N431 Care Plan # 2

Lakeview College of Nursing

Tasnim Mustafiz

Demographics (3 points)

Date of Admission 03/26/2023	Client Initials CP	Age 82	Gender Female
Race/Ethnicity White American	**Occupation Retired**	**Marital Status Divorce**	**Allergies Sulfa drugs & Doxycycline**
Code Status FULL	**Height 157.48 cm**	**Weight 63.400 Kg**	

Medical History (5 Points)

Past Medical History: Anemia, Chronic diastolic heart failure, CAD, Hyperlipidemia, Hypertension, Interstitial lung disease, Hypoparathyroidism, Ischemic heart disease, Moderate mitral regurgitation, Moderate mitral regulations, Pulmonary hypertension, Stented coronary artery, Type 2 diabetes mellitus, GERD.

Past Surgical History: Stented artery, Cardioversion, Partial hysterectomy.

Family History: The patient's mother had a heart failure and palpitation. No other family members on record at this time.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient denied any tobacco, alcohol, and drug.

Assistive Devices: N/A.

Living Situation: The patient lives alone and independently at her house.

Education Level: The patient has a high school diploma.

Admission Assessment

Chief Complaint (2 points): Shortness on breath.

History of Present Illness – OLD CARTS (10 points): An 82-year-old female comes to the emergency department via EMS due to shortness of breath. The patient has complained of nausea, dizziness, cough, chest pain, and fever for the past few days. The patient says chest

pain gets worse every time she coughs. The patient reports having yellow/green phlegm. The patient reports that she has not explicitly taken anything else for these symptoms. She has been only taking her prescribed medications, which did relieve her nausea.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Community-acquired pneumonia.

Secondary Diagnosis (if applicable): AKI & Chronic diastolic heart failure.

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

More people die from pneumonia than any other infection in the US. Depending on the environment in which it manifests, pneumonia can be hospital-acquired, community-acquired, or ventilator-associated. The etiologic pathogens differ greatly depending on the disease's environment. Males are more likely to develop pneumonia than females. The prevalence of pneumonia and its mortality both rise with advancing age (Pagana et al., 2018). The risk of bacterial pneumonia increases by comorbidity, a weakened immune system, and a reduced ability to prevent aspiration. It can happen in the community or within the first 48 hours following hospitalization or institutionalization, making CAP a frequent infectious condition. CAP patients may need to be hospitalized depending on pneumonia's severity. Annually, there are more than 3 million cases in the US. With an annual hospitalization rate of 2000 per 100,000 persons 65 and older, CAP rates rise with age (Capriotti & Frizzell, 2020). This diplococcus gram-positive bacteria infects the nasopharynx. Following colonization, organisms may directly extend into regions of the upper and lower respiratory tracts. A healthy host's anatomical and ciliary clearance mechanisms usually guard against clinical infection. However, variables that are both

chronic can interfere with clearance. Streptococcal pneumonia frequently starts with influenza. Alternately, pneumococci may enter typically sterile tissues by hematogenous dissemination following the mucosal invasion, including the blood, peritoneum, cerebrospinal fluid, or joint fluid (Capriotti & Frizzell, 2020). Traditionally, a viral disease comes before pneumonia and is followed by an early onset of high fever, frequently accompanied by rigors, a productive cough, pleuritic chest discomfort, dyspnea, tachypnea, tachycardia, fatigue, nausea, vomiting, diarrhea, sweats, malaise, and exhaustion. The patient might describe sputum with a bloody tint (Pagana et al., 2018). The patient has complained of nausea, dizziness, cough, chest pain, and fever for the past few days. The patient says chest pain gets worse every time she coughs. The patient reports having yellow/green phlegm. On physical examination, crackles are audible in the pneumonia-affected lung area. The affected lung region is dull to percussion in about half of all patients. Sputum culture and chest x-ray are examples of diagnostic diagnostics. Consolidation in the area of the pneumonia is visible on a chest x-ray, CT scan, blood tests, and sputum test (Pagana et al., 2018). This patient also got blood tests, CT scan, Chest X-ray, EKG, and sputum culture done to diagnose pneumonia properly. In the early stage of pneumonia, it can be treated with antibiotics, cough medication, and pain/fever management (Capriotti & Frizzell, 2020).

