N441 CARE PLAN # 1

Kadmiel Gwasira

Lakeview College of Nursing

N441: Adult Health 3

Michele Bergen

Date 10/20/24

Demographics

Date of Admission	Client Initials	Age	Biological Gender
10/10/24	TEC	74	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired Forger/Veteran	Widowed	Dulaglutide - Diarrhea Metformin - Diarrhea Semaglutide - Diarrhea
Code Status	**Height**	**Weight**	
Full	5’10” in	283 lb	

Medical History

Past Medical History: Prostate Cancer 09/03/2015, Congestive heart failure, Chronic obstructive pulmonary disease, Diabetes mellitus type 2, Glaucoma, heartburn, hypertension, Hyperlipidemia, Kidney stones, and tinnitus

Past Surgical History: Left extraocular aqueous shunt 10/28/14, Cataract Removal Left 10/28/14, Cystoscopy removal of bladder stones 9/3/15, Eye surgery, Tonsillectomy

Family History: Mother: Bladder cancer, Diabetes, Hypertension; Maternal Uncle: Prostate Cancer; Sister: Diabetes, Hypertension;

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Cigarette Smoker 1 Pack per day for 45 years, quit 2019, Never Vaped, history of alcohol use, quit 2005

Education: High School Diploma

Living Situation: Lives at home with daughter and her boyfriend

Assistive devices: Walker

Admission History

Chief Complaint: Shortness of Breath

History of Present Illness (HPI)– OLD CARTS

TEC is a 74-year-old male who has a history of COPD with chronic respiratory failure on 3 L oxygen. The onset of his symptoms started 3 days before the initial hospitalization. This happened while he was at home. The patient had shortness of breath, wheezing, abdominal pain, nausea, and vomiting. He reported taking half his “water pill” at home before admission. There were no alleviating factors, but he suffered from hematochezia. However, aggravating factors included lying down, causing the patient to feel unable to breathe, and sleeping in a recliner. The symptoms progressed 3 days after his admission on the 26th of September, to which he was admitted to Hoopeston Hospital and then transferred to Carle on 10/10/24. The AFib is controlled with Coreg, and the heart rate is controlled within two weeks of hospitalization. Protonix is used to treat heartburn, stomach ulcers, and reflux disease, and an EGD will survey the lining from the esophagus to the stomach. The patient was having severe hematochezia, and his O2 stat was decreasing due to not perfusing enough oxygen.

Admission Diagnosis

Primary Diagnosis:

Acute heart failure exacerbation, right lower extremity edema, and new onset of AFib

Secondary Diagnosis (if applicable):

Gastrointestinal bleeding, unspecified gastrointestinal hemorrhage type

Pathophysiology

Patients with preexisting COPD with newly diagnosed heart failure experience a greater risk of exacerbation of severe exacerbation. Heart failure develops when there are structural changes to the heart that cause it not to pump blood as efficiently as it once was before. With the effraction rate decreasing, blood backs up, and fluid builds up in the lungs or extremities. This can indicate congestive heart failure or, in this situation, chronic obstructive pulmonary disease, where the patient isn't able to get the fluid off the patient's body. MacLeod et al. (2021) suggest chronic obstructive pulmonary disease (COPD) is characterized by persistent, irreversible airflow limitation resulting from exposure to harmful particulates and is often accompanied by progressive inflammatory disease of the airways. Patients with COPD experience periods of acute symptom worsening or exacerbations of heart failure.

Signs and symptoms of acute heart failure include shortness of breath, especially during the night, and not being able to lie down flat. The patient also complained of chest pain, pressure, and discomfort. Swelling in the ankles, legs, or abdomen is commonly known as edema, which causes weight gain. Fatigue from the shortness of breath, coughing up white or pink frothy sputum, making the patient feel tired all the time. Feeling dizzy or weak, fainting, or feeling confused from not having enough oxygen in the blood. According to Axson et al. (2021), exacerbations are currently made based on sustained worsening of the common respiratory symptoms, which causes the patient to feel tired all the time.

The patient was diagnosed with acute heart failure but went through tests like an echocardiogram, which measured the amount of blood going to and from the heart, and an electrocardiogram to see the pulses of the heart. Blood tests can include B-type natriuretic

peptide and a basic CBC. Also, he had procedures of an EGD to see that he had a GI bleed, which was reasoning for his hemoglobin and hematocrit to be low.

