N321 CARE PLAN #1

Bailey McMasters

Lakeview College of Nursing

N321: Adult Health I

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February 21, 2025

Demographics

Date of Admission 02/15/2025	Client Initials JM	Age 91	Biological Gender Female
Race/Ethnicity Caucasian	Occupation Retired- Owned a music store	Marital Status Divorced	Allergies Prinivil (Lisinopril)
Code Status No CPR- Comfort focused treatment	Height 5’ 3”	Weight 149lb 14.6oz	

Medical History

Past Medical History: Arthritis, Asthma, Bacteriuria (11/13/2019), Cancer (HCC), Elevated Blood Pressure, Hypertension, Immunization due (10/13/2020), Osteoporosis, Vitamin D Deficiency (06/25/2019)

Past Surgical History: Adenoidectomy, Tonsillectomy, Total Nephrectomy (right)

Family History: No family history known by the patient and there is none documented in EMR or chart.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient has never smoked, never used smokeless tobacco, has never vaped, never used alcohol, never used drugs, and is not currently sexually active.

Education: The patient’s highest level of education is an Associate’s degree.

Living Situation: The patient lives at Hawthorne Assisted Living

Assistive devices: The patient is mainly wheelchair bound. The patient can transfer with assistance of a walker and/or staff.

Admission History

Chief Complaint: Cough and generalized weakness

History of Present Illness (HPI)– OLD CARTS

The patient was brought into the ER on February 15th, 2025 from Hawthorne Assisted Living. She had been experiencing a cough and generalized weakness. The patient states she had been experiencing these symptoms “for a few days”. The patient has a past diagnosis of dementia and is unable to recall the exact date. When talking to the patient, the cough was characterized as intermittent and non-productive. The patient states, “It feels like I have something in my chest I need to cough up, but nothing ever comes up no matter how hard I cough”. The generalized weakness is consistent and patient states, “I feel weak all over”. Covid test was taken, and the results were negative. When asked about aggravating factors, the patient states, “When I take deep breaths, it makes me cough” and “I also start coughing when I have to get up and move around”. Aggravating factors are determined to be deep breathing and upon exertion. The patient has tried “Halls cherry cough drops”, but they have not been helpful with decreasing her cough. When resting, the patient has found sitting up in the bed makes her cough lessen. However, the patient’s daughter states, “My mother often slouches when sitting in bed and in her wheelchair. Trying to keep her sitting up right can be difficult”. When asked about pain, the patient states, “My cough is not painful, it is just annoying”.

Admission Diagnosis

Primary Diagnosis: Community-Acquired Pneumonia (CAP)

Secondary Diagnosis (if applicable): Acute Respiratory Failure with Hypoxia

Pathophysiology

Community-acquired pneumonia, or CAP, is known as the second most frequent cause of mortality due to infectious disease, Capriotti (2024). This can be especially critical to understand when have patient with past medical histories of COPD and asthma as it affects the lungs. My

patient in this situation has a past medical history of asthma. There are multiple types of pneumonia, with these types being prevalent in different places. For example, there is hospital-associated pneumonia and ventilator-associated pneumonia, Capriotti (2024). These three pneumonias are regulated based on when the patient acquired them and how. CAP is commonly caused by bacteria such as *Legionella*, *Moraxella catarrhalis*, *Mycoplasma*, *Staphylococcus aureus*, *Streptococcus pneumoniae*, *H. influenzae*, and organisms that are gram-negative, Regunath & Oba (2024). Depending on which bacteria cause the pneumonia can determine the symptoms, treatment options, and type of pneumonia the patient has.