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J.P. (2020). ***Pathophysiology: Introductory concepts and clinical perspectives.*** **F.A. Davis Company.**

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

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	2.73	2.44	PT has low RBC related to anemia (Pagana et al., 2018).
Hgb	12 – 16	7.6	6.8	PT has low Hgb related to anemia (Pagana et al., 2018).
Hct	35 – 37	22.4	20	PT has low Hct related to anemia (Pagana et al., 2018).
Platelets	150,000 – 400,000	254	317	N/A
WBC	4,500 – 11,000	15.2	8.9	PT has high WBC related to the infection of the lungs (Pagana et al., 2018).
Neutrophils	45 – 75	87.6	70.9	PT has high neutrophils due to pneumonia (Pagana et al., 2018).
Lymphocytes	20 – 40	5.6	N/A	PT has high neutrophils due to pneumonia (Pagana et al., 2018).
Monocytes	4 – 6	5.8	N/A	N/A
Eosinophils	Less than 7%	N/A	N/A	N/A
Bands	50 – 65%	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135 – 145	133	130	PT has low sodium due to electrolyte imbalance (Pagana et al., 2018).
K+	3.5 – 5	4.7	4.2	N/A
Cl-	98 – 107	101	N/A	N/A

CO2	**21 – 31**	**N/A**	**N/A**	**N/A**
Glucose	**70 – 100**	**314**	**132**	**PT has high glucose due to type 2 diabetes (Pagana et al., 2018).**
BUN	**8 – 25**	**30**	**9**	**PT has high BUN related to dehydration & AKI (Pagana et al., 2018).**
Creatinine	**0.6 – 1.3**	**1.29**	**1.01**	**PT has high BUN related to AKI (Pagana et al., 2018).**
Albumin	**3.5 – 5.2**	**3.1**	**N/A**	**N/A**
Calcium	**8.6 – 10.2**	**7.9**	**N/A**	**PT has hypoparathyroidism related to AKI (Pagana et al., 2018).**
Mag	**1.6 – 2.6**	**N/A**	**N/A**	**N/A**
Phosphate	**2.5 – 4.5**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.1 – 1.4**	**0.2**	**0.4**	**N/A**
Alk Phos	**34 – 104**	**45**	**N/A**	**N/A**
AST	**10 – 30**	**24**	**15**	**N/A**
ALT	**10 – 40**	**18**	**N/A**	**N/A**
Amylase	**40 – 140 U/L**	**N/A**	**N/A**	**N/A**
Lipase	**11 – 82 U/L**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.5 – 2.0 mmoL/L**	**0.7**	**N/A**	**N/A**
Troponin	**0.00 – 0.03**	**N/A**	**N/A**	**N/A**
CK-MB	**5 – 25 mmol/L**	**N/A**	**N/A**	**N/A**
Total CK	**55 – 170 U/L**	**N/A**	**N/A**	**N/A**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	2 – 3	N/A	N/A	N/A
PT	9.5 – 11.3	N/A	N/A	N/A
PTT	30 – 40 sec	N/A	N/A	N/A
D-Dimer	≤ 250	N/A	N/A	N/A
BNP	< 100	N/A	N/A	N/A
HDL	> 40	N/A	N/A	N/A
LDL	< 130	N/A	N/A	N/A
Cholesterol	< 200	N/A	N/A	N/A
Triglycerides	< 150	N/A	N/A	N/A
Hgb A1c	< 7	N/A	N/A	N/A
TSH	0.5 – 5	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Negative	N/A	N/A	N/A
pH	Negative	N/A	N/A	N/A
Specific Gravity	Negative	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	Negative	N/A	N/A	N/A

RBC	**Negative**	**N/A**	**N/A**	**N/A**
Leukoesterase	**Negative**	**N/A**	**N/A**	**N/A**

