

N311 Care Plan 5

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Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Smalley

04/04/2024

Demographics (5 points)

Date of Admission 04/03/2024	Client Initials L.B	Age 58	Gender Male
Race/Ethnicity White	Occupation Unknown	Marital Status Married	Allergies No Known
Code Status Full	Height 5'10"	Weight 248.1 lbs.	

Medical History (5 Points)

Past Medical History: Cardiomyopathy (HCC), Class 3 sever obesity due to excess calories with serious comorbidity and body mass index (BMI) of 40.0 to 44.9 in adult (HCC) (02/03/2021), Congestive heart failure (HCC), Heart Attack (HCC), Hypertensin, and mixed hyperlipidemia.

Past Surgical History: Back Surgery, Cardiac Catheterization (06/28/2018)

Family History: Mother- Cancer. Father- Heart attack, Congestive Heart Failure, and Hypertension. Sister- (deceased) Diabetes. Brother- (alive) Cancer. Maternal Grandfather- Stroke. Paternal Grandfather- Heart Attack, Congestive Heart Failure, and Hypertension.

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

Tabacco: Former, unknown the frequency, quantity, and duration of use.

Alcohol: None

Drug: None

Admission Assessment

Chief Complaint (2 points): Pain with breathing and bloody cough.

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

Patient was admitted on 04/03/2024 for pleuritic chest pain and bloody tinged in sputum when coughing. These new symptoms started 5 days prior to being admitted but has had

respiratory issues since March when he was Covid positive. This is present bilaterally in the lower lobes of his lungs. When he was asked if he was still experiencing the pain he stated no and rated it as a 0 on the numeric pain scale from 0-10. His symptoms worsened when active for a long period of time. What helped to relieve those symptoms was taking a break and rest.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Pulmonary Embolism

Secondary Diagnosis (if applicable): None

Pathophysiology

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

A pulmonary embolism is simple; it is a blood clot within the lungs. A blood clot is a formation of blood cells that eventually clump together, creating a blockage. According to the Cleveland Clinic, the blood clot creates an issue for the blood flow going to the lung which causes problems with the oxygen levels within the lungs. Blood clots do not just form in the lungs. They are usually formed in the lower extremities, called deep vein thrombosis, that breaks away and travels to the lungs. There are a few leading causes of blood clots; some medical conditions, like cardiovascular-related issues, will increase the risk of getting a blood clot. Also, typically, after surgery or long bed rest, blood can collect/pool, which will lead to blood clots.

People with pulmonary embolism could experience one or all of these common symptoms as shortness of breath, chest pain, and/or fainting. According to the Mayo Clinic, shortness of breath would appear suddenly. It could happen at any time with no signs. Some patients will relate chest pain to having a heart attack. Some would exercise and have sharp pain when they deeply breath. The pain can cause someone to cough or feel like they need to bed/lean over to help relieve it. When it comes to fainting, not everyone would experience it. But when it does happen, someone's heart rate and blood pressure drop randomly and suddenly. Someone else can experience other symptoms like a cough with possible blood tinge sputum, irregular heart rate, lightheadedness/dizziness, excessive sweating, fever, leg pain/swelling, and/or clammy skin.

It is known that it is difficult to diagnose someone with pulmonary embolism. However, the way that they can test for it, according to the Mayo Clinic, is by blood work, chest x-ray, ultrasound, and CT pulmonary angiography. One of the main blood work you would use is a D

dimer. A D-dimer is a blood test to see if there is a blood clot by “measuring the amount of oxygen and carbon dioxide in the blood.” A chest X-ray gives us a visual of the heart, which can rule out other conditions with similar symptoms because a pulmonary embolism can not be diagnosed with an X-ray. An ultrasound is also called duplex and it is to test the “sounds of waves to the veins that are being tested.” Lastly, a CT Scan is a great way to test for a pulmonary embolism because it gives us a “3D image that can find changes such as pulmonary embolism within the arteries within the lungs.” According to Pagana, a CT scan is the most accurate form of x-ray to be completed. It will show you any abnormalities like blood clots, tumors, nodules, cysts, and so on.