Infection of pneumonia most often occurs when a person inhales droplets that contain the bacteria listed previously, Capriotti (2024). This is the portal of entry for the bacteria into the lungs, which is the organ of the body that pneumonia affects. From here, the bacteria or pathogens cause an inflammatory response by attaching to the tissue of the lungs or epithelium, Capriotti (2024). This sudden onset of inflammation then moves down through lower lobes of the lungs and begins affecting the alveoli, Capriotti (2024). Due to the inflammation, neutrophils are released from the capillaries of the lungs and vasodilation takes place, Capriotti (2024). Neutrophils begin phagocytosis and kill off the bacteria using species that are reactive to oxygen, degradative enzymes and antimicrobial proteins, Capriotti (2024). Furthermore, there is an increase in stimulation of goblet cells creating mucous, Capriotti (2024). The excess mucous and edema surround the capillaries and alveoli, Capriotti (2024). This results in the alveoli not being able to fully open, open at all, or close, Capriotti (2024). This is what creates the sound of crackles upon assessment of the lungs with a stethoscope, Capriotti (2024). When the patient was admitted, the nurse was able to hear crackles during her assessment. However, the medication and interventions were proving to work as there were no longer crackles in the lungs during my

shift. Due to the affected functioning of the alveoli and capillaries, gas exchange becomes minimal, Capriotti (2024). This can cause the patient to become hypercapnic and hypoxic, Capriotti (2024). This is what occurred with my patient's second diagnosis of acute respiratory failure with hypoxia.

The first signs and symptoms of pneumonia are most commonly found to be cough, fever, and chills, Regunath & Oba (2024). My patient first presented to the ER with coughing and generalized weakness. According to Capriotti (2024), the cough can either be productive or non-productive, which in my patient her cough was non-productive. The patient's generalized weakness can be seen as caused by the lack of gas exchange within the alveoli and capillaries. As the disease progresses, other symptoms can be chest pain, dyspnea, weight loss, and weakness, Regunath & Oba (2024). As previously stated, upon assessment, crackles can be heard throughout the lungs. In order to be certain of a diagnosis, the provider ordered a chest x-ray. Chest x-rays are seen as a necessary diagnostic procedure to run in order to diagnose pneumonia, Capriotti (2024). Between the crackles, coughing, pulse oximetry stat, and chest x-ray, these are the findings that determine the primary diagnosis of my patient.

Treatment of pneumonia involves oxygenation and antibiotic therapy, Capriotti (2024). cefTRIAXone is an antibiotic that is often prescribed during inpatient care of pneumonia that is not intensive, Regunath & Oba (2024). Oxygen delivered by nasal cannula and having the bed in Fowler's position are recommended, Capriotti (2024). My patient is prescribed and taking cefTRIAXone. My patient was also receiving a liter of oxygen by nasal cannula and her bed was in Fowler's position.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Pathophysiology Introductory Concepts and Clinical Perspectives* (3rd ed.). F.A. Davis.

Regunath, H., & Oba, Y. (2024). *Community-Acquired Pneumonia*. StatPearls.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Sodium	**132mmol/L**	**136mmol/L**	**136mmol/L – 145mmol/L**	**Hyponatremia could be caused by the patient having one kidney. This can lessen the amount of sodium her one kidney can filter through and keep within the body. The values trend up since admission most likely due to the antibiotics she has been taking to help her pneumonia, as antibiotics can increase sodium levels, Pagana et al. (2023).**
Chloride	**101mmol/L**	**108mmol/L**	**98mmol/L – 107mmol/L**	**Hyperchloremia could be caused by the patient**

				being dehydrated as evidence by dark yellow urine and poor skin turgor. The values trend up which could indicate the patient has not been having proper intake of water since admission, Pagana et al. (2023).
CO2, Venous	**19mmol/L**	**19mmol/L**	**22mmol/L – 30mmol/L**	**The decreased values of CO2, venous could be caused by from the patient experiencing diabetic ketoacidosis. Diabetic ketoacidosis can result from uncontrolled hyperglycemia, in which the patient has, Pagana et al. (2023).**
BUN/Creatine Ratio	**18 ratio**	**22 ratio**	**12 ratio – 20 ratio**	**The BUN/Creatine ratio is increased most likely**