Treatment of acute heart failure includes bronchodilators to open the airways, Coreg/Lipitor for hypertension, and metoprolol as a beta-adrenergic medication. Other treatments included therapy and oxygen therapy to help with his oxygen saturation levels through sleep and lying down. Lastly, for his GI bleed, he had Protonix and proton pump inhibitors to help with coating his stomach.

Pathophysiology References (2) (APA):

Axson, E. L., Bottle, A., Cowie, M. R., & Quint, J. K. (2021, April 29). Relationship between heart failure and the risk of acute exacerbation of COPD. Thorax. https://pmc.ncbi.nlm.nih.gov/articles/PMC8311079/#:~:text=Patients%20with%20COPD%20with%20newly,experienced%20a%20similarly%20increased%20risk.

MacLeod, M., Papi, A., Contoli, M., Beghe, B., Celli, B. R., Wedzicha, J. A., & Fabbri, L. M. (2021, April 24). *Chronic obstructive pulmonary disease exacerbation fundamentals: Diagnosis, treatment, prevention and disease impact*. Respirology (Carlton, Vic.). https://pubmed.ncbi.nlm.nih.gov/33893708/

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Glucose	160	142	74-100 mg/dL	Stress due to response to a cardiac event. Also, pt has DM type 2
Bun	55	76	8-26 mg/dL	Hypoperfusion from hemodynamic issues/impaired blood flow to the kidneys
Creatinine	2.20	2.75	0.70-1.30 mg/dL	Hypoperfusion from hemodynamic issues/impaired blood flow to the kidneys
Calcium	8.7	8.2	8.9-10.6 mg/dl	Vitamin D deficiency/also vomiting from the GI bleed
Albumin	3.1	2.8	3.4-4.8 g/dL	Possible malnutrition and liver disease
B-Natriuretic Peptide	802.0		0.0-100.0 pg/ml	The heart is working harder to pump blood
RBC	2.83	2.37	4.10-5.70 10^6/UL	The body is not capable of making enough blood due to GI bleed

HGB	8.5	7.1	12.0-18.0 g/dL	GI bleeding/body not making enough healthy RBC
HCT	28.2	23.3	37.0%-51.0%	GI bleeding/body not making enough healthy HCT
C-Reactive Protein	5.29		0.00-0.50 mg/dL	There is possibly an infection in the blood due to cellulitis
Platelet	110	90	140-400 10^3/uL	Possibly due to liver cirrhosis or certain medications (heparin)

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**
Chest X-Ray	Shortness of Breath	Worsening bilateral infiltrate likely to pulmonary venous congestion (Ahlawat et al., 2023)
Ultrasound	Shortness of breath	No sign of DVT
EGD/Colonoscopy	Hematochezia	The esophagus was normal. The examined duodenum was normal. Patchy moderate inflammation characterized by adherent blood, congestion (edema), erosions, and erythema was

		found in the entire examined stomach. Biopsies were taken with cold forceps for histology. (Safai Zadeh et al., 2023)
EGD/Colonoscopy	Hematochezia	Post polypectomy bleed; significant clot associated with the clip at all 3 large polypectomy sites in the cecum, proximal, and distal transverse colon without active bleeding noted. All sites were treated with epinephrine, clot shaving, and hemoclip application; the distal transverse site was the most suspicious of the 3 for recent bleeding with a larger than active oozing after partial clot removal. The site was treated with additional epinephrine and hemospray with good hemostasis. (Rangelov et al., 2020)

Diagnostic Test Reference (1) (APA):

Ahlawat, R., Hoilat, G. J., & Ross, A. B. (2023, August 8). *Esophagogastroduodenoscopy*. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK532268/

Rangelov, B. A., Young, A. L., Jacob, J., Cahn, A. P., Lee, S., Wilson, F. J., Hawkes, D. J., & Hurst, J. R. (2020, July 22). *Thoracic Imaging at exacerbation of chronic obstructive pulmonary disease: A systematic review*. International journal of chronic obstructive pulmonary disease. https://pmc.ncbi.nlm.nih.gov/articles/PMC7385406/

Safai Zadeh, E., Görg, C., Prosch, H., Horn, R., Jenssen, C., & Dietrich, C. F. (2023, February 17). The role of thoracic ultrasound for diagnosis of diseases of the chest wall, the mediastinum, and the diaphragm-narrative review and Pictorial Essay. Diagnostics (Basel, Switzerland). https://pmc.ncbi.nlm.nih.gov/articles/PMC9956010/

