N311 Care Plan 1

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N311: Foundations of Professional Practice

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Demographics (5 points)

Date of Admission	**Client Initials**	**Age**	**Gender**
9/18/2024	IB	92	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Not Employed	Window	Sulfamethoxazole-Trimethoprim, Amoxicillin, and Renicillin.
Code Status	**Height**	**Weight**	
CPR	5’6”	168 lb 3.4 oz	

Medical History (5 Points)

Past Medical History: Fall (on) (from) other stair & step, initial encounter. Fall (on)(from) side walk curd, subsequent encounter. Arthritis, Cardiac artery disease (CAD), chronic renal insufficiency, Stroke 2023, Glaucoma, goat, HTN, Hypothyroid, Prostate, Psoriasis, Sepsis.

Past Surgical History: Appendectomy, “R,L” cataract removal, tonsillectomy and adencidectomy, cervical laminectomy, Prostatectomy.

Family History: Father-CAD, Mother- Cancer Uterine.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): History Former Cigars, quit 20-30 years ago, 1.0 standard drinks alcohol, 1 glass of wine.

Admission Assessment

Chief Complaint (2 points): Trouble breathing, nausea, vomitting.

History of Present Illness – OLD CARTS (10 points): Pt notes ‘something is stuck in his throat, and very uncomfortable stomach’ at upper region and 5 x vomiting. Started at 1:30 PM yesterday and continued for 2 days. Pt notes symptom comes and goes when he feels fatigue and dizzy. Currently, pt rates his symptom’s severity as 0. He also notes that he’s taken

broad-spectrum antibiotics when he got admitted yesterday. Yet, it's unapparent why he presents with the above symptoms.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Unspecified bacterial pneumonia.

Secondary Diagnosis (if applicable):

Pathophysiology

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

Pathophysiology References (2) (APA):

Pathophysiology of Unspecified Bacterial Pneumonia

Unspecified bacterial pneumonia is an infection of the lung parenchyma by one or more bacterial pathogen(s) the identity of which was not attained.Pneumonia = bacterial infectionx = the lungsThe pathophysiology of pneumonia begins with a battering of the lungs by bacteria. Bacteria enter the alveoli. Bacteria provoke an immune response. At the cellular level, bacteria settle in the respiratory epithelium and trigger a local inflammation. The immune response entails the filling of alveoli with fluid, immune cells and cellular debris. This impairs gas exchange and reduces the oxygenation of blood.

Inflammation can spread into the parenchyma (tissue) of the lung, and sometimes in both lungs. After a period of time, and sometimes without treatment, the patient can develop hypoxaemia, sepsis and multi-organ failure. The elderly, such as the patient in our case, often have low immunity and commonly suffer from co-morbidities such as CAD or chronic renal insufficiency. If these young patients have picked up resistant organisms (eg, Methicillin-resistant Staphylococcus aureus or Vancomycin-resistant Enterococci), treatment

becomes more difficult because the antibiotics they use to treat the illness do not eliminate them efficiently (2021).

Generally speaking , clincally , bacterial pneumonia is manifested by fever, sputum cough , chest pain (dyspnoea) ,fatigue etc (2020).In the elderly, their symptoms are not obvious and patient might present with confusion ,lethargy or clinical worsening (2020). The main clinical symptoms in his case were shortness of breath ,vomiting and vomiting again and again.It might be related to systemic infection ,involving other systems.

Bacterial pneumonia is a clinical diagnosis. A presumptive diagnosis based on clinical signs and diagnostic testing is usually confirmed at the bedside with a chest X-ray (evidence of lung infiltrate) and in the laboratory with sputum and blood cultures (bacteriologic identification of the agent) and elevated WBC and inflammatory markers (ie, C-reactive protein (CRP)) confirming infection. Pulse oximetry and arterial blood gas (ABG) analysis confirm the extent of the hypoxaemia. For unspecified bacterial pneumonia, we are using broad-spectrum antibiotics pending culture identification of the pathogen that can then be treated with a targeted antibiotic.

Bacterial pneumonia can lead to drug-resistant sepsis with systemic complications and even death, especially in patients such as this who are elderly, have multiple comorbidities and likely a history of drug-resistant infections. A definitive diagnosis should be made early to expedite initiation of appropriate antibiotic therapy to avoid complications. This patient is elderly with multiple chronic medical conditions and likely a history of drug resistance and therefore requires close monitoring and individualised care.

References

Liu, P Y, Wang, C H, Chen, T L, & Wu,021). Clinical features and risk factors of pneumonia caused by multidrug-resistant organisms in patients with community-acquired pneumonia. Infection. 49(1), 111-119. https://doi.org/10.1007/s15010-021-01603-y

Metlay, J P, Waterer, G W, Long, A C, Anzueto, A, Brozek, J, Crothers, K, … Whitney, C G. Diagnosis and treatment of adults with community-acquired pneumonia. American Journal of Respiratory and Critical Care Medicine 2019, 200(7): e45-e67. https://doi.org/10.1164/rccm.201908-1700CP

Prina, E, O T Ranzani and A Torres. Community-acquired pneumonia. The Lancet 396, no. 10265 (2020): 1104-1120. 10.1016/S0140-6736(20)31230-5

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11:41	68	104/62	18	98.1 F	98%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:12	0-10	Heel/leg	2	Aching, tingling	Hydrocodone-acetaminophen