, deep breathing and coughing q 2 hrs with the nursing staff