N441 Care Plan

Lakeview College of Nursing

Chelsea Grubb

Demographics (3 points)

Date of Admission 03/17/2023	Client Initials M.P.	Age 69 years old	Gender Male
Race/Ethnicity White	**Occupation** Retired	**Marital Status** Divorced	**Allergies** NKA
Code Status Full	**Height** 6’0” ft.	**Weight** 138 lbs.	

Medical History (5 Points)

Past Medical History: M.P. has a past medical history of COPD, emphysema, mild lactose intolerance, and progressive advanced stage IV lung cancer.

Past Surgical History: M.P. has a past surgical history of a tonsillectomy, colonoscopy, cyst removal, and rotator cuff repair.

Family History: M.P. maternal mother has dementia, and paternal father had high cholesterol. His maternal sister has stage III lung cancer and hepatitis C. No other pertinent family history at this time.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): M.P. has recently quit smoking tobacco around 5 months ago, he was a 3 ½ pack smoker daily before quitting, he does crave nicotine every now and then. He claims to drink 1.2 oz of alcohol per week and does not currently use any illegal drugs.

Assistive Devices: He does not use any assistive devices.

Living Situation: M.P. lives alone in a single-story home in a rural neighborhood.

Education Level: His highest level of education is high school graduate. He has no learning barriers.

Admission Assessment

Chief Complaint (2 points): His chief complaint is worsening shortness of breath.

History of Present Illness – OLD CARTS (10 points): M.P. noticed a worsening SOB 11 days ago. He noticed not being able to catch his breath after his chemotherapy treatment on 03/17/2023 fully. He states that his upper chest is affected when taking deep breaths. This has been going on since 03/06/2023. He describes weakness as a primary characteristic of his SOB. Walking around and doing daily living activities seems to aggravate his symptoms further. There is nothing that seems to relieve his SOB. He has not been seen for SOB before. He claims to use his ProAir inhaler more often than usual, but it does not provide the relief he wants. He says that it is worse in the morning and nighttime. He says that the severity of his SOB is a 10/10 and has led him to come to OSF ED. He is being treated today, 03/21/2023, and seeking further evaluation and testing at OSF Danville ICU.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): His primary diagnosis on admission is acute respiratory failure.

Secondary Diagnosis (if applicable): His secondary diagnosis is bilateral pneumonia and atrial fibrillation with rapid ventricular rate.

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

Pathophysiology References (2) (APA):

Sudden acute respiratory failure occurs. It happens because of a condition or injury that impairs the lungs' capacity to expel carbon dioxide or provide oxygen. Most of the time, acute respiratory failure can be fatal if not treated immediately. The phrase respiratory failure implies the inability to maintain either the regular delivery of oxygen to tissues or the regular removal of carbon dioxide from tissues (Ma et al., 2021). Three processes are at play: the movement of tissues (by cardiac output), the movement of oxygen across the alveolus, and the removal of carbon dioxide from the blood into the alveolus with subsequent exhalation into the environment.

Respiratory failure can result from any stage in this process failing. Hypoxemic and hypercapnic respiratory failure are the two kinds of acute and chronic respiratory failure (Capriotti & Frizzell, 2020). These disorders frequently coexist and have the potential to result in catastrophic problems. Hypoxemia, also known as hypoxemic respiratory failure, is a condition with insufficient oxygen in the blood. When your blood contains too much carbon dioxide, you can experience hypercapnic respiratory failure, also known as hypercapnia. The patient's vital signs will remain unstable as breathing is more challenging for these patients.

Patients that smoke tobacco, drink excessive amounts of alcohol, have a family history of respiratory diseases, have a compromised immune system, or have chronic respiratory conditions such as lung cancer or COPD are at higher risk for developing acute respiratory failure. A doctor will confirm acute respiratory failure based on symptoms. There are, however, laboratory testing that can be done to confirm acute respiratory failure. A chest x-ray/CT and obtaining ABGs can confirm acute respiratory failure (Capriotti & Frizzell, 2020). Many complications stem from developing acute respiratory failure. Pulmonary embolism, pulmonary fibrosis, pneumothorax, pneumonia, renal failure, hepatic failure, and gastrointestinal hemorrhage are some conditions that acute respiratory failure leads to since it is a multi-system involvement (Ma et al., 2021). There are treatment options available depending on the patient's status.