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35 – 7.45**	**7.44**	**N/A**	**N/A**
PaO2	**35 – 45 mmHg**	**54**	**N/A**	**PT has an elevated PaO2 indicates alveolar hypoventilation (Pagana et al., 2018).**
PaCO2	**41 – 51 mmHg**	**28**	**N/A**	**PT has an elevated PaCO2 indicated a buildup of CO2 due to hypoventilation or respiratory failure caused by pneumonia (Pagana et al., 2018).**
HCO3	**22 – 26**	**24**	**N/A**	**N/A**
SaO2	**95 – 99%**	**84**	**N/A**	**PT has a decreased SaO2 related to SOB (Pagana et al., 2018).**

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative**	**N/A**	**N/A**	**N/A**
Blood Culture	**Negative**	**Negative**	**Negative**	**N/A**
Sputum Culture	**Negative**	**Negative**	**Negative**	**N/A**
Stool Culture	**Negative**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (1) (APA):

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

***Reference* (14th ed.). Mosby.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. **Chest X-ray**
   - **Tube placement.**
2. **CT ANGIO CHEST PULMONARY W/ CONTRAST**
   - **Emphysema and COPD.**
   - **Severe coronary artery atherosclerotic calcium.**
   - **Right upper lobe infiltrate.**
   - **Right hilar and mediastinal lymph node enlargement.**
3. **EKG – NSR.**

Diagnostic Test Correlation (5 points): The CT Angio chest pulmonary was ordered due to shortness of breath, chest pain, and dyspnea. EKG was ordered due to chest pain. There was multiple chest X-ray ordered due to tube placement.

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives.* F.A. Davis Company.

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

Home Medications (5 required)

Brand/ Generic	Metformin/ Glucophage	Furosemide /Lasix	Omeprazole/ Zegerid	Famotidine / Pepcid	Clopidogrel/ Plavix
Dose	**850 mg**	**20 mg**	**20 mg**	**20**	**75 mg**
Frequency	**BID**	**Daily**	**Daily**	**Daily**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**PO**	**PO**
Classification	**Pharmacologic: Antidiabetic Therapeutic: Biguanide**	**Pharmacologic: Loop diuretic Therapeutic: Sulfonamide derivative**	**Pharmacologic: Proton pump inhibitor Therapeutic: Antiulcer**	**Therapeutic class: H, - histamine receptor antagonist Pharmacological class: Antiulcer agent**	**P2Y 12 platelet inhibitor; platelet aggregation inhibitor**
Mechanism of Action	**Inhibits hepatic glucose production and increases sensitivity of peripheral tissue to insulin.**	**Acts on the ascending loop of Henle in the kidney, inhibiting reabsorption of electrolytes sodium and chloride, causing excretion of sodium, calcium. magnesium, chloride, water, and some potassium; decreases reabsorptio**	**By blocking the hydrogen potassium adenosine triphosphatase enzyme system, also known as the proton pump, in gastric parietal cells, omeprazole prevents the secretion of stomach acid prevents more HCl.**	**Inhibits histamine at H, - receptor site in gastric parietal cells, which inhibits gastric acid secretion while pepsin remains at a stable level.**	**Binds to ADP receptors on the surface of activated platelets, blocking ADP and deactivating nearby glycoprotein receptors and prevents fibrinogen from attaching to receptor.**

		n of sodium and chloride and increases excretion of potassium in the distal tubule of the kidney; responsible for slight antihypertensive effect and peripheral vasodilatation.			
Reason Client Taking	**To treat high blood sugar.**	**Decreased edema in lung tissue, peripherally; decreased B/P.**	**To treat erosive esophagitis due to acid-medicated GERD**	**PT is taking this med to treat GERD.**	**To reduce stroke events with the patient with hypercholesteremia and possible atherosclerosis.**
Contraindications (2)	**Alcoholism, renal failure.**	**Anuria, hypovolemia**	**Hypersensitivity to the components of omeprazole, concurrent therapy with rilpivirine containing products.**	**Hypersensitivity to h2-receptor, other histamine.**	**Active bleeding; hypersensitivity to clopidogrel.**
Side Effects/Adverse Reactions (2)	**Heart failure, hypoglycemia.**	**Orthostatic hypotension, polyuria**	**Leukopenia and hypomagnesemia**	**Renal disease & insomnia.**	**TTP; neutropenia.**
Nursing Consideration	**Assess for hypoglycemic**	**Assess fluid volume**	**For a once-daily dose,**	**Instruct the patient**	**Be aware that**

