N431 Care Plan # 2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 11-10-22	Client Initials HD	Age 88 years old	Gender female
Race/Ethnicity Caucasian	Occupation retired	Marital Status single	Allergies Benzocaine- difficulty breathing Lidocaine- difficulty breathing Succinylcholine- seizures
Code Status Full	Height 152 centimeters	Weight 49.3 kilograms	

Medical History (5 Points)

Past Medical History: Anxiety, diastolic congestive heart failure, aortic stenosis, chronic

obstructive pulmonary disease, chronic kidney disease, anemia, coronary artery disease,

hypertension, high cholesterol, hypothyroidism, gastroesophageal reflux disease.

Past Surgical History: Coronary artery bypass graft (8-13-14), total hip arthroplasty (4-24-20),

cataract surgery (no known date), cholecystectomy (no known date), carotid endarterectomy (10-

4-17).

Family History: Father- stroke, mother- cancer and hypertension.

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

tobacco user from the age of 20 years old to 59 years old. Patient report using cigarettes with and

average of one pack of cigarettes per day. Patient denies the use of drugs and alcohol.

Assistive Devices: The patient uses four liters of oxygen at home. Patient uses walker and gait

belt.

Living Situation: Lives at home with significant other.

Education Level: Patient reports some college attended but no college degree.

Admission Assessment

Chief Complaint (2 points): Shortness of breath and back pain.

History of Present Illness – OLD CARTS (10 points): The patient presents with shortness of breath and back pain. The patient reports that the shortness of breath and back pain began early in the morning on 11-10-22. The back pain is located in the middle of the back. The duration of the back pain is chronic but became worse on 11-10-22. The shortness of breath started to be noticeable on 11-10-22. The back pain is chronic sharp pain. Moving around makes the shortness of breath and back pain worse and nothing alleviates these symptoms. No treatment at home is indicated for the new shortness of breath and back pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Chronic obstructive pulmonary disease exacerbation.

Secondary Diagnosis (if applicable): N/A

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

Chronic obstructive pulmonary disease is a chronic inflammatory lung disease that causes obstructed airflow from the lungs (Mayo Clinic Staff, 2020). These two chronic obstructive pulmonary disease types include emphysema and chronic bronchitis (Mayo Clinic Staff, 2020). Chronic bronchitis is inflammation of the lining of the bronchial tubes, and emphysema is a condition where the destruction of bronchioles of the lungs occurs (Mayo Clinic Staff, 2020). The patient's chart does not specify what type of chronic obstructive pulmonary disease they have. The cause of chronic obstructive pulmonary disease can be a result of smoking tobacco, which causes up to 90% of cases, an alpha-1 antitrypsin (AAT) deficiency, secondhand smoke, air pollution, workplace dust, and fumes (Cleveland Clinic Medical Professional, 2022). This

patient does have a history of being a previous smoker with one pack a day history for 39 years. Symptoms of chronic obstructive pulmonary disease can include feeling shortness of breath, feeling short of breath on exertion, wheezing, chest tightness, a chronic cough that may produce sputum that may be clear, white, yellow, or greenish, frequent respiratory infections, lack of energy, unintended weight loss, and swelling in ankles, feet, or legs (Mayo Clinic Staff, 2020). This patient shows symptoms of shortness of breath and a chronic cough at this time. The are many different diagnostic tests to diagnose someone with chronic obstructive pulmonary disease. Some diagnostic tests may include reviewing past medical history, a physical exam, spirometry testing, pulse oximetry, arterial blood gases (ABGs), electrocardiogram, chest X-radiation, computerized chest tomography, and exercise testing (Cleveland Clinic Medical Professional, 2022). This patient already has a past medical history of chronic obstructive pulmonary disease, an exacerbation. The patient had no diagnostic testing related to chronic obstructive pulmonary disease exacerbation. Treatment options for the chronic obstructive pulmonary disease include managing chronic obstructive pulmonary disease symptoms. Some management options may include bronchodilators, steroids, oxygen, antibiotics, vaccinations, pulmonary rehabilitation, anticholinergics, leukotriene modifiers, diuretics, expectorants, antihistamines, and antivirals (Cleveland Clinic Medical Professional, 2022). The patient is on supplemental oxygen at four liters nasal cannula, albuterol, and furosemide.

