

**N311 Care Plan 3**

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Lakeview College of Nursing

N311: Foundations of Professional Practice

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### Demographics (5 points)

<b>Date of Admission</b> 10/2/2023	<b>Client Initials</b> MP	<b>Age</b> 89	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> Bookkeeper	<b>Marital Status</b> Single	<b>Allergies</b> Penicillin
<b>Code Status</b> DNR	<b>Height</b> 5'4"	<b>Weight</b> 155lbs	

### Medical History (5 Points)

**Past Medical History:** Hypothyroidism, hypertension, anemia of chronic renal failure (stage 4 severe), obstructive sleep apnea, hyperlipidemia, coronary artery disease involving native coronary artery of native heart, ground-level fall, chronic back pain, chronic kidney disease (stage IV HCC), allergic rhinitis, non-ST elevated myocardial infarction, bronchopneumonia, pulmonary embolism, atypical chest pain, left ventricular outflow obstruction.

**Past Surgical History:** Cardiac catheterization in 2019, cardiac catheterization in 2020, cataract removal in 2017, cholecystectomy in 2014, urethral stricture dilation in 2016.

**Family History:** The client has no pertinent family history.

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

The client has no pertinent tobacco, alcohol, or drug use.

### Admission Assessment

**Chief Complaint (2 points):** The client came to the emergency room complaining of shortness of breath and an injury to the left shoulder due to a fall.

**History of Present Illness – OLD CARTS (10 points):**

The client stated that she had been experiencing shortness of breath and pain in her left shoulder for three days prior to entering the emergency room. The client denied having any pain in her chest and stated that all of her pain was in her left shoulder. The client stated that she

experienced shortness of breath all day and that the pain in her shoulder would come and go in waves. The client stated that her chest felt heavy and that the pain in her shoulder was dull and aching. When asked about aggravating factors and associated manifestations, the client indicated that movement worsened both the shortness of breath and the shoulder pain. Rest and pain medication helped alleviate the pain for the client. This admission to the hospital is the first time the client has sought treatment for her symptoms.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (3 points):** COPD exacerbation

**Secondary Diagnosis (if applicable):** This client does not have a secondary diagnosis.

### **Pathophysiology**

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

#### **Pathophysiology of COPD**

COPD is a respiratory disease that impacts millions of people every year. COPD is characterized by a limit of airflow, excess mucous production in the bronchioles of the lungs, and inflammation. If this inflammation is not treated, the lungs' structures will evolve to get more oxygen into the lungs. The walls of the lungs will thicken, pulmonary arteries will undergo vasoconstriction, and the client can develop right ventricle hypertrophy, which can develop into right ventricle failure. Chronic COPD can lead to a variety of problems as well. In those with this condition, the chemoreceptors and brain become used to elevated levels of CO<sub>2</sub> in the blood. Over time, these body parts become accustomed to the rise in levels and will become immune to noticing high levels of CO<sub>2</sub>. This can be dangerous as elevated levels of CO<sub>2</sub> can lead to hypoxia (Capriotti, 2020).

#### **Signs and Symptoms of COPD**

COPD has many symptoms, and they often worsen without treatment of the disease. Some examples of these signs and symptoms include wheezing while breathing, tightness in the chest, lack of energy, chronic coughing that can consist of mucus, frequent respiratory infections, and shortness of breath. These symptoms can be treated but often worsen if risk factors, such as smoking, are not reduced (Mayo Clinic Staff, 2020).

### **Diagnosis and Treatment of COPD**

COPD is difficult to diagnose, and many are not diagnosed until further along in the disease progression. Some tests that a doctor may use include lung tests, chest X-rays, CT scans, blood gas analysis, and other lab tests. Treatment of COPD often includes quitting smoking, the use of bronchodilators, inhaled steroids, combination inhalers, oral steroids, oxygen therapy, and pulmonary rehabilitation programs (Mayo Clinic Staff, 2020).

### **Pathophysiology References (2) (APA):**

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2<sup>nd</sup> ed.). F.A. Davis Company.