s (2)	**reactions (sweating, weakness, dizziness, anxiety, tremors, hunger), hyperglycemic reactions soon after meals; these occur rarely with this product. Monitor CBC.**	**status. Assess patient for tinnitus, hearing loss, ear pain; periodic testing of hearing is needed when high doses of this product are given by IV route.**	**administer omeprazole before meals, ideally in the morning, and an antacid if necessary. Be aware that medicine may interfere with a patient's ability to absorb vitamin B-12; keep an eye out for macrocytic anemia.**	**to carefully chew the tablet. Advice the patient not to take famotidine with other acid-reducing products.**	**clopidogrel prolongs bleeding time; assess for hypoglycemia.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Monitor vitamin B12, blood sugar.**	**LFS, Electrolyte imbalance.**	**Monitor the patient's WBC count for leukopenia.**	**Monitor I&0 ratio, BUN, creatinine, CBC with differential monthly.**	**Coagulation times; RBC/Hct/Hgb.**
Client Teaching Needs (2)	**Teach patient to regularly self-monitor blood glucose using blood glucose meter. Teach patient symptoms of hypo/hyperglycemia, what to do about each.**	**Teach patient to take the medication earl in the day to prevent nocturia. Instruct the patient to lake with food or milk if Gl symptoms of nausea**	**Instruct the patient to swallow the tablet whole. Avoid fatty food.**	**Advice PT to avoid NSAID, alcohol, & spice. Encourage PT to stop smoking.**	**Monitor for unusual bleeding; discourage use of NSAIDS.**

		and anorexia occur.			

Hospital Medications (5 required)

Brand/ Generic	**Enoxaparin/ Lovenox**	**Insulin Aspart/ NovoLOG**	**Lisinopril/ Prinivil**	**Amiodarone/ Nexterone**	**Aspirin/ Acetylsalicylic acid**
Dose	**40 mg**	**Per Low Dose Sliding Scale**	**5 mg**	**100 mg**	**81 mg**
Frequency	**Once a day.**	**Before meals.**	**Daily**	**Daily**	**Daily**
Route	**SQ**	**SQ**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacologic class: Low-molecular-weight heparin Therapeutic class: Anticoagulant**	**Pharmacologic class: Human insulin Therapeutic class: Antidiabetic**	**Pharmacologic: Angiotensin-converting enzyme (ACE) inhibitor Therapeutic: Antihypertensive**	**Pharmacologic: Antidysrhythmic (Class III) Therapeutic: lodinated benzofuran derivative**	**Pharmacologic: Nonopioid analgesic Therapeutic: Salicylate**
Mechanism of Action	**Potentiates the action of antithrombin IlI, a coagulation inhibitor. By binding with antithrombin III, enoxaparin**	**Lowers blood glucose Levels by stimulating peripheral glucose uptake by fat and skeletal**	**It may lower blood pressure by preventing angiotensin I from becoming angiotensin II. A potent vasoconstri**	**Prolongs action potential duration and effective refractory period, noncompetitive . a- and 3-adrenergic**	**Blocks pain impulses by blocking COX-1 in CNS, reduces inflammation by**