Pathophysiology References (2) (APA):

Cleveland Clinic Medical Professional. (2022, May 17). *COPD: Causes, symptoms, diagnosis, treatment & prevention*. Cleveland Clinic. Retrieved November 19, 2022, from https://my.clevelandclinic.org/health/diseases/8709-chronic-obstructive-pulmonary-disease-copd

Mayo Clinic Staff. (2020, April 15). *COPD*. Mayo Clinic. Retrieved November 19, 2022, from

https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.0-5.8 x10^6/mcL	==3.21 x10^6/mcL==	N/A	The patient has a past medical history of anemia.
Hgb	12.0-15.8g/dL	==10.1 g/dL==	N/A	The patient has a past medical history of anemia.
Hct	36-47%	==30.2%==	N/A	The patient has a past medical history of anemia.
Platelets	140-440 K/mcL	180 K/mcL	N/A	
WBC	4.0-12.0 K/mcL	6.5 K/mcL	N/A	
Neutrophils	40-60%	==94.3%==	N/A	The patient has a past medical history of chronic obstructive pulmonary disease. This can also indicate a possible underlying infection that is not known at this time.
Lymphocytes	19-49%	==4.1%==	N/A	The patient has a past medical history of chronic obstructive pulmonary disease (Moon et al., 2020). This can also indicate a possible underlying infection that is not known at this

				time.
Monocytes	3.0-13.0%	<mark>1.5%</mark>	N/A	The patient has a past medical history of chronic obstructive pulmonary disease. This can also indicate a possible underlying infection that is not known at this time.
Eosinophils	0.0-8.0%	1.2%	N/A	
Bands	0.0-10.0%	1.4%	N/A	

Chemistry <mark>Highlight All Abnormal Labs</mark>—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 mmol/L	135 mmol/L	N/A	
K+	3.5-5 mmol/L	4.6 mmol/L	N/A	
Cl-	98-107 mmol/L	99 mmol/L	N/A	
CO2	21-31 mmol/L	28 mmol/L	N/A	
Glucose	70-99 mg/dL	77 mg/dL	N/A	
BUN	7-25 mg/dL	<mark>51 mg/dL</mark>	N/A	The patient has a past medical history of chronic kidney disease.
Creatinine	0.50-1.20 mg/dL	<mark>1.58 mg/dL</mark>	N/A	The patient has a past medical history of chronic kidney disease.
Albumin	3.5-5.7 g/dL	4 g/dL	N/A	
Calcium	8.6-10.3 mg/dL	8.9 mg/dL	N/A	
Mag	1.6-2.6 mg/dL	2.2 mg/dL	N/A	
Phosphate	2.4-4.5 units/L	2.8 units/L	N/A	
Bilirubin	0.3-1.0 mg/dL	0.4 mg/dL	N/A	
Alk Phos	44–147 units/L	98 units/L	N/A	

AST	5-30 U/L	29 U/L	N/A	
ALT	5-30 U/L	29 U/L	N/A	
Amylase	30-125 U/L	N/A	N/A	
Lipase	10-150 U/L	N/A	N/A	
Lactic Acid	4.5-19.8 mg/dL	N/A	N/A	
Troponin	0-0.4 ng/mL	0.074ng/mL	N/A	
CK-MB	0-4 ng/mL	N/A	N/A	
Total CK	25-200 units/ L	N/A	N/A	