Acute respiratory failure needs to be treated right away by doctors because it is potentially fatal. You can get breathing assistance and stop further organ damage with emergency medical care. A doctor can treat any underlying issues causing respiratory failure if stable. An ET tube is often placed in patients with acute respiratory failure. Pain management and supplemental oxygen may help manage this emergent disease. Acute respiratory failure is an emergency and should not go untreated as the end result could be death.

Pathophysiology References (2) (APA):

Capriotti, T. & Frizzell, J.P. (2020). *Pathophysiology: Introductory Concepts and Clinical Perspectives.* (2nd ed.). F.A. Davis Company.

Ma, M., Feeley T., McCauley, P., Duncan, J., Maudarbaccus, F., Murphy, O. (2021). Acute respiratory failure in immunosuppressed patients admitted to ICU. *Journal of Critical Care*, 63, 26-31. https://doi.org/10.1016/j.jcrc.2021.01.004

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	4.6 m/uL-6.0 m/uL	3.89 m/uL	3.20 m/uL	Decrease RBC levels due to advanced stage IV lung cancer (Kee, 2019).
Hgb	13.8 g/dL-18 g/uL	11.4 g/dL	14.4 g/dL	Decreased Hbg levels due to advanced stage IV lung cancer (Kee, 2019).
Hct	40%-54%	34.1%	43.7%	Decreased Hct levels due to advanced stage IV lung cancer (Kee, 2019).
Platelets	150,000 uL-400,000 uL	138,000 uL	184,000 uL	Decreased admission platelet level count due to chemotherapy (Kee, 2019).
WBC	4.5 uL-10.0 uL	1.60 uL	1.80 uL	Decreased WBC levels due to radiation therapy (Kee, 2019).
Neutrophils	55 uL-70 uL	74.1 uL	85.2 uL	Increased neutrophil count due to neoplasm (Kee, 2019).
Lymphocytes	20 uL-40 uL	10.2 uL	14.4 uL	Decreased lymphocytes due to radiation therapy and stage IV cancer (Kee, 2019).
Monocytes	2 uL-8 uL	4.3 uL	8.0 uL	Within normal range.
Eosinophils	1 uL-4 uL	0.0 uL	0.2 uL	Within normal range.
Bands	50%-65%	N/A	N/A	Not completed on this admission.

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 mEq/L-145 mEq/L	135 mEq/L	138 mEq/L	Within normal range.
K+	3.5 mEq/L-5.3 mEq	3.5 mEq/L	3.5 mEq/L	Within normal range.
Cl-	95 mEq/L-105 mEq/L	104 mEq/L	105 mEq/L	Within normal range.
CO2	22 mEq/L-30 mEq/L	22 mEq/L	29 mEq/L	Within normal range.
Glucose	70 mg/dL-110 mg/dL	92 mg/dL	110 mg/dL	Within normal range.
BUN	5 mg/dL-25 mg/dL	16 mg/dL	18 mg/dL	Within normal range.
Creatinine	0.5 mg/dL-1.2 mg/dL	0.7 mg/dL	0.8 mg/dL	Within normal range.
Albumin	3.5 g/dL-5.0 g/dL	3.7 g/dL	3.5 g/dL	Within normal range.
Calcium	4.5 mEq/L-5.5 mEq/L	8.2 mEq/L	7.3 mEq/L	Increased calcium levels due to advanced progressing cancer (Kee, 2019).
Mag	1.5 mEq/L-2.5 mEq/L	1.7 mEq/L	1.4 mEq/L	Within normal range.
Phosphate	1.7 mEq/L-2.6 mEq/L	N/A	N/A	Not completed on this admission.
Bilirubin	0.1 mg/dL-1.2 mg/dL	0.3 mg/dL	0.6 mg/dL	Within normal range.
Alk Phos	1 unit/dL-50 units/dL	49 units/dL	47 units/dL	Within normal range.
AST	0-35 units/L	19 units/dL	23 units/dL	Within normal range.
ALT	7-55 units/L	16 units/dL	17 units/dL	Within normal range.
Amylase	60-120 units/L	N/A	N/A	Not completed on this admission.
Lipase	0-160 units/L	N/A	N/A	Not completed on this admission.
Lactic Acid	5-20 mg/dL	5.7 mg/dL	9.9 mg/dL	Within normal range.