				due to the patient being dehydration as evidence by dark yellow urine and poor skin turgor. The values trending up could mean the patient has not been drinking the proper intake of water during admission, Pagana et al. (2023).
Glucose	**164mg/dL**	**150mg/dL**	**70mg/dL – 99mg/dL**	**Hyperglycemia could be caused by the patient's prescribed antidepressant, DULoxetine (Cymbalta). This is because antidepressants can increase glucose values. The values trend down most likely the patient takes acetaminophen (Tylenol), which can**

				decrease glucose values, Pagana et al. (2023).
Calcium	**8.4mg/dL**	**8.0mg/dL**	**8.7mg/dL – 10.5mg/dL**	**Hypocalcemia could be caused by the patient's past diagnosis of Vitamin D deficiency, as this can lead to decreased levels of calcium. The value trends down most likely from the patient's use of albuterol, for patient's asthma, and aspirin, Pagana et al. (2023).**
Phosphorus	**Not Available**	**1.4mg/dL**	**2.5mg/dL – 4.5mg/dL**	**Hypophosphatemia is most likely caused by the patient's past diagnosis of Vitamin D deficiency, Pagana et al. (2023).**
Albumin	**3.3g/dL**	**3.0g/dL**	**3.5g/dL – 5.0g/dL**	**The decreased albumin values could be caused by possible liver disease,**

				as Albumin is synthesized in the liver. The value trends down mostly likely because the patient is on comfort care so the hospital is not treating it, Pagana et al. (2023).
Neutrophils	**86.1%**	**Not Available**	**47.0% - 73.0%**	**Neutrophilia can be caused by the patient's use of aspirin, as this increases neutrophil levels. Also, neutrophilia could be caused by inflammation within the lungs caused by primary diagnosis, Pagana et al. (2023).**
MPV	**8.0fl**	**Not Available**	**9.7fl – 12.4fl**	**Decreased MPV value may be caused by patient's previous diagnosis of osteoporosis. This is**

				because MPV level can be low when platelet production from the bone marrow is low, Pagana et al. (2023).
Lymphocytes	**5.4%**	**Not Available**	**18.0% - 42.0%**	**Lymphocytopenia can be caused by the patient's use of antibiotics to treat pneumonia and use of antihistamines, Pagana et al. (2023)**
Absolute Neutrophils	**8.90 10(3)/mcL**	**Not Available**	**1.60 10(3)/mcL – 7.70 10(3)/mcL**	**Increased neutrophils can be caused by the patient's use of aspirin, as this increases neutrophil levels. Also, neutrophilia could be caused by inflammation within the lungs caused by primary diagnosis, Pagana et al. (2023).**
Absolute	**0.60**	**Not**	**1.3**	**Decreased lymphocytes**

Lymphocytes	**10(3)/mcL**	**Available**	**10(3)/mcL – 3.2 10(3)/mcL**	**can be caused by the patient's use of antibiotics to treat pneumonia and use of antihistamines, Pagana et al. (2023)**

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
Chest X-Ray: This test was ordered to determine if the patient had inflammation of the lung. If found positive for it, it would be diagnosed that the patient had pneumonia, Pagana et al. (2023)	**The client was experiencing cough, weakness, and crackles were found within the lungs during the assessment.**	**Evidence of enlarged bronchovascular markings bilaterally, as well as infiltrates in both lower lobes of the lungs.**
N/A	**N/A**	**N/A**
N/A	**N/A**	**N/A**
N/A	**N/A**	**N/A**
N/A	**N/A**	**N/A**

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's Diagnostic & Laboratory Test Reference* (16th ed.). Elsevier.