Active Orders

Active Orders	Rationale
Glucose	Pt has DM type 2
HCT/HGB	Bleeding
CBC	Infection and Possible GI Bleed/H&H
Cephalexin	Cellulitis
Full Code	Pt wants all life-saving measures
Diet diabetic/cardiac	Due to HTN and DM type 2

Medications

Home Medications (Must List ALL)

Brand/Generic	Albuterol/ Proventil 90 mcg Inhaler PRN	Allopurinol/Zyloprim 300 mg BID	Aspirin/ Ecotrin 81 mg q.d.	Atorvastatin/ Lipitor 80 mg q.d.	Carvedilol /Coreg 12.5 mg BID	Cholecalciferol/ Vitamin D3 25 mcg BID
Classification	Bronchodilator/adrenergic	Hyperuricemia Tx - Xanthine Oxidase/antigout	NSAID/ Antiplatet / Salicylate	Antihyperlipidemic - HMGCOA reductase inhibitor/ Antihyperlipidemic	Antihypertensive/ Nonselective beta blocker and alpha-1 blocker	vitamin D analogs/vitamin D deficiency
Reason Client Taking	To prevent/treat bronchospasms	To treat for kidney stones or gout	To prevent acute MI and ischemic strokes	To control lipid levels	To control hypertension	To treat Vitamin D deficiency
List two teaching	-Teach pt	-Take after	-Take	-Take	-Take	-Chew or

needs for the medication pertinent to the client	how to use an inhaler -Instruct pt to wash mouthpiece with water once a week	meals and drink water -Instruct pt to report unusual bleeding or bruising	med with food or after meals -Advise pt to avoid alcohol	drug at the same time each day -Notify provider is muscle pain/tenderness -Advise pt with DM to monitor glucose levels	drug with food -Warn pt that med can cause dizziness, light-headedness, orthostatic hypotension	crush before swallowing -Administer with the largest meal of the day -Take as directed by your doctor
Key nursing assessment(s) prior to administration	-Monitor serum potassium level -monitor respiratory rate, O2 stat, lung songs	-Monitor CBC and uric acid levels -Maintain a fluid intake of 2L daily -Monitor pt for skin rash after initiation of therapy. Jones & Bartlett Learning. (2023)	-Higher risk of toxicity in elderly pts -Monitor salicylate level	-Monitor Liver enzymes -Monitor client BS if Diabetic	-Monitor glucose levels -Monitor Bp and pulse before administration -Monitor I/O and daily weight. Jones & Bartlett Learning. (2023)	-Monitor blood levels after 3 months
Brand/Generic	Dorzolamide 2%/Trusopt BID	Empagliflozin/ Jardiance 25 mg q.d.	Fluticasone propionate-salmeterol/ Advair diskus 250-50 mcg/dose Inhaler BID	Insulin glargine/ Lantus solostar 100 unit/mL 20 units @ bedtime q.d.	Mirtazapine/ Remeron 15 mg q.d.	Sertraline/ Zoloft 50 mg q.d.
Classification	Topical carbionic	Sodium glucose	Corticosteroid//	antidiabetics/	Tetracyclic	Selective Serotonin

	anhydrase inhibitor/glaucoma	contransporter 2 inhibitor/antidiabetic	antiasthmatic	dipeptidyl peptidase -4 (DPP-4) inhibitors	antidepressant/ antidepressant	Reuptake inhibitor/ Antianxiety
Reason Client Taking	Treat increased pressure from open-angle glaucoma	improve glycemic control in pts with DM Type 2	Prevent asthma attacks/	-improve control in pts with DM	-Treat depression and anxiety	-Treat depressive disorder and PTSD
List two teaching needs for the medication pertinent to the client	-Wash hands prior to administration -Dont allow dropper tip to touch eye -monitor for skin rash, and swelling	- Take in the morning or as PCP prescribes -Monitor Glucose levels -Advise proper fluid intake	-Use as prescribed by a provider, 2 inhalations to wait 1 minute between -gargle and rinse mouth after each dose	- take as directed -don't use if having hypoglycemia or not checked BS	-Take bed at bedtime -drug might cause pupillary dilation -Avoid hazardous activities until CNS effects are known	-Drug might cause mild pupillary dilation -Take the dose immediately after mixing it
Key nursing assessment(s) prior to administration	-Notify Pcp if bitter taste after administration -Monitor for HA, nosebleed, dry mouth	-Asess pts volume status -Obtain serum creatinine level -Monitor pts BP and cholesterol level. Jones & Bartlett Learning. (2023)	-assess muscle strength during long-term use -assess cortisol levels	-Assess BS/HBA 1C -Assess for skin lesions and orientation/ reflexes. Jones & Bartlett Learning. (2023)	-Monitor pt for akathisia development -Watch for suicidal tendencies	-Monitor liver enzymes and BUN and serum creatinine levels -monitor for hypo-osmolarity. Jones & Bartlett Learning. (2023)
Brand/Generic	Sitagliptin/ Januvia 50 mg q.d.	Tiotropium bromide/ Spiriva 18 mcg	Vitamin B comp and Vit C q.d.			