Other Tests <mark>Highlight All Abnormal Labs</mark>—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	0.9-1.2	N/A	N/A	
PT	11-14 sec	N/A	N/A	
PTT	20-40 sec	N/A	N/A	
D-Dimer	< 500 ng/mL	N/A	N/A	
BNP	< 100 mg/mL	<mark>332 pg/mL</mark>	N/A	The patient has a past medical history of chronic kidney disease.
HDL	40-80 mg/dL	N/A	N/A	
LDL	85-125 mg/dL	N/A	N/A	
Cholesterol	3-5.5 mmol/ L	N/A	N/A	
Triglycerides	50-150 mg/dL	N/A	N/A	
Hgb A1c	4%-6%	N/A	N/A	
TSH	0.5-5 mIU/L	N/A	N/A	

Urinalysis <mark>Highlight All Abnormal Labs</mark>—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, clear	N/A	N/A	
pH	5.0-9.0	N/A	N/A	
Specific Gravity	1.003-1.013	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0.0-0.5	N/A	N/A	
RBC	0.0-3.0	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

Arterial Blood Gas <mark>Highlight All Abnormal Labs</mark>—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	
PaO2	80-100 mmHg	N/A	N/A	
PaCO2	35-45 mmHg	N/A	N/A	

HCO3	22-26 mEq/ L	N/A	N/A	
SaO2	92-100%	N/A	N/A	

Cultures <mark>Highlight All Abnormal Labs</mark>—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	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (1) (APA):

Writers, R. N. S. (2021, July 28). *Laboratory values: NCLEX-RN*. RegisteredNursing.org. Retrieved October 18, 2021, from https://www.registerednursing.org/nclex/laboratory-values/.

Moon, S. W., Leem, A. Y., Kim, Y. S., Lee, J.-H., Kim, T.-H., Oh, Y.-M., Shin, H., Chang, J., & Jung, J. Y. (2020). Low serum lymphocyte level is associated with poor exercise capacity and quality of life in chronic obstructive pulmonary disease. *Scientific Reports, 10*(1). https://doi.org/10.1038/s41598-020-68670-3

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Magnetic resonance imaging of the lumbar spine without contrast reveals a fracture of T3, T11, and L1 (11-14-22). Magnetic resonance imaging of the thoracic spine without contrast reveals fractures (11-14-22).

Diagnostic Test Correlation (5 points): The patient has magnetic resonance imaging without contrast due to the patient complaining of back pain. Contrast is not used because to the patient's creatinine level. The magnetic resonance imaging will show more detailed bone fractures and soft tissue damage. According to Fayad (2022), "Magnetic resonance imaging involves the use of protons in the body react to the energy and create highly detailed pictures of the body's structures, including soft tissues, nerves and blood vessels".

Diagnostic Test Reference (1) (APA):

Fayad, L. M. (2022, September 6). *CT scan versus MRI versus X-ray: What type of imaging do I need?* CT Scan Versus MRI Versus X-Ray: What Type of Imaging Do I Need? | Johns Hopkins Medicine. Retrieved November 19, 2022, from

https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/ct-vs-mri-vs-xray

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

Home Medications (5 required)

Brand/Generic	Equ-ProAir HFA/ albuterol	Lipitor/ atorvastatin	Cardizem/ diltiazem	Levo-T/ levothyroxine	Protonix/ pantoprazole
Dose	90 mcg/inhalation	40 mg	90mg	88 mcg	40 mg
Frequency	As needed	Every morning	Twice a day	Every	Once a day