Active Orders

Active Orders	Rationale
Diet CHO consistent medium calorie	**The order helps to maintain a patient's weight during admission.**
OT and PT evaluate and treat	**This order is to evaluate how well the patient can complete ADLs and to perform activities such as active or passive ROM to keep the patient's muscles from deteriorating.**
Aerosol Nebulizer- initial, one time	**The order is to help the patient's asthma.**
Aerosol Nebulizer- subsequent albuterol, every 4 hours PRN	**This order is to help the patient's asthma.**
Oxygen therapy- routine, continuous; device, nasal cannula; initiate O2; Triate O2 to maintain SpO2%: 92%-96%; Pulse Oximetry, spot	**The order is to maintain the patient's O2 status and increase gas exchange since the patient's diagnosed pneumonia is interfering with normal function.**
Admission weight	**This order is to be able to calculate drug dosages.**
For blood sugar of 70mg/dL or less	**This order is a guideline for was carbohydrates and juices to give in case the patient's blood sugar drops.**
Home Oxygen Qualification	**This order is to see if the patient is able to leave the hospital and have oxygen therapy**

	at home.
Insert/Maintain Peripheral IV	**This order is to keep the IV intact for when medications or solutions need to me administered.**
Intake and Output	**This order is to evaluate how much the client is eating and how much their body is excreting.**
Notify Provider	**This order is in case of a situation that requires the provider to be notified.**
Nursing Communication	**This order is to allow effective nursing techniques such as passing patient information during hand offs and shift changes.**
Nursing Nightly Calls	**This order is for in case the nurse needs to contact the patient's family during the night.**
Perform POC Blood Glucose- AC and HS	**This order is placed so the patient's blood glucose is checked before meals and at bedtime.**
Place Seq Comp Device (HUC Orders Equip)	**This order is placed so the device can support the patient with proper blood circulation.**
Post Hypoglycemia Treatment and Blood	**This order is a guideline in case the**

Sugar greater than or equal to 80mg/dL	**patient's blood sugar increases.**
Up with Assistance	**This order is placed because the patient needs to be helped when getting up.**
Vital Signs per Unit Routine	**This order is so the patient's vitals can be taken to be monitored.**

Medications

Home Medications (Must List ALL)

Medications	Reason for taking
traMADol (Ultram)	**Analgesic- narcotic: This is to help with the pain from the patient's arthritis and osteoporosis.**
acetaminophen (Tylenol)	**Analgesic- nonnarcotic: This is to help with the patient's headaches.**
aspirin	**Analgesic- nonnarcotic: This is to help with the patient's arthritis and inflammation in the lungs caused by primary diagnosis.**
Albuterol 108 (90 Base) MCG/ACT Aerosol solution	**Antiasthmatic: This is to help with the patient's asthma.**
HumaLOG KwikPen	**Antidiabetic: This is to help with the**

	patient's hyperglycemia.
insulin glargine (Lantus Solostar)	**Antidiabetic: This is to help with the patient's hyperglycemia.**
naloxone HCL (Narcan)	**Antidote: This is to help treat suspected opioid overdose.**
loratadine (Claritin)	**Antihistamine: This is to help manage patient's allergies.**
simvastatin (Zocar)	**Antihyperlipidemic: This is to lower the patient's cholesterol.**
losartan (Cozaar)	**Antihypertensive: This is to lower the patient's blood pressure.**
lidocaine (Lidoderm)	**Dermatological: This is to help treat heart arrhythmias due to patient's heart murmur.**
glucose blood (EvenCare G2 test)	**Diagnostic Product: This is to help measure the patient's blood glucose.**
polyethylene glycol (Glycolax)	**Laxative: This is to help with constipation due to slowed peristalsis caused by age.**
Blood Glucose Monitoring Suppl	**Medical Device: This is to measure blood glucose.**
Lancets Misc	**Medical Device: This is used to prick the finger in order to get blood for blood glucose tests.**

alendronate (Fosamax)	**Misc. Endocrine: This is to help treat the patient's osteoporosis.**
methocarbamol (Robaxin)	**Skeletal Muscle Relaxant: This is to relax the patient's muscles.**
tiZANidine (Zanaflex)	**Skeletal Muscle Relaxant: This is to relax the patient's muscles.**
cholecalciferol (Vitamin D-3)	**Vitamin: This is to help with the patient's Vitamin D deficiency.**