Pathophysiology References (2) (APA):

Mayo Foundation for Medical Education and Research. (2022a, December 1). *Pulmonary embolism*. Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/diagnosis-treatment/drc-20354653>

Mayo Foundation for Medical Education and Research. (2022b, December 1). *Pulmonary embolism*. Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc-20354647>

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed.). Mosby.

Professional, C. C. medical. (2023, April 20). *What is a pulmonary embolism?*. Cleveland Clinic. <https://my.clevelandclinic.org/health/diseases/17400-pulmonary-embolism>

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.

Lab	Normal Range	Admission Value	Today's Value (Without Diff.)	Reason for Abnormal Value
RBC	4.10-5.70 10(6)/mL	5.67	5.12	
Hgb	12.0-15.8 g/dL	15.5	14.1	
Hct	36.0-47.0%	47.2	42.7	
Platelets	140-440 10(3)/mcL	564	435	
WBC	4.00-12.00 10(3)/mL	15.6	13.20	When someone's white blood cell count is elevated, it is an indication that they have inflammation. He was diagnosed with pulmonary embolism which is causing inflammation in their lung.
Neutrophils	1.60-7.70 10(3)/mL	88.1	N/A	
Lymphocytes	1.30-3.20 10(3)/mcL	8.3	N/A	
Monocytes	0.20-1.00 10(3)/mcL	3.4	N/A	
Eosinophils	0.00-0.40 10(3).mcL	0.0	N/A	
Bands	0.0-6.0%	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 (BMP)	Reason For Abnormal
Na-	136-145 mmol/L	141	142	
K+	3.5-5.1 mmol/L	4.5	4.1	

Cl-	98-107 mmol/L	107	111	This patient can experience excessive infusion of saline due to being on IV pump being continuous.
CO2	22-30 mmol/L	24	20	Patient has a history of Congestive heart failure and Cardiomyopathy with could indicate renal failure which is related to the decrease value in CO2.
Glucose	74-106 mg/dL	126	92	
BUN	8-26 ratio	8	10	
Creatinine	0.70-1.30 mg/dL	0.72	0.63	Increased levels are a sign of reduced renal blood flow, patient has a history of heart disease which causes reduced blood flow to the kidneys so it is an expected finding.
Albumin	3.5-5.0 g/dL	3.6	N/A	
Calcium	8.7-10.5 mg/dL	9.9	8.9	
Mag	1.6-2.6 mg/dL	N/A	N/A	
Phosphate	3.0-4.5 mg/dL	N/A	N/A	
Bilirubin	0.2-1.2 mg/dL	0.5	N/A	
Alk Phos	40-150 U/L	102	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	Yellow/Clear	Was not collected	Was not collected	
pH	5.0-9.0	N/A	N/A	
Specific Gravity	1.003-1.030	N/A	N/A	
Glucose	Negative	N/A	N/A	

Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	Negative, 0-5/hpf	N/A	N/A	
RBC	Negative, 0-2/hpf	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

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	Was Not Collected	Was Not Collected	
Blood Culture	Negative/No Growth	Was Not Collected	Was Not Collected	
Sputum Culture	Negative/No Growth	Was Not Collected	Was Not Collected	
Stool Culture	Negative/No Growth	Was Not Collected	Was Not Collected	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

- CT scan: Filling defect in the lower lobe pulmonary arteries bilaterally.
 - o At Ct scan allows us to see a cross-view of the chest and to be able to see any tissue densities or demonstrating lesions.

Diagnostic Imaging Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2021). *Mosby's diagnostic and laboratory test reference* (15th ed.). Mosby.