	every four hours			morning	
Route	Inhale	Oral	Oral	Oral	Oral
Classification	Pharmacologic: Adrenergic (Jones & Bartlett, 2020). Therapeutic: Bronchodilator (Jones & Bartlett, 2020).	Pharmacologic: HMG-CoA reductase inhibitor (Jones & Bartlett, 2020). Therapeutic: Antihyperlipidemic (Jones & Bartlett, 2020).	Pharmacologic: Calcium channel blocker (Jones & Bartlett, 2020). Therapeutic: antihypertensive (Jones & Bartlett, 2020).	Pharmacologic: synthetic thyroxine (Jones & Bartlett, 2020). Therapeutic: thyroid hormone (Jones & Bartlett, 2020).	Pharmacologic: proton pump inhibitor (Jones & Bartlett, 2020). Therapeutic: antiulcer (Jones & Bartlett, 2020).
Mechanism of Action	Attaches to beta 2 receptors resulting to the relaxation of bronchial smooth muscle (Jones & Bartlett, 2020).	Increasing the number of LDL receptors to promote reuptake and breakdown (Jones & Bartlett, 2020).	Relaxes coronary and vascular smooth muscle to reduce blood pressure (Jones & Bartlett, 2020).	Replaces endogenous thyroid hormone (Jones & Bartlett, 2020).	Inhibits the proton pump reducing the amount of HCL in gastric acid (Jones & Bartlett, 2020).
Reason Client Taking	Chronic obstructive pulmonary disease	Hyperlipidemia	hypertension	hypothyroidism	Gastroesophageal reflux disease
Contraindications (2)	The use of furosemide and a history of hypertension (Jones & Bartlett, 2020).	Drinking grapefruit juice and anemia (Jones & Bartlett, 2020).	Pulmonary congestion and using the same line as furosemide (Jones & Bartlett, 2020).	The use of heparin and drinking grapefruit juice (Jones & Bartlett, 2020).	Leucopenia and hyperlipidemia (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Hypokalemia and anxiety (Jones &	Can cause anemia and hypoglycemia (Jones &	Acute renal failure and leukopenia (Jones &	Heart failure and angioedema (Jones &	Leucopenia and hyperlipidemia (Jones &

	Bartlett, 2020).	Bartlett, 2020).	Bartlett, 2020).	Bartlett, 2020).	Bartlett, 2020).
Nursing Considerations (2)	Drug tolerance may occur and wait one minute between inhalations (Jones & Bartlett, 2020).	Report to the provider and halt administration if myopathy symptoms occur (Jones & Bartlett, 2020). Liver function tests may be ordered frequently (Jones & Bartlett, 2020).	Assess for heart failure symptoms and watch for digitalis toxicity (Jones & Bartlett, 2020).	Use in cautiously in elderly with cardiac problems and thyroid function test may be ordered regularly (Jones & Bartlett, 2020).	Do not give longer than necessary and monitor for bone fractures (Jones & Bartlett, 2020).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor potassium levels and monitor blood pressure (Jones & Bartlett, 2020).	Monitor liver enzymes and blood glucose (Jones & Bartlett, 2020).	Monitor blood pressure closely and monitor creatinine (Jones & Bartlett, 2020).	Monitor prothrombin time and monitor thyroid levels (Jones & Bartlett, 2020).	Monitor magnesium levels and monitor for diarrhea (Jones & Bartlett, 2020).
Client Teaching Needs (2)	How to clean mouthpiece and how to use inhaler (Jones & Bartlett, 2020).	Notify provider immediately if muscle pai with a fever occurs (Jones & Bartlett, 2020). Take medication at the same time every day (Jones & Bartlett, 2020).	Do not suddenly stop taking this drug and monitor blood pressure before administration (Jones & Bartlett, 2020).	Take in the morning 30 minutes before meals and do not take calcium or iron supplements four hours after the administration of this drug (Jones & Bartlett, 2020).	Do not crush pill and report any diarrhea to provider (Jones & Bartlett, 2020).