		q.d.				
Classification	dipeptidyl peptidase-4 (DPP-4) inhibitors/antidiabetic	Anticholinergics/ bronchodilator	-water-soluble vitamins			
Reason Client Taking	To control high blood sugar	-Prevent shortness of breath, coughing	to treat or prevent vitamin deficiency due to poor diet			
List two teaching needs for the medication pertinent to the client	-Emphasize diet control and exercise program -teach pt how to monitor glucose level -teach pt to report the development of blisters	-tell the provider of urinating, eye pain, palpitations, and vision changes -Rinse mouth after treatment throat dryness and irritation	- store away from light -take wih foods rich in Vitamin b12 like meat, poultry, fish, eggs, dairy products			
Key nursing assessment(s) prior to administration	-Monitor pt for hypoglycemia/moitor glucose levels -Assess renal function before therapy. Jones & Bartlett Learning. (2023)	-Monitor for angioedema, bronchspasms, and skin reactions -monitor renal function	-monitor blood levels -monitor for constipation, diarrhea, or upset stomach. Jones & Bartlett Learning. (2023)			

Hospital Medications (Must List ALL)

Brand/Generic	Apixaban/ Eliquis 5 mg BID	Cephalexin/ Keflex 40 mg QID	Ferrous sulfate/ferretab 324 mg Every other day	Folic acid/Folacin 1 mg q.d.	Metoprolol tartrate/ 125 mg BID	Protonix/ Pantoprazole 40 mg BID
Classification	Direct Factor XA inhibitors/Anticoagulant	First-generation cephalosporin/ antibiotic	Hematinic/ antianemic	Folic acid Preparations/Vitamin B	Beta-adrenergic Blocking Agents/ antihypertensive	Proton-pump Inbitiors/antiulcer
Reason Client Taking	Antiplatelet/ DVT or PE recurring	Treatment of respiratory infection/ prevention	To treat or prevent anemia	-To treat for folate deficiency anemia -improve heart health	To manage HTN and treatment of MI	-Treat erosive esophagitis associated with GERD
List two teaching needs for the medication pertinent to the client	-Dont stop taking apixaban consult with PCP -Swallow tablet whole don't crush -Notify PCP of any bleeding	- Complete the full coarse of therapy -report watery/bloody stools to the provider	-Take on an empty stomach and don't chew tablet -Take with orange juice to help with absorption	-Take as directed by you PCP -Don't take larger amounts then prescribed	-Intrust pt to take at the same time each day -Urge diabetic to check Blood glucose level	-Don't chew or break tablet -take 30 minutes before meal -relief of symptoms with come 2 weeks later
Key nursing assessment(s) prior to administration	-Monitor hepatic function -Discontinue before procedures. Jones &	-obtain culture and sensitivity -Monitor BUN and	-Monitor pt for s/s of iron overdose, abdominal distension	- assess for skin rash, itching, and difficulty breathini	-Assess ECG -Check for s/s of poor glucose control	-Monitor PT and INR -Monitor Urine output -Monitor

	Bartlett Learning. (2023)	creatinine -Aseess ALT, AST, CBC	, diarrhea, nausea	ng. Jones & Bartlett Learning. (2023)	- Monitor peripher al vascular	for bone fracture
Brand/Generic	Tamsulosin/ Flomax 0.4 mg q.d.					
Classification	Selective estrogen receptor modulator/an ti-estrogen agent					
Reason Client Taking	To treat BPH					
List two teaching needs for the medication pertinent to the client	-Instruct pt not to chew, crush, or open capsule -advise pt to change position slowly. Jones & Bartlett Learning. (2023)					
Key nursing assessment(s) prior to administration	-drug should be given on an empty stomach -monitor BP for orthostatic hypotension					