**Current Medications (10 points, 2 points per completed med)
*5 different medications must be completed***

Medications (5 required)

Brand/ Generic	Empagliflozin (Jardiance)	Albuterol Aerosol Solution Inhaler	Sacubitril- Valsartan (Entresto)	Heparin (Porcine)	Doxycycline Hyclate (Vibramycin)
Dose	10 mg	108 (90 Base) MCG/ACT	97-103 mg	36 mL	100 mg in 0.9% sodium chloride 100 mL IVPB
Frequency	Daily	2 puffs, PRN every 4 hours for wheeze or cough	2 times daily	1 Hour countries infusion	One time
Route	Oral	Oral	Oral	IV	IV
Classification	Pharmacologic: Sodium glucose cotransporter 2 inhibitor Therapeutic: Antidiabetic	Pharmacologic: Adrenergic Therapeutic: Bronchodilator	Pharmacologic: Angiotensin receptor neprilysin inhibitor Therapeutic: Angiotensin receptor neprilysin inhibitor	Pharmacologic: Anticoagulant Therapeutic: Anticoagulant	Pharmacologic : Tetracycline Therapeutic: Antibiotic

Mechanism of Action	“Decreased blood glucose levels.” (Jones & Bartlett, 2023, p. 446).	“Relax bronchial smooth muscle cells and inhibit histamine release.” (Jones & Bartlett, 2023, p. 34).	“Sacubitril is a pro-drug that acts as a neprilysin inhibitor.” (Nicolas, 2022). “Valsartan is an angiotensin receptor blocker.” (Nicolas, 2022).	“Preventing fibrin formation and existing clot extension.” (Jones & Bartlett, 2023, p. 648).	“Exerts a bacteriostatic effect against a wide variety of gram-positive and gram-negative organisms. (Jones & Bartlett, 2023, p. 416).
Reason Client Taking	Unclear why the patient is taking this medication because this medication is to treat high blood glucose and his last lab work was in the normal range.	Patient was admitted with pain when breathing and this inhaler is to help relieve the pain and help promote normal/ clear breath sounds.	The patient is hypertension and congestive heart failure, this is to help control his blood pressure.	The patient had blood clots in his lungs and this is to break those blood clots up and prevent any new ones from forming.	Unclear why this patient is taking medication because this is to treat an infection but there is no indication of an infection, only inflammation.
Contraindications (2)	1. Dialysis Therapy 2. Severe renal impairment	1. Hypersensitivity to albuterol 2.?	1. Hypersensitivity to any component of sacubitril-Valsartan. 2. History of angioedema due to an ACEI or ARB	1. Uncontrolled active bleeding 2. excepts in disseminated intravascular coagulation (DIC)	1. Hypersensitivity to doxycycline 2. Hypersensitivity to other tetracyclines
Side Effects/Adverse Reactions (2)	1. Hypotension 2. Ketoacidosis	1. Hypotension 2. Bronchospasm	1. Hyperkalemia 2. Irregular heartbeat	1. Thrombosis 2. Hemorrhage	1. Intracranial hypertension 2. Hepatotoxicity

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). *2023 Nurse's drug handbook* (22nd ed.). Jones & Bartlett Learning.

Nicolas, D. (2022, May 26). *Sacubitril-Valsartan*. StatPearls [Internet].
<https://www.ncbi.nlm.nih.gov/books/NBK507904/#article-41513.s5>

Assessment

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

<p>GENERAL: Alertness: A/O x4 Orientation: A/O x4 Distress: None Overall appearance: Well grooms</p>	<p>Patient was alert and oriented x4. He appeared well groomed and no distress.</p>
<p>INTEGUMENTARY: Skin color: Normal for skin tone Character: Dry and flakey. Toenail fungal Temperature: Normal Turgor: Normal Rashes: None Bruises: None Wounds: None Braden Score: 21 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A</p>	<p>The patient's overall skin was normal to his skin color, normal warm and dry temperature, normal turgor, no rash/bruises/wounds, and no drains present. Normal quantity, distribution, and texture of hair. Normal nails without clubbing or cyanosis. On his lower legs, they were little dry and flakey. He had some toenail fungal starting. Braden Score was at 21 which is a low risk for developing a pressure ulcer.</p>
<p>HEENT: Head/Neck: Normal. (Did not palpate lymph nodes, per Professor Smalley) Ears: External was normal, no otoscope available. Eyes: External was normal, no ophthalmoscope available. Nose: External and internal was normal Teeth: External and internal was normal.</p>	<p>Patient head and neck were symmetrical. The trachea was midline. We did not palpate thyroid or lymph nodes or pulses. PERRLA bilaterally was intact. Bilateral eyes were normal with normal sclera white, cornea clear, conjunctiva pink, and no visible drainage from eyes. There was not a ophthalmoscope present. Bilateral ears auricles no visible deformities, lumps, or lesions. No otoscope present. Septum was midline with no visible bleeding or drainage. Did not palpate frontal sinuses. Mouth and throat were normal with good oral hygiene with no lesions. Tonsils were moist and pink. Uvula was midline and soft palate raised and fell symmetrically. Hard palate was intact.</p>
<p>CARDIOVASCULAR: Heart sounds: Normal S1, S2, S3, S4, murmur etc.</p>	<p>Patient had normal heart sound with S1 and S2 present without murmurs. The peripheral pulse was 1+ and all capillary refills were normal. No</p>