Troponin	< 0.1 ng/mL	0.3 ng/mL	0.5 ng/mL	Increased troponin levels due to myocardial injury (Kee, 2019).
CK-MB	< 5.0 ng/mL	N/A	N/A	Not completed on this admission.
Total CK	5-25 IU/L	N/A	N/A	Not completed on this admission.

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	< 1.1	1.0	N/A	Within normal range.
PT	11-13.5	N/A	N/A	Not completed on this admission.
PTT	25 seconds-35 seconds	N/A	N/A	Not completed on this admission.
D-Dimer	< 0.50 ng/mL	2,043 ng/mL	1,110 ng/mL	Increased D-dimer levels due to malignancy (Kee, 2019).
BNP	0-100 mg/dL	53 mg/dL	N/A	Within normal range.
HDL	< 40 ng/dL	N/A	N/A	Not completed on this admission.
LDL	< 100 mg/dL	N/A	N/A	Not completed on this admission.
Cholesterol	< 200 mg/dL	N/A	N/A	Not completed on this admission.
Triglycerides	< 150 mg/dL	N/A	N/A	Not completed on this admission.
Hgb A1c	< 5.7%	N/A	N/A	Not completed on this admission.
TSH	0.5-5.0 mIU/L	0.8 mIU/L	N/A	Within normal range.

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	Light straw-dark amber	N/A	N/A	Not completed on this admission.
pH	4.5-8.0	N/A	N/A	Not completed on this admission.

Specific Gravity	1.005-1.030	N/A	N/A	Not completed on this admission.
Glucose	Negative	N/A	N/A	Not completed on this admission.
Protein	2 mg/dL-8 mg/dL	N/A	N/A	Not completed on this admission.
Ketones	Negative	N/A	N/A	Not completed on this admission.
WBC	Negative	N/A	N/A	Not completed on this admission.
RBC	Negative	N/A	N/A	Not completed on this admission.
Leukoesterase	Negative	N/A	N/A	Not completed on this admission.

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

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
pH	7.35-7.45	7.45	Pending results	Within normal range.
PaO2	75-100 mmHg	78 mmHg	Pending results	Within normal range.
PaCO2	35-45 mmHg	21 mmHg	Pending results	Decreased PaCO2 levels due to hypoxemia (Kee, 2019).
HCO3	22-26 mEq/L	23 mEq/L	Pending results	Within normal range.
SaO2	95%-100%	98%	Pending results	Within normal range.

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/No growth	N/A	N/A	Not completed on this admission.

Blood Culture	Negative/No growth	No growth	N/A	Within normal range.
Sputum Culture	Normal URT	N/A	Pending results	Pending sputum culture results.
Stool Culture	Normal intestinal flora	N/A	N/A	Not completed on this admission.

Lab Correlations Reference (1) (APA):

Kee, J. L. F. (2019). *Pearson Handbook of Laboratory & Diagnostic Tests with Nursing Implications* (9th Ed.). Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The patient got a CT with contrast. The patient has received multiple CTs with contrast due to his stage IV lung cancer. The patient receives these monthly to compare them in contrast to his stage IV lung cancer.

Diagnostic Test Correlation (5 points): A computerized tomography (CT) scan combines several X-ray images of your body from various angles to produce cross-sectional images (slices) of your bones, blood vessels, and soft tissues (Pagana et al., 2019). A CT with contrast allows the provider to see a more detailed version of the patients' lungs and surrounding chest cavity. The recent CT with contrast showed extensive bilateral pneumonia infiltrates.

Diagnostic Test Reference (1) (APA):

Pagana, K.D., & Pagana, T. J., Pagana, T. N. (2019). *Mosby's Manual of Diagnostic and Laboratory Test Reference* (15th Ed.). Mosby.