Hospital Medications (Must List ALL)

Brand/ Generic	**aspirin chewable tablet: 81mg, oral, daily**	**azithromycin (Zithromax): 500mg in sodium chloride 0.9% 250ml IVBP, IV Q24hrs, admin over 60 minutes, 250ml/hr**	**cefTRIAXone (Rocephin): injection 2g IV, daily**	**DULoxetine (Cymbalta): capsule 60mg, oral, daily, do not crush**	**guaiFENesin (Mucinex): SR tablet 600mg, oral, 2 times daily, do not crush**	**insulin glargine (Lantus): 100 unit/ml injection 10 units, SUBQ, nightly**
Classification	**Pharmacologic: Salicylate Therapeutic: NSAID**	**Pharmacologic: Macrolide Therapeutic: Antibiotic**	**Pharmacologic: Third generation cephalosporin Therapeutic:**	**Pharmacologic: Selective serotonin and norepinephrine reuptake**	**Pharmacologic: Therapeutic:**	**Pharmacologic: Therapeutic:**

			Antibiotic	**inhibitor Therapeutic: antidepressant**		
Reason Client Taking	**This is to help with the patient's arthritis and inflammation in the lungs caused by primary diagnosis.**	**This medication is for the patient's Community Acquired Pneumonia.**	**This medication is for the patient's Community Acquired Pneumonia.**	**This is to treat the patient's neuropathic pain cause by patient's hyperglycemia**		
Key nursing assessment(s) prior to administration	**The patient's blood pressure.**	**The patient's blood pressure.**	**The patient's labs for the liver.**	**The patient's use of NSAIDs**		
Brand/ Generic	**insulin lispro (HumaLOG): 100 unit/ml injection 2-12 units, SUBQ, 3 times daily after meals. If BS is: 70-180 give no correction insulin; 181-200 give 2 units; 201-**	**insulin lispro (HumaLOG): 100 unit/ml injection 2-6 units, SUBQ, nightly. If BS is: 70-200 give no correction insulin; 201-250 give 2 units; 251-300 give 3 units; 301-**	**loratadine (Claritin): tablet 10mg, oral, daily**	**losartan (Cozaar): tablet 100mg, oral, daily**	**potassium & sodium phosphates (PHOSNAK): 280-160-250 MG packet, 1 packet, oral, 3 times daily with meals**	**Simvastatin (Zocar): tablet 40 mg, oral, nightly**

	250 give 4 units; 251-300 give 6 units; 301-350 give 8 units; 351-400 give 10 units; 401- or greater give 12 units and call physician.	**350 give 4 units; 351-400 give 5 units; 401- or greater give 6 units and call physician.**				
Classification	**Pharmacologic: Therapeutic:**	**Pharmacologic: Therapeutic:**	**Pharmacologic: Therapeutic:**	**Pharmacologic: Therapeutic:**	**Pharmacologic: Therapeutic:**	**Pharmacologic: Therapeutic:**
Reason Client Taking						
Key nursing assessment(s) prior to administration						
Brand/ Generic	**Vitamin D3: tablet 25mcg, oral, daily**	**Not Available**	**Not Available**	**Not Available**	**Not Available**	**Not Available**
Classification	**Pharmacologic: Therapeutic:**					
Reason Client						

Taking						
Key nursing assessment(s) prior to administration						

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1.		**1.** **2.**
2.		**1.** **2.**
3.		**1.** **2.**

Medications Reference (1) (APA)

2024 Nurse's Drug Handbook, (2023). Jones & Bartlett Learning. 691-693.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions:**	**The patient is alert and oriented 2x. She was oriented to place and person. She would fluctuate between knowing why she was in the hospital to then not knowing. There are no signs of acute distress, and the patient is well groomed. Ther are no infection control**