Hospital Medications (5 required)

Brand/Generic	Lasix/ furosemide	Ativan/ lorazepam	Dilaudid/ hydromorph one	Hydrocodon e-acetaminop hen/ Norco	Heparin sodium injection/ heparin sodium
Dose	80 mg	0.5 mg	0.5 mg	5 mg	5,000 unit
Frequency	Twice a day	Once	Every four hours	Every four hours	Twice a day
Route	Oral	IVP	IVP	Oral	subcutaneous
Classification	Pharmacolo gic: loop diuretic (Jones & Bartlett, 2020). Therapeutic: antihyperten sive (Jones & Bartlett, 2020).	Pharmacologi c: benzodiazepi ne (Jones & Bartlett, 2020). Therapeutic: anxiolytic (Jones & Bartlett, 2020).	Pharmacolo gic: Opioid (Jones & Bartlett, 2020). Therapeutic: Opioid analgesic (Jones & Bartlett, 2020).	Pharmacolo gic: nonsalicylat e/ opioid (Jones & Bartlett, 2020). Therapeutic : opioid analgesic and non-opioid analgesic (Jones & Bartlett, 2020).	Pharmacologi c: Anticoagulant (Jones & Bartlett, 2020). Therapeutic: anticoagulant (Jones & Bartlett, 2020).
Mechanism of Action	Inhibits sodium and water reabsorption (Jones & Bartlett, 2020).	Inhibits gamma-aminobutyric acid (Jones & Bartlett, 2020).	Binds to opioid receptors (Jones & Bartlett, 2020).	Binds to opioid receptors and inhibits prostaglandi n production (Jones & Bartlett, 2020).	Inactivates thrombin (Jones & Bartlett, 2020).
Reason Client Taking	hypertension	Claustrophob ia	Severe pain	Severe pain	Prophylaxis for deep vein thrombosis
Contraindication s (2)	Levothyroxi ne use and	Respiratory insufficiency	Diuretic use and	Diuretic use and	Back pain and underlying

	anuria (Jones & Bartlett, 2020).	and CNS depressant medications (Jones & Bartlett, 2020).	benzodiazep ine use (Jones & Bartlett, 2020).	benzodiazep ine use (Jones & Bartlett, 2020).	bleeding (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Hypokalemi a and hyponatremi a (Jones & Bartlett, 2020).	Respiratory depression and suicidal ideation (Jones & Bartlett, 2020).	CNS depression and respiratory depression (Jones & Bartlett, 2020).	Respiratory depression and liver failure (Jones & Bartlett, 2020).	Back pain and thrombocytop enia (Jones & Bartlett, 2020).
Nursing Considerations (2)	Obtain a daily weight and monitor blood pressure (Jones & Bartlett, 2020).	Monitor respiratory depression and use extreme caution for elderly patients (Jones & Bartlett, 2020).	Monitor for respiratory depression use cautiously in uncontrollab le blood pressure (Jones & Bartlett, 2020).	Increases the risk of addiction and use in extreme caution for those with chronic obstructive pulmonary disease (Jones & Bartlett, 2020).	Monitor platelets count closely and assess for bruising (Jones & Bartlett, 2020).
Key Nursing Assessment(s)/L ab(s) Prior to Administration	Monitor potassium and blood pressure (Jones & Bartlett, 2020).	Respiratory assessment and platelet count (Jones & Bartlett, 2020).	Respiratory assessment and pain assessment (Jones & Bartlett, 2020).	Respiratory assessment and liver enzymes (Jones & Bartlett, 2020).	Assess for bruising or bleeding and monitor platelet count (Jones & Bartlett, 2020).
Client Teaching Needs (2)	Take blood pressure before administrati on and monitor weight daily (Jones & Bartlett, 2020).	Avoid alcohol and report excessive drowsiness (Jones & Bartlett, 2020).	May cause drowsiness and only take as directed by provider (Jones & Bartlett, 2020).	Take drug exactly as ordered and notify all providers of medication use (Jones & Bartlett, 2020).	Notify immediately if bleeding occurs and monitor for black or bloody stools (Jones & Bartlett, 2020).