Current Medications (10 points, 1 point per completed med)

10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Breo Ellipta/fluticasone furoate	ProAir/ albuterol	Robitussin-DM/ dextromethorphan-guaifenesin	Spiriva/ tiotropium	The patient only took four home medications.
Dose	100 mcg	108 mcg	10 mg/5 mL	1.25 mcg	N/A
Frequency	One time per day	Two puffs every four hours	10 mL every four hours as needed	Two puffs one time daily	N/A
Route	Inhalation	Inhalation	P.O.	Inhalation	N/A
Classification	Pharmacological class: Beta-2-agonists Therapeutic class: bronchodilator (Jones & Bartlett Learning, 2020).	Pharmacological class: Beta-2-agonists Therapeutic class: bronchodilator (Jones & Bartlett Learning, 2020).	Pharmacological class: antitussives Therapeutic class: expectorant (Jones & Bartlett Learning, 2020).	Pharmacological class: anticholinergics Therapeutic class: bronchodilator (Jones & Bartlett Learning, 2020).	N/A
Mechanism of Action	Fluticasone furoate, an inhaled corticosteroid (ICS), and vilanterol, a long-acting beta2-adrenergic agonist, are combined in Breo Ellipta (Jones &	Albuterol relaxes the smooth muscles of all airways, from the trachea to the terminal bronchioles. Reduced release of mediators from mast	The cough reflex is suppressed by dextromethorphan, which penetrates the blood-brain barrier and activates sigma opioid receptors on the cough center in the central nervous system (Jones &	By inhibiting muscarinic cholinergic receptors, tiotropium counteracts the effects of acetylcholine. The parasympathetic nervous system is in charge of	N/A

	Bartlett Learning, 2020).	cells into the airway is also associated with higher levels of cyclic AMP (Jones & Bartlett Learning, 2020).	Bartlett Learning, 2020).	maintaining resting broncho motor tone and plays a significant part in the autonomic regulation of the airways (Jones & Bartlett Learning, 2020).	
Reason Client Taking	Cough	Cough	Cough	Cough	N/A
Contraindications (2)	The two contraindications are patients with weakened immune systems and cancer patients (Jones & Bartlett Learning, 2020).	The two contraindications are sensitivity to albuterol and recent myocardial impairment (Jones & Bartlett Learning, 2020).	The two contraindications are smoking while taking this medication and having emphysema (Jones & Bartlett Learning, 2020).	The two contraindications are being older than age 65 and having cardiac arrhythmias (Jones & Bartlett Learning, 2020).	N/A
Side Effects/Adverse Reactions (2)	The two adverse effects are headache and sore throat (Jones & Bartlett Learning, 2020).	The two adverse effects are chest pain and restlessness (Jones & Bartlett Learning, 2020).	The two side effects of Robitussin-DM are drowsiness and feeling anxious (Jones & Bartlett Learning, 2020).	The two side effects are dry mouth and chest pain (Jones & Bartlett Learning, 2020).	N/A
Nursing Considerations (2)	The nurse should ask the patient if he is allergic to milk and obtain a full	Two nursing considerations are asking the patient if he is allergic to	The two nursing considerations are monitoring for dizziness and implementing fall precautions	The two nursing consideration are obtaining a full set of vitals and	N/A

	set of vitals (Jones & Bartlett Learning, 2020).	any medications and watching the patient while he is breathing (Jones & Bartlett Learning, 2020).	due to the adverse effects of this drug (Jones & Bartlett Learning, 2020).	assessing the cardiac/respiratory system (Jones & Bartlett Learning, 2020).	
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	The nurse should assess lung sounds and assess the patients pulse prior to administration (Jones & Bartlett Learning, 2020).	The nurse should monitor the patients respiratory status and assess the oxygen saturation rate before the use of ProAir (Jones & Bartlett Learning, 2020).	The nurse should assess the patients vitals and listen to lung sounds (Jones & Bartlett Learning, 2020).	The nurse should obtain a EKG prior to administration and assess the patients heart rate (Jones & Bartlett Learning, 2020).	N/A
Client Teaching needs (2)	Instruct the patient to put the inhaler over their mouth and breath out slowly after inhaling for three to four seconds. The patient should use the inhaler the same time every day (Jones & Bartlett Learning, 2020).	Educate the patient on the side effects of taking ProAir including the main side effect of feeling jittery and instructing him on rinsing his mouth after the use of ProAir (Jones & Bartlett	Educate the client to only take if needed and never to take more than recommended to prevent overdose (Jones & Bartlett Learning, 2020).	Educate the patient on the adverse effects of Spiriva and report any signs of allergies to his provider. The nurse should also have the patient demonstrate the correct way to use the inhaler to receive adequate	N/A

		Learning, 2020).		treatment (Jones & Bartlett Learning, 2020).	