	rapidly binds with and inactivates clotting factors (primarily factor Xa and thrombin). Without thrombin, fibrinogen can't convert to fibrin and thrombus can't form.	**muscle by inhibiting haptic glucose production .**	**ctor, angiotensin II, also causes the adrenal cortex to release aldosterone (Jones & Bartlett, 2020). Angiotensin II production in the kidneys and blood vessels may be inhibited by lisinopril. Reduced aldosterone release results in increased sodium and water excretion and decreased reabsorptio n, which lowers blood pressure.**	**inhibition; increases PR and QT intervals, decreases sinus rate, decreases peripheral vascular resistance.**	**inhibition of prostaglan din synthesis; antipyretic action results from vasodilatat ion of peripheral vessels; decreases platelet aggregatio n.**
Reason Client Taking	**To prevent deep vein thrombosis.**	**To improve glycemic control in patients with diabetes mellitus**	**To treat hypertensio n.**	**Decreased amount ventricular dysrhythmias.**	**To decrease chest pain.**
Contraindicati ons (2)	**Active major bleeding;**	**Hypersensi tivity o**	**Hypersensit ivity to**	**Urinary retention,**	**GL bleeding,**

	thrombocytopenia.	**regular human insulin or any of its compounds, chronic lung disease.**	**lisinopril or other ACE inhibitors. Hereditary or idiopathic angioedema or a history of angioedema connected to previous ACE inhibitor treatment.**	**cardiac disease.**	**bleeding disorders.**
Side Effects/Adverse Reactions (2)	**Hyperlipidemia, hyperkalemia**	**Hypoglycemic, weight gain**	**Acute renal failure, hyponatremia**	**Blurred vision, hyper/hypothyroidism**	**Flushing, Tinnitus**
Nursing Considerations (2)	**Solution should appear clear, colorless to pale yellow. Always flush I.V. access with 0.9% Sodium Chloride Injection or 5% Dextrose Injection before and after administration.**	**Monitor patient's blood glucose level closely and check potassium levels.**	**Patients with fluid volume deficits, heart failure, decreased renal function, or sodium depletion should use lisinopril with caution (Jones & Bartlett, 2020). Keep an eye out for dehydration, which can cause hypotension, particularly**	**Monitor electrolytes: potassium, sodium, chloride Monitor liver function studies: AST, ALT, bilirubin, alkaline phosphatase.**	**Administer to patient crushed or whole; chewable tab should be chewed. Give with food or milk to decrease gastric symptoms; separate by 2 hr of enteric product; absorption may be slowed.**

			if the patient has diarrhea or vomiting (Jones & Bartlett, 2020).		
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Monitor the patient's serum potassium level because this drug can cause hyperkalemia and watch closely to the patient's WBC count because this medication can cause thrombocytopenia.**	**Administer at the beginning of meals, check blood sugar.**	**Monitor for hyponatremia. Monitor serum magnesium.**	**Monitor for increased T4, ALT, AST, GGI, alk phos, cholesterol, lipids, PI, INR. Monitor for decrease T13.**	**Monitor liver function, coagulation studies.**
Client Teaching Needs (2)	**NSAIDs may increase risk for bleeding. Teach patient or family member how to give enoxaparin at home.**	**Teach patient how to check blood sugar, teach patient and family what to do if patient is hypoglycemic.**	**Inform the patient that lisinopril helps control hypertension but does not cure it and that they may require lifelong therapy (Jones & Bartlett, 2020). Encourage the patient to take lisinopril every day**	**Instruct patient to use sunscreen and protective clothing to prevent burning associated with photosensitivity. Instruct patient to complete follow-up appointment with health care provider, including pulmonary function studies, chest x-ray,**	**Teach patient to report any symptoms of renal/hepatic toxicity, visual changes, ototoxicity, allergic reactions, bleeding (long-term therapy) Instruct patient to take with 8 oz of water.**

			simultaneously (Jones & Bartlett, 2020).	**ophthalmic examinations.**	

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:**	**Alert and oriented** **Oriented to person, place, and time** **Not in apparent distress** **Clean and neat**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Tan, normal for race** **Dry** **Warm** **Normal** **No skin turgor** **N/A** **N/A** **Braden score: 25**

HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck symmetrical** **A pink, moist ear with no apparent lesions** **Sclera was white, cornea was clear, conjunctiva was pink, with no drainage noted.** **Midline septum, no drainage or bleeding apparent.** **Patient wear dentures**
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: Lower extremities**	**S1 and S2 heart sounds are present with no murmurs, rubs, or gallops.** **Normal rhythm** **Radial pulses 2+ bilaterally.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Clear and equal bilaterally in all lobes** **Breath sounds clear throughout anterior and posterior 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:**	**Regular** **Cardiac diet** **63.400 cm** **155.48 kg** **Bowel sounds active in all quadrants.** **Soft but, nontender to palpitation in all quadrants** **N/A** **No pain or mass noted** **No rash noted** **No distention noted** **No incisions noted** **No scars noted** **No drains present** **No wounds noted**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒**	**Yellow** **Clear** **Normal output**

Dialysis: Y ☐ N ☒ **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Not performed**
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 ☐**	**No obvious deficits noted** **ROM actively in upper/lower extremities bilaterally** **Strength: 5/5- normal, active motion against full resistance in both upper/lower extremities bilaterally** **N/A** **Fall risk: 0** **All extremities have equal strength** **PT is independent. No, assistance require.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**This patient has fair judgement and limited insight to disease process. Thought process is normal.** **Perceptive to touch, heat/cold, and pain.** **Patient is alert and oriented to person, place, time, and situation.** **Good, clear with speech attachment to trach** **No obvious deficits** **Alert**
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):**	**Television, hanging out with her grandkids, and going to church.** **No deficits noted.** **Integrity vs despair** **This patient is a Christian and believes in Jesus. The patient is very involved in the neighborhood church.** **Patient has family support.**

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

Time	**Pulse**	**B/P**	**Resp Rate**	**Temp**	**Oxygen**
0734	**83**	**151/73**	**20**	**36.8**	**96 (Room Air)**
1045	**75**	**139/69**	**20**	**36.1**	**95 (Room Air)**

Vital Sign Trends: The patient vital signs fluctuated due to the patient receiving BP medication. The patient vital signs are in the expected range.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0734	Numeric	N/A	0/10	N/A	N/A
1045	Numeric	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Peripheral IV Location: Left Wrist (3/26/2023) & Right wrist (3/26/2023) Size: 18 Gauge Dry, clean, and intact. No erythema, drainage, ect. Midline: 18 g (03/28/2023) Dry, clean, and intact. No erythema, drainage, ect.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Breakfast: 250 mL, orange juice 50 mL, and coffee 50 mL. = 350 mL	Urine = 150 mL

Nursing Care

Summary of Care (2 points)

Overview of care: The patient came to the emergency department complaining of shortness of breath, nausea, dizziness, cough, chest pain, and fever for the past few days. The patient is awake. The patient was diagnosed with pneumonia. The patient was calm and cooperative with the care the team provided.

Procedures/testing done: The patient had a chest x-ray, CT, and EKG.

Complaints/Issues: N/A.

Vital signs (stable/unstable): The vital signs were stable within the patient's normal range.

Tolerating diet, activity, etc.: Cardiac diet.

Physician notifications: No physician notifications at this time.

Future plans for client: Evaluate the patient's response to new medications or test results.

Discharge Planning (2 points)

Discharge location: The patient plans to return home with her son.

Home health needs (if applicable): N/A.

Equipment needs (if applicable): N/A.

Follow up plan: Follow up with doctor to discuss her lab results.

Education needs: If the patient is prescribed new medications or education for abnormal test results and what that means for her health. Also, educate patient on cardiac diet.

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

Nursing Diagnosis	**Rationale** • Explain	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the

• 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	why the nursing diagnosis was chosen			client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
Ineffective breathing pattern related to respiratory muscle fatigue as evidenced by shortness of breath.	**This patient suffers from shortness of breath due to an oxygen level of 84 at admission.**	**Assess and record respiratory rate and depth at least every four hours to detect early signs of a respiratory compromise.** **Monitor ABG values and pulse oximeter readings to evaluate oxidization and respiratory status.**	**1. The patient's respiratory rate will stay within normal limits.**	**The patient demonstrates Maximum long expansions with educated ventilation.**
Risk for infection related to pneumonia as evidenced by fever.	**This patient is at risk for infection due to a high WBC count.**	**Monitor vital signs closely.** **Assess the patient's immunization status.**	**1. The patient will remain free from signs and symptoms of infection.**	**The patient will perform good handwashing techniques and know signs/symptoms of infection.**