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Protonix	treats heartburn, stomach ulcers, and reflux disease	**1.** Low vitamin B12 level **2.** Unusual bruising or bleeding Jones & Bartlett Learning. (2023)
2. Cephalexin	utilized in the treatment of infections	**1.** Nausea **2.** Renal failure Jones & Bartlett Learning. (2023)
3. Coreg	To control AFib	**1.** Shortness of breath **2.** Feeling weak or easily tired Jones & Bartlett Learning. (2023)

Medications Reference (1) (APA)

Jones & Bartlett Learning. (2023). 2023 Nurse's drug handbook (19th ed.). Jones & Bartlett Learning

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** Alert **Orientation:** To person, place, and situation **Distress:** No acute/apparent distress **Overall appearance:** Well-groomed and pleasant **Infection Control precautions:** None noted **Client Complaints or Concerns:** None Noted	
VITAL SIGNS:	

Temp: 98.2 F **Resp rate:** 18 RR **Pulse:** 112 HR **B/P:** 125/80 **Oxygen:** 3L **Delivery Method:** Nasal Cannula	
PAIN ASSESSMENT: **Time:** 1200 **Scale:** 0-10 **Location:** 0 **Severity:** None **Characteristics:** None **Interventions:** None	
IV ASSESSMENT: **Size of IV:** 20 G **Location of IV:** Right Antecubital **Date on IV:** 10/9/24 **Patency of IV:** Clean, dry, intact, free of redness, and infuses freely **Signs of erythema, drainage, etc.:** None present **IV dressing assessment:** Clean, dry, intact **Fluid Type/Rate or Saline Lock:** Saline Locked	
INTEGUMENTARY: **Skin color:** White, normal for race **Character:** Dry, Intact **Temperature:** Warm **Turgor:** 2+ quick to return **Rashes:** None noted **Bruises:** None noted **Wounds:** Right anterior Lower leg cellulitis **Braden Score: 19 No risk** **Drains present: Y☐ N ☒** **Type:**	
HEENT: **Head/Neck:** The head and neck are symmetrical; the trachea is symmetrical upon palpation. The thyroid is nonpalpable, and lymph nodes are not swollen **Ears:** The auricle is pink and moist, and no lesions are present **Eyes:** The sclera was white, the cornea was clear, and the conjunctiva was pink, with no discharge noted, EOMs intact, and Peerla is fast to respond with no debris on the internal	.

or external parts of the eyes **Nose:** Septum is midline with no drainage or bleeding noted **Teeth:** Good detention with some missing teeth	
CARDIOVASCULAR: **Heart sounds:** S1 and S2 present with no murmurs, gallops, or rubs. PMI palpable at the 5th intercostal space at MCL **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Newly diagnosed Afib **Peripheral Pulses:** 1+ weak upon palpation on lower extremities, 2+ upon upper extremities **Capillary refill:** less than 3 seconds in all extremities **Neck Vein Distention: Y** ☐ **N** ☒ **Edema Y** ☒ **N** ☐ **Location of Edema:** Lower extremities +2 mild, +1 trace in upper arms	.
RESPIRATORY: **Accessory muscle use: Y**☐ **N** ☒ **Breath Sounds: Location, character** Anterior/posterior clear upon upper lobes, but diminished on the lower lobes.	.
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet:** Diabetic, Cardiac **Is Client Tolerating Diet?** Yes **Height:** 5’ 10” **Weight:** 283 lbs **Auscultation Bowel sounds:** Present in all four quadrants **Last BM:** 10/20/24 **Palpation: Pain, Mass etc.:** No pain or mass noted **Inspection:** No lesions or rashes noted **Distention:** No distention noted **Incisions:** No incisions noted **Scars:** No scars noted **Drains:** No drains noted **Wounds:** Right anterior Lower leg cellulitis	.