Mayo Clinic Staff. (2020, April 15). *COPD*. Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679>

### **Laboratory Data (20 points)**

**\*If laboratory data is unavailable, values will be assigned by the clinical instructor\***

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

<b>Lab</b>	<b>Normal Range</b>	<b>Admission Value</b>	<b>Today's Value</b>	<b>Reason for Abnormal Value</b>
<b>RBC</b>	3.80-5.30	2.63	2.53	The client has anemia, and in

	10(6)/mcL	10(6)/mcL	10(6)/mcL	anemia, the body loses RBCs slowly over time (Capriotti, 2020).
<b>Hgb</b>	12.0-15.8 g/dL	7.9 g/dL	7.8 g/dL	Anemia gradually depletes Hgb levels (Capriotti, 2020).
<b>Hct</b>	36.0-47.0%	24.1%	23.2%	Anemia gradually depletes Hct levels (Capriotti, 2020).
<b>Platelets</b>	140-440 10(3)/mcL	242 10(3)/mcL	240 10(3)/mcL	
<b>WBC</b>	4.00-12.00 10(3)/mcL	11.00 10(3)/mcL	10.90 10(3)/mcL	
<b>Neutrophils</b>	47.0-73.0%	72.3%	Not documented	
<b>Lymphocytes</b>	18.0-42.0%	19.0%	Not documented	
<b>Monocytes</b>	4.0-12.0%	9.9%	Not documented	
<b>Eosinophils</b>	0.0-5.0%	1.3%	Not documented	
<b>Bands</b>	0-3%	Not documented	Not documented	

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
<b>Na-</b>	136-145 mmol/L	137 mmol/L	140 mmol/L	
<b>K+</b>	3.5-5.1 mmol/L	4.2 mmol/L	4.1 mmol/L	
<b>Cl-</b>	98-107 mmol/L	103 mmol/L	106 mmol/L	
<b>CO2</b>	22-30 mmol/L	24 mmol/L	21 mmol/L	
<b>Glucose</b>	70-99 mg/dL	84 mg/dL	93 mg/dL	
<b>BUN</b>	10-20 mg/dL	17 mg/dL	12 mg/dL	
<b>Creatinine</b>	0.60-1.00 mg/dL	0.78 mg/dL	0.92 mg/dL	
<b>Albumin</b>	3.5-5.0 g/dL	3.8 g/dL	Not documented	

<b>Calcium</b>	8.7-10.5 mg/dL	9.5 mg/dL	Not documented	
<b>Mag</b>	1.6-2.6 mg/dL	Not documented	Not documented	
<b>Phosphate</b>	40-150 U/L	108 U/L	Not documented	
<b>Bilirubin</b>	0.2-1.2 mg/dL	0.7 mg/dL	Not documented	
<b>Alk Phos</b>	40-150 U/L	108 U/L	Not documented	

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

This client did not receive these tests.

<b>Lab Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>Color &amp; Clarity</b>	N/A	N/A	N/A	N/A
<b>pH</b>	N/A	N/A	N/A	N/A
<b>Specific Gravity</b>	N/A	N/A	N/A	N/A
<b>Glucose</b>	N/A	N/A	N/A	N/A
<b>Protein</b>	N/A	N/A	N/A	N/A
<b>Ketones</b>	N/A	N/A	N/A	N/A
<b>WBC</b>	N/A	N/A	N/A	N/A
<b>RBC</b>	N/A	N/A	N/A	N/A
<b>Leukoesterase</b>	N/A	N/A	N/A	N/A

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

This client did not receive these tests.

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

**Lab Correlations Reference (1) (APA):**

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2<sup>nd</sup> ed.). F.A. Davis Company.

**Diagnostic Imaging**

**All Other Diagnostic Tests (10 points):** This client did not receive any imaging.

**Diagnostic Imaging Reference (1) (APA):** N/A

**Assessment**

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

General, Psychosocial/Cultural, and ONE focused assessment specific to the client is required.

The student and instructor may complete these assessments together.