<p>Cardiac rhythm (if applicable): N/a Peripheral Pulses: 1+ Capillary refill: Less than 3 seconds Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema: Right lower leg there was a trace and Left lower leg was +1</p>	<p>neck vein distention. He had a trace of edema in his lower right leg and 1+ in his lower left leg.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character: Bilaterally lower lobes were diminished. Scant inspiratory crackles in right base. No productive cough.</p>	<p>Patient had normal rate and pattern of respiration. Respiration was symmetrical and non-labored. Bilateral lower lobes had diminished breath sounds. Scant inspiratory crackles in the right base. Minimum coughing with no productive mucus.</p>
<p>GASTROINTESTINAL: Diet at home: Cardiac Restrictions Current Diet: Cardiac Restrictions Height: 5'10" Weight: 248.1 lbs Auscultation Bowel sounds: Normal Last BM: Previous night (04/03/2024) Palpation: Pain, Mass etc.: None and no pain Inspection: N/A Distention: N/A Incisions: N/A Scars: N/A Drains: N/A Wounds: N/A Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: N/A Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A</p>	<p>The patient is on a cardiac restriction diet while admitted and when he gets discharge. His height is 5'10" and weights 248.1lbs. He has normal bowel sounds that are normoactive in all four quadrants. Abdomen was soft with no pain or tenderness, no organomegaly or masses, and no bruise/wounds/lesions/distention/incision/drains in all four quadrants. Last bowel movement was the previous night (04/03/2024). Patients have no ostomy, nasogastric, or feeding tube/PEG tube.</p>
<p>GENITOURINARY: Color: Dark yellow/orange (sample that was given) Character: Clear Quantity of urine: 2 times by 1030 Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: N/A Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A Size: N/A</p>	<p>When the patient gave a urine sample, it was dark yellow/orange color and clear. Patient had no pain when urinating. By 1030, he has gone the bathroom with no problems. He was not on dialysis. I did not inspect his genitals. He did not have a catheter.</p>

<p>MUSCULOSKELETAL: Neurovascular status: Normal ROM: Normal Supportive devices: None Strength: All Equal ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 25 (low) Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>(Waved by Professor Smalley) Patient had normal neurovascular status. Normal ROM in all extremities. Hand grips and pedal pushed/pull was normal and equal in strength. Patient is independent with moving and activities. He does not using any supportive devices. Patient stated that he does not need help with ADL. Fall risk score is at a 25, which is a low risk.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: x4 Mental Status: Happy and content Speech: Normal Sensory: Normal LOC: None</p>	<p>(Waved by Professor Smalley) Patient was oriented x4. He was happy and content, normal speech, normal sensory, and no LOC. Patient MAEW good and PERAL was intact.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Talking with people, spending time with his grandkids, working outside Developmental level: Appropriate for age. Religion & what it means to pt.: Christian Personal/Family Data (Think about home environment, family structure, and available family support): Wife, family.</p>	<p>L.B. was a very nice older gentleman who was admitted with pain while breathing and coughing blood. He was not in any distress and was well groomed and level of development was appropriate to his age. His coping methods was spending time with his grandkids and family. He loves to talk with other people and was very nice when Professor Smalley was teaching me how to do a full assessment. He does love working outside in his free time. He is a Christian but couldn't explain what it meant to him but did go to church every Sunday. He lived with his wife at their house. His environment and family support is very supportive and caring.</p>

Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1115	52	89/55	14	96.4°F	94%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1115	Numeric	N/A	0	N/A	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
<ul style="list-style-type: none"> - 2 Small Water: 480 mL/cc - Food: Ate all of his breakfast - IV: Heparin in the right (36x6)= 216 mL and Antibiotic in the left (100cc) - Total: 796 mL 	<ul style="list-style-type: none"> - 300 mL (0802) - 2-time urine in the toilet - Give 1 sample.