Medications Reference (1) (APA):

Jones & Bartlett. (2020). *Nurse's Drug Handbook* (12th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) – <mark>HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS</mark>

GENERAL: Alertness: Orientation: Distress: Overall appearance:	The client is alert and oriented times four and does not show any signs of distressed. The client is well groomed.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y☐ N ☐ Type:	The client's skin appropriate for ethnicity and is dry and intact. The client's temperature is warm. <mark>The clients skin turgor is loose</mark> with no rashes or wounds noted. <mark>The patient has scattered bruising around the abdomen.</mark> <mark>The Braden score is nineteen.</mark> No drains are present.
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	The client's head is normocephalic, the neck is supple, and no masses noted. The ears are symmetrical with no signs of drainage present. The pupils are equal and reactive to light. PERLA and EOM intact. The nares are patent with no signs of deviated septum. The gums are pink, moist, and intact. No masses or lesions

	noted. The patient wears well-fitting dentures upper and lower.
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 heart sounds auscultated with no murmurs present. S1 and S2 with normal sinus rhythm. +2 radial pulses noted bilaterally. The capillary refill less than three seconds noted in all extremities. No signs of neck vein distention or edema.
RESPIRATORY: Accessory muscle use: Y☐ N ☐ Breath Sounds: Location, character	The client showed no signs of accessory muscle being used. Anterior and posterior breath sounds auscultated clear and diminished in the lower lobes bilaterally.

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 ☐   N ☐
Nasogastric: Y ☐   N ☐
   Size:
Feeding tubes/PEG tube Y ☐   N ☐
   Type:
	The client's diet at home and the current diet is regular. The client is 152 centimeters and weighs 49.3 kilograms. The client has active bowel sounds in all four quadrants and the last bowel movement was on 11-9-20. The client's abdomen is soft and nontender with no masses noted. There are no signs of incisions or wounds in the abdominal area. Abdominal distention is noted. No ostomy is present. Nasogastric tube is not present. No feeding or PEG tubes are present.

GENITOURINARY:
Color:
Character:
Quantity of urine:
Pain with urination: Y ☐   N ☐
Dialysis: Y ☐   N ☐
Inspection of genitals:
Catheter: Y ☐   N ☐
   Type:
   Size:
	The client did not produce any urine during this shift. The client reports no pain with urination. The client is not receiving dialysis. The genitalia are clean, dry, and intact. No catheter is present.

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 ☐	The neurovascular status is intact. The range of motion is intact active and passively. The client does use a walker and has strength 5/5 bilaterally. <mark>The client does need activities of daily living assistance and is a fall risk. The patient is up with one person assist with the use of walker and gait belt. The fall score is sixty and the client needs support to stand and walk with a walker.</mark>
NEUROLOGICAL: MAEW: Y ☐ N☐ PERLA: Y ☐ N☐ Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐ Orientation: Mental Status: Speech: Sensory: LOC:	The client moves all extremities well. PERLA is intact. The strength is equal in arms and legs. The client is oriented times four. The client's speech is clear. No sensory or LOC.
PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	The client talks with others as a coping method. The client has some college attended. The client does not specify religion. The client lives at home with significant other.

Vital Signs, 2 sets (5 points) – <mark>HIGHLIGHT ALL ABNORMAL VITAL SIGNS</mark>

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0744	92 beats per minute	<mark>174/92 mmHg</mark>	18 breaths per minute	36.7℃ tympanic	99% on four liters nasal cannula
1039	95 beats per minute	<mark>191/95 mmHg</mark>	18 breaths per minute	37.2℃ tympanic	93% on four liters nasal

					cannula

Vital Sign Trends:

The blood pressure is worsening, and the oxygen saturation is worsening but within normal

limits. The second set of vitals are after the patient is anxious.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numeric	Back	7/10	Constant sharp	Pain medication hydromorphone administered.
1039	Numeric	Back	6/10	Constant sharp	Repositioning

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22 gauge Location of IV: right wrist Date on IV: 11-13-22 Patency of IV: patient Signs of erythema, drainage, etc.: no signs of erythema, drainage, etc. IV dressing assessment: The dressing is clean, dry, and intact.	75ml/hr of normal saline

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
One milk carton -355ml	No output noted

Nursing Care

Summary of Care (2 points)

Overview of care: The patient reports no shortness of breath through the shift. The patient does report 7/10 back pain. Hydromorphone is administered for the pain and the pain is rated a 6/10 approximately one hour and a half later. The patient received anxiety inducing information from the hospitalist that the vital signs reflect. Ativan was not administered due to a one-time dose that needs to be administered 30 minutes prior to a procedure. The patient is agitated and anxious throughout the shift.