<p><b>GENERAL:</b></p> <p><b>Alertness:</b></p> <p><b>Orientation:</b></p> <p><b>Distress:</b></p> <p><b>Overall appearance:</b></p>	<p>The client was alert and oriented times four, she showed no signs of acute distress, and her overall appearance was good and within defined limits.</p>
<p><b>INTEGUMENTARY:</b></p>	<p>The skin was fair, smooth, dry, and warm. The skin</p>

<p><b>Skin color:</b></p> <p><b>Character:</b></p> <p><b>Temperature:</b></p> <p><b>Turgor:</b></p> <p><b>Rashes:</b></p> <p><b>Bruises:</b></p> <p><b>Wounds: .</b></p> <p><b>Braden Score:</b></p> <p><b>Drains present: Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/></p> <p><b>Type:</b></p>	<p>showed no signs of dehydration or tenting. There were no signs of rashes or wounds. There was bruising on the client's left arm and shoulder that resulted from a fall prior to her entrance to the emergency room. The client did not have any drains, and her Braden score was 14.</p>
<p><b>HEENT:</b></p> <p><b>Head/Neck:</b></p> <p><b>Ears:</b></p> <p><b>Eyes:</b></p> <p><b>Nose:</b></p> <p><b>Teeth:</b></p>	<p>The head and neck were symmetrical, with no signs of lesions, rashes, bruising, or deformities. The ears were symmetrical, with no signs of redness or drainage. The client displayed PERRLA bilaterally, and her eyes were symmetrical. Her sclera was white bilaterally, and there was no sign of drainage from her eyes. Her nose was moist and pink, and her septum was midline. Her teeth were well cared for, and her gums were pink and moist.</p>
<p><b>CARDIOVASCULAR:</b></p> <p><b>Heart sounds:</b></p> <p><b>S1, S2, S3, S4, murmur etc.</b></p> <p><b>Cardiac rhythm (if applicable):</b></p> <p><b>Peripheral Pulses:</b></p> <p><b>Capillary refill:</b></p> <p><b>Neck Vein Distention: Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/> <b>Edema</b> <b>Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/></p> <p><b>Location of Edema:</b></p>	<p>This examination has not been covered in class at this time.</p>
<p><b>RESPIRATORY:</b></p> <p><b>Accessory muscle use: Y</b> <input type="checkbox"/> <b>N</b> <input type="checkbox"/></p> <p><b>Breath Sounds: Location, character</b></p>	<p>This examination has not been covered in class at this time.</p>

<p><b>GASTROINTESTINAL:</b></p> <p><b>Diet at home:</b></p> <p><b>Current Diet</b></p> <p><b>Height:</b></p> <p><b>Weight:</b></p> <p><b>Auscultation Bowel sounds:</b></p> <p><b>Last BM:</b></p> <p><b>Palpation: Pain, Mass etc.:</b></p> <p><b>Inspection:</b></p> <p>    <b>Distention:</b></p> <p>    <b>Incisions:</b></p> <p>    <b>Scars:</b></p> <p>    <b>Drains:</b></p> <p>    <b>Wounds:</b></p> <p><b>Ostomy:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Nasogastric:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>    <b>Size:</b></p> <p><b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>    <b>Type:</b></p>	<p>This examination has not been covered in class at this time.</p>
<p><b>GENITOURINARY:</b></p> <p><b>Color:</b></p> <p><b>Character:</b></p> <p><b>Quantity of urine:</b></p> <p><b>Pain with urination:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Dialysis:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Inspection of genitals:</b></p> <p><b>Catheter:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p>	<p>This examination has not been covered in class at this time.</p>

<b>Type:</b> <b>Size:</b>	
<b>MUSCULOSKELETAL:</b> <b>Neurovascular status:</b> <b>ROM:</b> <b>Supportive devices:</b> <b>Strength:</b> <b>ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/></b> <b>Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/></b> <b>Fall Score:</b> <b>Activity/Mobility Status:</b> <b>Independent (up ad lib) <input type="checkbox"/></b> <b>Needs assistance with equipment <input type="checkbox"/></b> <b>Needs support to stand and walk <input type="checkbox"/></b>	This examination has not been covered in class at this time.
<b>NEUROLOGICAL:</b> <b>MAEW: Y <input type="checkbox"/> N <input type="checkbox"/></b> <b>PERLA: Y <input type="checkbox"/> N <input type="checkbox"/></b> <b>Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/></b> <b>Arms <input type="checkbox"/> Both <input type="checkbox"/></b> <b>Orientation:</b> <b>Mental Status:</b> <b>Speech:</b> <b>Sensory:</b> <b>LOC:</b>	This examination has not been covered in class at this time.
<b>PSYCHOSOCIAL/CULTURAL:</b> <b>Coping method(s):</b> <b>Developmental level:</b> <b>Religion &amp; what it means to pt.:</b> <b>Personal/Family Data (Think about home</b>	This examination has not been covered in class at this time.

environment, family structure, and available family support):	
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**Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
08:35	83	126/67	18	96.8°F Temporal	96% Nasal cannula 3L/min

**Pain Assessment, 1 set (5 points)**

Time	Scale	Location	Severity	Characteristics	Interventions
11:12	0-10	Left shoulder	4-5	Aching, dull, burning	Rest and Tylenol PRN for the pain

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
Input was not being recorded for this client.	Output was not being recorded for this client.