Hospital Medications (5 required)

Brand/Generic	Eliquis/ apixaban	Pulmicort/ budesonide	Zofran/ ondansetron	NicoDerm/ nicotine	The patient only receives four hospital medications due to being put on comfort care.
Dose	5 mg	500 mcg	4 mg	5 mg-15 mg	N/A
Frequency	Two times daily	Two times daily	Every six hours or as needed	Apply new patch every 24 hours	N/A
Route	P.O.	Inhalation	P.O.	Patch	N/A
Classification	Pharmacological class: anticoagulant Therapeutic class: anticoagulant (Jones & Bartlett Learning, 2020).	Pharmacological class: corticosteroid Therapeutic class: corticosteroid (Jones & Bartlett Learning, 2020).	Pharmacological class: antiemetic Therapeutic class: antiemetic (Jones & Bartlett Learning, 2020).	Pharmacological class: cholinergic Therapeutic class: smoking cessation agent (Jones & Bartlett Learning, 2020).	N/A
Mechanism of Action	Antithrombin III is not necessary for antithrombo	Budesonide is a synthetic glucocorticoid steroid linked to the hormone	Ondansetron prevents and treats nausea and vomiting by acting both	The usage of nicotine patches helps people quit smoking. The	N/A

	tic action. The prothrombinase enzyme and both free and clot-bound are inhibited by apixaban (Jones & Bartlett Learning, 2020).	cortisol or hydrocortisone, which is secreted by the adrenal glands and occurs naturally. Strong anti-inflammatory effects of glucocorticoid hormones, such as cortisol or budesonide, diminish airway inflammation and hyperreactivity (Jones & Bartlett Learning, 2020).	centrally and peripherally. Ondansetron acts on the vagus nerve to have peripheral effects as well. It functions by activating the 5-HT3 receptors present in the terminals of the vagus nerve. The vagus nerve can detect gastrointestinal (GI) tract stimuli for nausea and vomiting, such as stomach irritants (Jones & Bartlett Learning, 2020).	patches deliver nicotine, which is then absorbed by the skin. As nicotine is released, it binds to nicotine receptors in the body and lessens cravings for nicotine and the withdrawal symptoms that come with quitting smoking (Jones & Bartlett Learning, 2020).	
Reason Client Taking	A-fib	Chest tightness/cough	Nausea	Nicotine abstinence	N/A
Contraindications (2)	The two contraindications are having an active bleed or having a sensitivity reaction to Eliquis (Jones & Bartlett Learning, 2020).	The two contraindications are being lactose intolerant and having a lowered immune system (Jones & Bartlett Learning, 2020).	The two contraindications are having a low potassium blood level and being hypersensitive to Zofran (Jones & Bartlett Learning, 2020).	The two contraindications are having a myocardial episode within the last thirty days and having an irregular heart rate (Jones & Bartlett Learning,	N/A