Procedures/testing done: The patient is scheduled for a computerized tomography later in the day.

Complaints/Issues: The patient complains of back pain, frustration, and anxiety throughout the shift. Pain medication and relaxation techniques are utilized during this shift. Therapeutic communication is utilized during this shift to relieve patients' frustration and anxiety.

Vital signs (stable/unstable): The vital signs are unstable s the blood pressure is elevated. The nurse is aware of the unstable vital signs.

Tolerating diet, activity, etc.: The patient is up with one person assistance with walker and gait belt. The patient is tolerating a regular diet well but has not had a bowel movement since 11-9-22.

Physician notifications: The physician has ordered a computerized tomography test later this day. A one-time dose of Ativan is to be administered 30 minutes prior to the diagnostic test.

Future plans for client: The future plans for the patient it to have a bowel movement, control back pain, and manage chronic obstructive pulmonary disease symptoms.

Discharge Planning (2 points)

Discharge location: The patient plans to discharge to home with significant other.

Home health needs (if applicable): the patient will go home with oxygen.

Equipment needs (if applicable): the patient will go home with oxygen.

Follow up plan: A follow up plan has not been initiated due to the patient needing to stay

inpatient longer.

Education needs: The patient needs to be educated on managing chronic obstructive

pulmonary disease, the use of oxygen at home, the computerized tomography testing, and pain

management.

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

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.
1. Impaired gas exchange related to chronic disease process as evidenced by irritability	The patient is diagnosed with chronic obstructive pulmonary disease exacerbation and when the oxygen saturation	1. Assess and record pulmonary status every four hours (Phelps, 2020). 2. Change the	1. The patient will remain above 92% oxygen saturation throughout the hospital stay (Phelps, 2020).	Goal met the patient's pulmonary status is assessed every four hours. Goal partially met. The patient refuses half of the two hour turns due to pain.

(Phelps, 2020).	lowers the patient presents with irritability.	patients position every two hours (Phelps, 2020).		
2. Acute pain related to a physical injury as evidenced by a self-report of pain (Phelps, 2020).	The patient reports a 7/10 pain on the numeric pain scale.	1. Use pain scale to rate the pain (Phelps, 2020). 2. Encourage patient to report what pain reducing techniques work well (Phelps, 2020).	1. The patient will report a 4/10 on the numeric pain scale throughout hospital stay (Phelps, 2020).	Goal met. The patient report pain throughout this shift using the numeric pain scale. Goal met. The patient reports what pain medications work well with pain management.
3. Risk for falls related to difficulty with gait as evidenced by impaired balance (Phelps, 2020).	The patient is a high risk for fall due to a fall score of 60. The patient is also using assistive devices for ambulation.	1. Assess the patient's ability to use the call light (Phelps, 2020). 2. Teach patient how to properly use assistive devices (Phelps, 2020).	1. The patient demonstrates how to ambulate without falls throughout the patient's hospital stay (Phelps, 2020).	Goal met. The patient shows how to properly use the call light and to call before getting up. Goal met. The patient demonstrated how to properly use a walker.
4. Anxiety related to stressors as evidenced by increase	This patient reports anxiety from claustrophobia and a procedure that is in a	1. Listen attentively to allow patient to express feelings (Phelps,	1. The patient will utilize relaxation techniques every four hours (Phelps,	Goal met. This student nurse listened to patient express feelings of anxiety. Goal met. The patient utilizes

in blood pressure (Phelps, 2020).	confined space.	2020). 2. Teach patient relaxation techniques (Phelps, 2020).	2020).	relaxation techniques such as guided imagery and deep breathing.