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis\***

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
<ul style="list-style-type: none"> <li>Include full nursing diagnosis with “related to” and “as evidenced by” components</li> <li>Listed in order</li> </ul>	<ul style="list-style-type: none"> <li>Explain why the nursing diagnosis was chosen</li> </ul>			<ul style="list-style-type: none"> <li>How did the client/family respond to the nurse’s actions? <ul style="list-style-type: none"> <li>Client response, status of goals and outcomes,</li> </ul> </li> </ul>

by priority – highest priority to lowest priority pertinent to this client				modifications to plan.
<p><b>1. Ineffective breathing pattern related to chronic obstructive pulmonary disease as evidenced by altered chest excursion and tachypnea (Phelps, 2021).</b></p>	<p>I chose this diagnosis because the client was breathing faster than the expected range and was utilizing accessory muscles to breathe.</p>	<p><b>1. Elevate the head of the bed to aid in easing client's breathing (Phelps, 2021).</b></p> <p><b>2. Assess the client's respiratory rate and depth at least every four hours to assess for respiratory compromise (Phelps, 2021).</b></p>	<p><b>1. The client will maintain an oxygen saturation level above 95% every day until discharge.</b></p>	<p>The client was able to maintain an oxygen saturation level above 95% by elevating the head of the bed and utilizing the tri-pod position to increase breathing patterns.</p>
<p><b>2. Acute pain related to a physical injury as evidenced by protective and expressive behavior (Phelps, 2021).</b></p>	<p>I chose this diagnosis because the client expressed having pain in her left shoulder following a ground-level fall.</p>	<p><b>1. Administer pain medication as needed and/or as prescribed (Phelps, 2021).</b></p> <p><b>2. Encourage the client to inform members of the healthcare team which pain-relieving methods are most effective to give the client control over their</b></p>	<p><b>1. The client will be able to identify the onset of her pain and notify her healthcare team so that the pain-relieving plan can be carried out. This will be done by the client every day until discharge (Phelps, 2021).</b></p>	<p>The client was able to identify the onset of her pain, and the proper pain medication or alternative therapy was administered.</p>

		pain management care (Phelps, 2021).		
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**Other References (APA):**

Phelps, L. L. (2021). *Nursing diagnosis reference manual* (12<sup>th</sup> ed.). Wolters Kluwer.

**Concept Map (20 Points):**

### Subjective Data

The client had bruising on her left shoulder.

The client was using accessory muscles to breathe.

The client came in complaining of shortness of breath and pain in her left shoulder.

The client's respirations were on the higher side of the normal range at 18. The client rated her pain as a 4-5 on a 0-10 scale. She described the pain as dull and aching.

The client receives oxygen through a nasal cannula at 3L/min.

### Objective Data

### Nursing Diagnosis/Outcomes

1. Ineffective breathing pattern related to elevated chest of the bed to aid in increasing client's breathing (Phelps, 2021).  
evidenced by altered chest excursion and tachypnea.

2. Acute pain related to a physical injury (Phelps, 2021).  
The client is an 89-year-old Caucasian female. The client is single and is a retired bookkeeper.

The client is 5'4", 155lbs, and is allergic to penicillin.

### Client Information

2. The client was able to identify the onset of her pain, and the proper pain medication or alternative therapy was administered.

1. Elevate the head of the bed to aid in increasing client's breathing (Phelps, 2021).  
2. Assess the client's respiratory rate and depth at least every four hours to assess for respiratory compromise (Phelps, 2021).

3. Administer pain medication as needed and/or as prescribed (Phelps, 2021).

4. Encourage the client to inform members of the healthcare team which pain-relieving methods are most effective to give the client control over their pain, and the proper pain medication or pain management care (Phelps, 2021).

### Nursing Interventions