				2020).	
Side Effects/Adverse Reactions (2)	The two side effects are weakness and constipation (Jones & Bartlett Learning, 2020).	The two side effects are congestion and nausea (Jones & Bartlett Learning, 2020).	The two side effects are dizziness and headache (Jones & Bartlett Learning, 2020).	The two side effects are nervousness and headache (Jones & Bartlett Learning, 2020).	N/A
Nursing Considerations (2)	The two nursing consideration are putting the patient on bleeding precaution protocol and monitoring the patient closely (Jones & Bartlett Learning, 2020).	The two nursing considerations are implementing ROM exercises to minimize muscle wasting and monitor the patient for itching of the skin (Jones & Bartlett Learning, 2020).	The two nursing considerations are implementing fall precaution due to the side effects of this medication and hooking the patient up to continuous heart monitoring (Jones & Bartlett Learning, 2020).	The two nursing consideration are using safe handling while applying the patch and applying the patch in a clean, dry, hairless area of skin (Jones & Bartlett Learning, 2020).	N/A
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	The nurse should assess the patients vitals and do a cardiac and neuro assessment before administration (Jones & Bartlett Learning, 2020).	The nurse should monitor the patient's respiratory rate and assess the patient's respiratory status (Jones & Bartlett Learning, 2020).	The nurse should monitor the patients I/O's prior to administration since this can cause a discrepancy in fluid electrolyte imbalance (Jones & Bartlett Learning, 2020).	The nurse should ask the patient if they have craved nicotine today before applying the patch in order to ensure treatment is needed at that time (Jones & Bartlett Learning, 2020).	N/A
Client	Educate the	The nurse	The nurse	Educate the	N/A

Teaching needs (2)	patient on the signs and symptoms of bleeding and not to skip taking this medication (Jones & Bartlett Learning, 2020).	should educate the patient on swishing their mouth out with water after administration and education should be given on thrush (Jones & Bartlett Learning, 2020).	should teach the patient about the side effects of Zofran and not push their call light if they need to ambulate (Jones & Bartlett Learning, 2020).	patient on avoiding wearing the patch on the same site more than once per week and monitoring for side effects like, dizziness, headache, nausea (Jones & Bartlett Learning, 2020).	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (19th Ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and oriented x3. The patient appears to be mildly anxious and distressed due to his breathing. His overall appearance is suited per situational circumstances.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 21 **Drains present: Y**☐ **N** ☒ **Type:**	The patient has pale, dry and warm to touch skin. This patient's skin turgor is less than two seconds. There are no rashes, bruises, or wounds upon inspecting. The patients Braden score is a 21. There are no drains present.

HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head, and neck symmetrical, no tracheal deviation, non-palpable thyroid, non-palpable lymph nodes. The patient has normal cephalic, trachea is midline and portioned. There are no wounds or drainage from ears. The patient responds to instructions given well this ensures his hearing is adequate. Septum is midline, turbinates are moist and pink bilaterally and there are no visible bleeding or polyps present. Bilateral frontal sinuses are nontender to palpate. Oral cavity is pink and moist. The patients has all his teeth intact.
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:**	Clear S1 and S2 without murmurs, gallops, or rubs. S3 and S4 were not present. The patient has a normal sinus rhythm. Peripheral pulses were a +2. Capillary refills were less than 3. No neck vein distention or edema noted.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	The patient has bilateral rhonchi anteriorly with crackles at the lung bases. The patient has labored breathing as well. There is no use of his accessory muscle. The patient does not have an ET tube.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:**	The patients diet at home is normal. The patients current diet here at the hospital is a liquid diet. The patient is 6’0” and weights 138 lbs. During auscultation of bowel sounds were nondistended and present to be normoactive in all four quadrants, and patients last bowel movement was 03/18/2023. No pain upon palpations or masses noted. No distention, incisions, scars, or wounds present. The patient does not have an ostomy, nasogastric tube, or feeding/PEG tube.

Scars: **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	The patient appears to have straw-amber colored urine. The urine is odorless and clear. The patient has an adequate amount of urine. The patient does not complain of pain with urination. The patient is not on dialysis and inspection of his genitals were WDL. The patient does not have a foley catheter and urinates into his bedside urinal independently.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 80 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☒	No observed joint swelling, or joint tenderness. The patient does have some moderate weakness bilaterally. During ROM he was unable to hold his own weight for longer than ten seconds without feeling extremely weak. His strength is a 1+ bilateral. He does need help with his ADL due to his moderate generalized weakness. The patient is a high fall risk and his fall score is an 80. He does show some difficulty with mobility and needs assistance when standing and ambulating. He does not use any assistive devices.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	MAEW and PERLA are all WDL. The patient does have equal strength in all four extremities bilaterally but does show moderate generalized weakness. His orientation, mental status, speech, sensory are all normal and suitable per his stated age. There is no concern for his level of consciousness.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:**	The patient shows signs of coping by watching tv and reading a book. His developmental level is normal. The patient claims he is not religious and

Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	does not practice any certain religion. The personal has adequate family support at home. His son is at bedside today showing him support. He is a family orientated individual.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0858	80	90/58	23	97.9 F (oral)	99%
1245	77	92/63	25	98.0 F (oral)	98%

Vital Sign Trends/Correlation: The patients vitals are stable currently. However, his blood pressure is on the lower end the physician says that this is suitable for this specific patient. The patient continues to be on the higher side for his respiratory rate due to his admission diagnosis. The patients vitals will be watched closely and obtained every two hours due to the patients status. The patient will be on continuous monitoring to ensure proper care.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0858	Numerical Rating Scale (NRS) 0	N/A	N/A	N/A	N/A
1245	Numerical Rating Scale (NRS) 0	N/A	N/A	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:**	The patient has a 20 G in his right upper arm. The 20 G IV was placed on 03/17/2023 upon

Date on IV: **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	admission. The patency of this IV flushes without resistance. There is no signs of erythema or drainage. The IV dressing has a transparent Tegaderm covering it and is clean, dry and intact. The patient does not have any fluids going at the moment. The IV is documented appropriately in Epic under the patients chart.
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☒ N ☐** **CLABSI prevention measures:**	8.5 Fr. Single lumen port located in the patients right upper chest. The patient had this port placed upon admission on 03/17/2023. The patency of this port flushes without resistance. There is no drainage or erythema upon inspection. The dressing was changed 03/20/2023 per protocol with the initials R.D. (RN) placed on the clean, dry and intact dressing. There is a CUROS green cap on the tubing since it is not in use currently. There is multiple CUROS caps and alcohol pads hanging on IV for easy access. Sterile aseptic CLABSI techniques were used in prevention when accessing the patients port. A full IV assessment was documented appropriately in EPIC under the patients chart.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
120 mL of pulp-free apple juice 100 mL of fat free chicken broth 260 mL of water = 480 mL	600 mL of urine

Nursing Care

Summary of Care (2 points)

Overview of care: The patient is alert and orientated x3. The patient has adequate I/O’s. The patient remains in bed most of the day due to drowsiness and generalized weakness. The patient did not leave the floor today to do any test or procedures. The patient’s vitals remained stable. The patient is tolerating the clear liquid diet well. There is no known discharge date at this time. The patient will remain at OSF ICU until end of life since the patient is now on comfort care.

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

Complaints/Issues: The patient does not have any complaints or issues. The patient is in the acceptance part of grieving with his stage IV lung cancer.

Vital signs (stable/unstable): The patient has stable vitals, although the patients blood pressure does remain lower and the respiratory rate higher side, the physician is aware and understanding of these vital signs.

Tolerating diet, activity, etc.: The patient is tolerating his clear liquid diet and mild bed rest as needed well. The client will continue to be on a clear liquid diet due to his dysphagia stemming from his generalized weakness.

Physician notifications: The physician was notified of his vital signs and respiratory assessment.

Future plans for client: There are no future plans for this patient due to the patients condition.

Discharge Planning (2 points)

Discharge location: The patient does not have a discharge location due to his health status and being a comfort care patient.

Home health needs (if applicable): The patient does not need any home health needs because he is on comfort care.

Equipment needs (if applicable): The patient does not need any equipment at home due to being on comfort care.

Follow up plan: There is no follow up plan with M.P. because he is on comfort care.

Education needs: The patient is given education on his declining health status and understands the deposition of his status here at the hospital. The patient has come to realization of his disease and its progression. The patient is seeking comfort through his family.

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. Ineffective airway clearance related to pleuritic pain as evidence by increased shortness of breath.	Patient is at increased risk for ineffective airway clearance due to increased respiratory rate.	**1.**Elevate the HOB to 30 degrees. **2.**Suction the patient frequently.	**1.** The patient tolerated the HOB being elevated and tolerated being suctioned every two hours or as needed by the patient.	The patient responded well to these given interventions. There are no modifications needed.
2. Impaired	The patient is	**1.** Assess the	**1.** The patients'	The patient