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"> • 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 	<ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 			<ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? (Intervention) <ul style="list-style-type: none"> • Client response, status of goals and outcomes, modifications to plan. (Outcome)
1. Impaired gas	The patient	1. “Monitor	1. “The patient	- Patient and wife

<p>exchange related to decreased oxygen levels as evidenced by vial sign being 94% on room air and diminished lung sounds.</p>	<p>is on the low side of the normal range for oxygen saturation at 94%, admitted with pain when breathing and bloody cough, and diminished lung sounds in assessment.</p>	<p>vital signs and heart rhythm at least every 4 hours to detect tachycardia and tachypnea.” (Phelps, 2023, p. 278).</p> <p>2. “Have patient turn, cough, and deep breath every 4 hours to prevent atelectasis or fluid buildup in lungs and to enhance blood oxygen levels.” (Phelps, 2023, p. 279).</p>	<p>would have normal breathing sounds.” (Phelps, 2023, p. 278).</p>	<p>understood and agreed with the interventions while having him monitor his vital signs at home and cough deeply or deep breathing every 4 hours to prevent fluid buildup in his lungs.</p> <p>- The patient and wife response to goals were good and that if his breathing worsens, to call the office to be evaluation for further actions. Patient also demonstrated good technique of taking deep breaths and coughing deeply.</p>
<p>2. Risk for decreased activity tolerance as evidenced by imbalance between oxygen supply/demand.</p>	<p>The patient was admitted with pain when breathing and low oxygen levels.</p>	<p>1. “Assess patients’ level of function using the function mobility scale to determine patients’ capabilities.” (Phelps, 2023, p. 7).</p> <p>2. “Help the patient identify activities that</p>	<p>1. “The patient is maintaining muscle strength and joint ROM.” (Phelps, 2023, p. 6).</p>	<p>- The patient and wife were agreeable and understood the interventions of assessing for any abnormal in function of mobility and to develop plans to achieve daily activities.</p> <p>- The patient demonstrated each ROM and understood the importance of</p>

		are personally meaningful and develop a realistic plan to incorporate meaningful activities into the daily routine.” (Phelps, 2023, p. 7).		doing this to keep his muscle strength.
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Other References (APA):

Phelps, L.L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.

Concept Map (23 Points):

Subjective Data

Nursing Diagnosis/Outcomes

- Visual:
 - o Well-groomed and very nice
 - o No bruises
 - o Covid Positive in March

Vital:

Mild cough at times but no sputum

Abnormal Labs:

- o Increased: Cl- and WBC
 - o Decreased: CO2 and creatinine
- 0 pain on the numeric scale of 0-10
- Stool and urine are normal with no

Objective Data

Stool and urine are normal with no pain or discomfort.

Abnormal Assessment:

- o Braden Scale, edema, lung sounds, urine color, and fall risk score.

L.P. is a 58-year-old who was admitted to the hospital for pain in chest and coughing bloody sputum. Patient has a history of congestive heart failure and hypertension.

Impaired gas exchange related to decreased oxygen levels as evidenced by vital sign being 94% on room air and diminished lung sounds.

Risk for decreased activity tolerance related to oxygen supply/demand.

Risk for imbalance between oxygen supply/demand.

Client Information:

- o The patient is maintaining muscle strength and joint ROM

- Monitor vital signs and heart rhythm at least every 4 hours to detect tachycardia and tachypnea.

Have patient turn, cough, and deep breath every 4 hours to prevent atelectasis or fluid buildup in lungs and to enhance blood oxygen levels.

Assess patients' level of function using the function mobility scale to determine patients' capabilities.

Helping patient strength and joint ROM are personally meaningful and develop a realistic plan to incorporate meaningful activities into the daily routine.