Ostomy: Y ☐ N ☒ **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY: **Color:** Amber **Character:** Clear **Quantity of urine:** 50 mL **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** Genital intact **Catheter: Y ☐ N ☒** **Type:** **Size:**	No dysuria, no urgency, no frequency, no hematuria
Intake (in mLs) 480 mL 240 mL **Output (in mLs)** None noted as pt voided in bed on Pad Should be at least 30 ml an hour	
MUSCULOSKELETAL: **Neurovascular status:** Nail beds were normal and intact; lower extremities have non-pitting edema **ROM:** Full ROM **Supportive devices:** 2-wheeled walker **Strength:** +2 on all extremities **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒** **Fall Score:** 3 **Activity/Mobility Status:** **Activity Tolerance:** Pt is a one-assist **Independent (up ad lib)** **Needs assistance with equipment ☒** **Needs support to stand and walk**	.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** He is alert and orientated x4 **Mental Status:** Widowed	

Speech: Good **Sensory:** No obvious deficits **LOC:** Alert and Oriented	
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** Spending time with daughter **Developmental level:** Formal Operational stage/no deficits observed **Religion & what it means to pt.:** Catholic and doesn't go to church **Personal/Family Data (Think about home environment, family structure, and available family support):** Pt is widowed and currently lives with his daughter and her boyfriend.	.

Discharge Planning

Discharge location: Home with his daughter and her boyfriend

Home health needs: Automatic blood pressure cuff, log book for blood pressure and what he eats/diets, water container for how much he drinks, pill separator for his medications/pill crusher, O2 monitor, scale, an emergency button for falls at home, and wristband for medical condition.

Equipment needs: shower chair with back, railings on both sides of the stairs, gait belt, rolling walker

Follow up plan: Home care orders will need to be faxed to the VA for them to set up after discharge.

Education needs: Fall Prevention, pain medicine instructions, introduction to hand hygiene, preventing DVTs, Gastrointestinal bleeding, Diet modification, Medication education on Coreg, PT follow-up

Nursing Process
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	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**
❖ Impaired gas exchange r/t inflammation of lung and airways, as evidenced by SOB (Ackley et al., 2020)	The X-Ray showed pulmonary emphysema, with scarring seen in the bilateral pulmonary apices	1. Pt able to oxygenate above 92% O2 well and not feel dizzy with exertion	1. Encourage the pt to deep breath and cough 2. Assisting pt with positioning to promote gas exchange	Pt ABG and O2 status will stat in normal limits through activity and physical therapy.
❖ Ineffective airway clearance r/t fatigue, as evidenced by Dyspnea (Ackley et al., 2020)	COPD causes shortness of breath as there is an obstruction.	1. Patients maintain an effective respiratory pattern with no dyspnea, and unlabored RR and rhythm	1. Auscultating breath sounds and vital signs 2. Assess ABGs/ applying oxygen	PT O2 stat will be able 92% throughout the hospital stay.

❖ Deficient Fluid Volume r/t GI hemorrhage evidenced by hematochezia and polyps on EGD	Hematochezia during the EGD with polyps viewed and clipped	1. Pt able to demonstrate efficient fluid volume by evidence of stable H/H	1. Assess nutritional status and monitor I/O 2. Treat the underlying cause/giving blood products for low H/H	Pt able to maintain adequate fluid volume as evidenced by vital signs and balance I/O lastly not Nasues or vomiting
❖ Activity intolerance r/t COPD/Malnutrition as evidenced by fatigue upon physical activity (Ackley et al., 2020)	COPD worsens the lung, which causes physical activities to become more challenging.	1. Pt's vital signs will normalize with activity, with no dyspnea episodes	1. Performing range of motion exercises whilst on bed rest. 2. Provide supplemental oxygen therapy.	Evaluation pt current activity level, and monitoring pts cardiopulmonary response.
❖ Deficient knowledge r/t lack of information as evidenced by the development of worsening conditions (Ackley et al., 2020)	Contributing factors like s/s or treatments can cause worsening outcomes. Teaching is done to prevent any future exacerbations	1. Pt able to verbalize factors contributing to worsening COPD	1. Instruct the pt on how to recognize and prevent exacerbations 2. Education on hygiene practices	Pt is will demonstrate the use of an inhaler and oxygen as well for verbalizing symptoms that could warrant an intervention.

Other References (APA)

Ackley, B. J., Ladwig, G. B., & Flynn, M. M. B. (2020). Nursing diagnosis handbook: An evidence-based guide to planning care. Elsevier.