gas exchange related to fluid filled alveoli as evidence by hypoxemia.	at risk for impaired gas exchange due to inadequate respiratory rate.	patients' respirations every two hours. **2.**Assess the patients mental status every two hours.	respiratory rate will remain on the higher side but stable and the ABGs will remain in normal limits.	responded well to these given interventions and understood all given information provided. There are no modifications needed at this time.
3. Ineffective breathing pattern related to decreased lung expansion as evidence by bilateral rhonchi with crackles.	The patient is at increased risk for ineffective breathing pattern due to the fluid in the patients lungs.	**1.**Auscultate the patients breath sounds every four hours. **2**Assess the patients ABGs every eight hours.	**1.** The patients lung sounds improved, and the patient no longer had crackles. The patients ABGs remained within normal limits.	The patient tolerated these interventions and education was given on what ABGs are. There is no need for modifications at this time.
4. Decreased cardiac output related to alterations in the rate as evidence by hypotension.	The patient is at increased risk for decreased cardiac output due to the patient intermittently being in a-fib**.**	**1.**Assess the patients heart rate every four hours. **2.** Auscultate the patients heart sounds every four hours.	**1.** The patient remains in normal sinus rhythm and has a normal heart rate.	The patient tolerated these interventions adequately. The patient understood being at risk for decreased cardiac output. No modifications are needed at this time.
5. Activity intolerance related to generalized weakness as evidence by fatigue.	The patient is at increased risk for activity intolerance due to the patient having a strength of a 1+ bilaterally.	**1.**Check the patients vital signs before and after activity and compare results. **2.**Assess the desired level of activity per the patient's strength.	**1.** The patient vital signs were within normal limits before and after activity. The patients activity tolerance improved and showed significant independence with gait.	The patient tolerated the given interventions and responded well to being able to ambulate more efficiently and independently. There are no modifications needed.

Other References (APA):

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

Concept Map (20 Points

M.P. noticed a worsening SOB 11 days ago. He noticed not being able to catch his breath after his chemotherapy treatment on 03/17/2023 fully. He states that his upper chest is affected when taking deep breaths. This has been going on since 03/06/2023. He describes weakness as a primary characteristic of his SOB. Walking around and doing daily living activities seems to aggravate his symptoms further. There is nothing that seems to relieve his SOB. He has not been seen for SOB before. He claims to use his ProAir inhaler more often than usual, but it does not provide the relief he wants. He says that it is worse in the morning and nighttime. He says that the severity of his SOB is a 10/10 and has led him to come to OSF ED. He is being treated today, 03/21/2023, and seeking further evaluation and testing at OSF Danville ICU.

Subjective Data

1. Ineffective airway clearance related to pleuritic pain as evidence by increased shortness of breath.
   - The patient tolerated the HOB being elevated and tolerated being suctioned every two hours or as needed by the patient.
2. Impaired gas exchange related to fluid filled alveoli as evidence by hypoxemia.
   - The patients respiratory rate will remain on the higher side but stable and the ABGs will remain in normal limits.
3. Ineffective breathing pattern related to decreased lung expansion as evidence by bilateral rhonchi with crackles.
   - The patients lung sounds improved, and the patient no longer had crackles. The patients ABGs remained within normal limits.
4. Decreased cardiac output related to alterations in the rate as evidence by hypotension.
   - The patient remains in normal sinus rhythm and has a normal heart rate.
5. Activity intolerance related to generalized weakness as evidence by fatigue.
   - The patient vital signs were within normal limits before and after activity. The patients activity tolerance improved and showed significant independence with gait.

Nursing Diagnosis/Outcomes

Objective Data

- BP: 90/58
- HR: 80
- RR: 23
- Temp: 97.9 F (oral)
- O2: 99%
- Pain level: 0

Client Information

- M.P.
- Male
- 69 years old
- Divorced
- Admitted for worsening shortness of breath
- Full Code

1. Elevate the HOB to 30 degrees. Suction the patient frequently.
2. Assess the patients' respirations every two hours. Assess the patients mental status every two hours.
3. Auscultate the patients breath sounds every four hours. Assess the patients ABGs every eight hours.
4. Assess the patients heart rate every four hours. Auscultate the patients heart sounds every four hours.
5. Check the patients vital signs before and after activity and compare results. Assess the desired level of activity per the patients strength.

Nursing Interventions