Other References (APA):

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

Kluwer.

Concept Map (20 Points):

Subjective Data

The patient reports a pain of 7/10 and 6/10 on the numeric pain scale located in the back. The patient reports shortness of breath on admission to the hospital. The patient is a 39 year past smoker. The patient reports when they were a one pack a day smoker. The patient denies alcohol or drug use.

Nursing Diagnosis/Outcomes

Impaired gas exchange related to chronic disease process as evidenced by irritability (Phelps, 2020).
Outcome: The patient will remain above 92% oxygen saturation throughout the hospital stay (Phelps, 2020).
Acute pain related to a physical injury as evidenced by a self-report of pain (Phelps, 2020).
Outcome: The patient will report a 4/10 on the numeric pain scale throughout hospital stay (Phelps, 2020).
Risk for falls related to difficulty with gait as evidenced by impaired balance (Phelps, 2020).
Outcome: The patient demonstrates how to ambulate without falls throughout the patient's hospital stay (Phelps, 2020).
Anxiety related to stressors as evidenced by increase in blood pressure (Phelps, 2020).
Outcome: The patient will utilize relaxation techniques every four hours (Phelps, 2020).

Objective Data

0744: HR:92 beats per minute, BP: 174/92 mmHg, RR:18 breaths per minute, Temp.:36.7°C tympanic, O2sat.:99% on four liters nasal cannula
1039:HR:95 beats per minute, BP: 191/95 mmHg, RR: 18 breaths per minute, TEMP.: 37.2°C tympanic, O2 sat.: 93% on four liters nasal cannula
BNP: 332 pg/mL, BUN: 51 mg/dL, Creatinine: 1.58 mg/dL, Neutrophils: 94.3%, Lymphocytes: 4.1%, Monocytes: 1.5%, RBC: 3.21 x10^6/mcL, Hgb: 10.1 g/dL, Hct: 30.2% Magnetic resonance imaging of the lumbar spine without contrast reveals a fracture of T3, T11, and L1 (11-14-22). Magnetic resonance imaging of the thoracic spine without contrast reveals fractures (11-14-22).

Client Information

Past Medical History: Anxiety, diastolic congestive heart failure, aortic stenosis, chronic obstructive pulmonary disease, chronic kidney disease, anemia, coronary artery disease, hypertension, high cholesterol, hypothyroidism.
Past Surgical History: Coronary artery bypass graft (8-13-14), total hip arthroplasty (4-24-20), cataract surgery (no known date), cholecystectomy (no known date), carotid endarterectomy (10-4-17).
Family History: Father- stroke, mother- cancer and hypertension.
Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Former tobacco user from the age of 20 years old to 59 years old. Patient report using cigarettes with an average of one pack of cigarettes per day. Patient denies the use of drugs and alcohol.
Assistive Devices: The patient uses four liters of oxygen at home. Patient uses walker and gait belt.
Living Situation: Lives at home with significant other.
Education Level: Patient reports some college attended but no college degree.
The patient presents with shortness of breath and back pain. The patient reports that the shortness of breath and back pain began early in the morning on 11-10-22. The back pain is located in the middle of the back. The duration of the back pain is chronic but became worse on 11-10-22. The shortness of breath started to be noticeable on 11-10-22. The back pain is chronic sharp pain. Moving around makes the shortness of breath and back pain worse and nothing alleviates these symptoms. No treatment at home is indicated for the new shortness of breath and back pain.

Nursing Interventions

Assess and record pulmonary status every four hours (Phelps, 2020).
Change the patients position every two hours (Phelps, 2020).
Use pain scale to rate the pain (Phelps, 2020).
Encourage patient to report what pain reducing techniques work well (Phelps, 2020).
Assess the patient's ability to use the call light (Phelps, 2020).
Teach patient how to properly use assistive devices (Phelps, 2020).
Listen attentively to allow patient to express feelings (Phelps, 2020).
Teach patient relaxation techniques (Phelps, 2020).