Ineffective airway clearance related to excessive mucus as evidenced by community-acquired pneumonia.	**This patient is suffering from excessive production of yellow/green phlegm.**	**Elevate the head of the bed and change position frequently.** **Auscultate lung fields, noting areas of decreased or absent airflow and adventitious breath sounds: crackles, wheezes.**	**1. The patient will maintain a patent airway with breath sounds clearing and the absence of dyspnea, or cyanosis, as evidenced by keeping a patent airway and effectively clearing secretions.**	**The patient will identify/demonstrate behaviors to achieve airway clearance.**
Risk for unstable blood glucose level related to adequate blood sugar monitoring as evidenced by high blood sugar of 314 during admission.	**This patient is at risk for AKI related to high blood sugar. The patient's creatinine and BUN are high, putting the patient at risk for AKI.**	**Assess for the underlining cause of elevated serum glucose level, including inadequate dietary intake, illness, and poor medication management.** **Evaluate serum electrolyte levels.**	**1. This patient will be free from symptoms of hypoglycemia and hyperglycemia.**	**The patient verbalizes the glucose management plan.**

Other References (APA):

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

Wolters Kluwer

Concept Map (20 Points):

Subjective Data

The patient has complained of nausea, dizziness, cough, chest pain, and fever for the past few days. The patient says chest pain gets worse every time she coughs. The patient reports having yellow/green phlegm.

Nursing Diagnosis/Outcomes

Ineffective breathing pattern related to respiratory muscle fatigue as evidenced by shortness of breath.

1. **Ineffective breathing pattern related to respiratory muscle fatigue as evidenced by shortness of breath.**
   - **The patient demonstrates Maximum long expansions with educated ventilation.**
2. Risk for infection related to pneumonia as evidenced by fever.
   - **The patient will perform good handwashing techniques.**
3. Ineffective airway clearance related to excessive mucus as evidenced by community-acquired pneumonia.
   - **The patient will identify/demonstrate behaviors to achieve airway clearance.**
4. Risk for unstable blood glucose level related to adequate blood sugar monitoring as evidenced by high blood sugar of 314 during admission.
   - This patient will be free from symptoms of hypoglycemia and hyperglycemia.

Objective Data

RBC - 2.44
Hgb - 6.8
Hct - 20
WBC - 15.2
Neutrophils - 87.6
Lymphocytes - 5.6
Na - 130
Glucose - 132
BUN - 8
Creatinine - 1.23
Albumin - 3.1
Calcium - 7.9
PaO2 - 54
PaCO2 - 28
SaO2 - 84
BP - 139/69
CT - Pneumonia
Chest X-rays - Plural effusion.

Client Information

Age: 82, Female
Height: 157.48 cm
Weight: 63.4 kg
Allergies: Sulfa drugs & Doxycycline
White American
This patient came to the ED due to SOB.

Past Medical History: Anemia, Chronic diastolic heart failure, CAD, Hyperlipidemia, Hypertension, Interstitial lung disease, Hypoparathyroidism, Ischemic heart disease, Moderate mitral regurgitation, Moderate mitral regulations, Pulmonary hypertension, Stented coronary artery, Type 2 diabetes mellitus, GERD.

Nursing Interventions

1. Assess and record respiratory rate and depth at least every four hours to detect early signs of a respiratory compromise.
2. Monitor ABG values and pulse oximeter readings to evaluate oxidization and respirtatory status.
3. Monitor vital signs closely.
4. Assess the patient's immunization status.
5. Elevate the head of the bed and change position frequently.
6. Auscultate lung fields, noting areas of decreased or absent airflow and adventitious breath sounds: crackles, wheezes.
7. Assess for the underlining cause of elevated serum glucose level, including inadequate dietary intake, illness, and poor medication management.
8. Evaluate serum electrolyte levels.