Client Complaints or Concerns:	**precautions in place for the client. The client complained of a headache while being given her medication.**
VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	**The client's temperature was 99.1 F. The client's respiratory rate was 20/minute. The patient's pulse was 72/bpm. The patient's blood pressure was 166/90. The client's oxygen was 91%. Oxygen status is highlighted since active order is placed to keep patient's O2 from 92%-96%. The patient was on 1 liter of oxygen being delivered by a nasal cannula.**
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:** **Interventions:**	**The time of the pain assessment was 0757. On a scale of 1-10, the patient said the severity of her pain was "a 9 out of 10". The location of her pain was in her head and neck. The patient stated, "The pain feels achy, and it moves down into my neck". The intervention taken was the patient was given two Tylenol (acetaminophen).**
IV ASSESSMENT: **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **Fluid Type/Rate or Saline Lock:**	**The size of the patient's IV was a 22 gauge. The location of the IV was the patient's left posterior forearm. The date listed on the IV was 02/16/25. The IV was patent, saline flushes easily went through the line without issues. There are no signs of erythema, drainage, etc. The assessment of the IV dressing shows that it is dry, clean, and intact with a transparent dressing. The IV is flushed and saline locked.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type: none**	**The patient's skin is cream colored and appropriate for age. The temperature of her skin was warm, and her skin turgor was greater than 3 seconds. There were no rashes or bruises noted on the patient. There was a small sore on the patient's right arm in the antecubital area. The patient's Braden score is 15 and there are no drains present.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head/Neck: There are no bumps, lumps, or lesions noted. Head is normocephalic and neck is midline.** **Ears: Ears are symmetrical without lesions or deformities. No drainage noted.** **Eyes: Eyes are symmetrical with EOMs and PERRLA intact. Cornea are clear, sclera are**

	white, and conjunctiva are pink. No drainage or discharge noted. **Nose: Nose is symmetrical, and septum is midline. No drainage noted.** **Teeth/Mouth: Teeth are intact and appropriate for age. They are slightly yellow and deteriorated. Oral mucosa is pink and moist. There are no lesions or sores noted.**
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: none**	**S1 and S2 heart sounds are present. The patient has a heart murmur which was heard upon auscultation. The patient has a normal cardiac rate and rhythm. Peripheral pulses were palpable and non-bounding. Capillary refill was less than 3 seconds. There was no neck vein distention or edema noted.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The patient's breath sounds were clear and heard throughout despite the diagnoses of CAP. No crackles, rhonchi, or stridor noted. The patient did hesitate to take deep breaths, as this was an aggravator to her coughing.**
GASTROINTESTINAL: **Diet at home:** **Current Diet:** **Is Client Tolerating 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:**	**Client follows a diet to help control her diabetes. This is the diet she is placed on at the hospital. The client is not complaining about the diet. However, she has only been eating about 25% of her meals. The patient's height is 5' 3" and her weight is 149lb and 14oz. Upon auscultation, bowel sounds were present in all four quadrants. The patient could not remember her last bowel movement and it was not charted by the nurses. The patient felt no pain and no masses were felt upon palpation. During inspection, there was no distention, incisions, drains, or wounds found. However, the patient had a scar on her stomach from the removal of a kidney due to cancer. The patient did not have an ostomy, nasogastric tube, or a feeding tube.**
GENITOURINARY: **Color:**	**The patient's urine was dark yellow and clear. When the container was emptied during the**

Character: **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: external purewick** **Size: N/A**	**assessment, the quantity was 350ml. There were no other output numbers for urine charted. The patient had no pain when urinating and was not in dialysis. The patient did have an external catheter. The catheter was an external Purewick.**
Intake (in mLs) **Output (in mLs)**	**The client's total intake while in shift was 337.5 ml. The client's total output during the shift was 350 ml. Intake and Output were not being recorded by the other nurses. The numbers I have here are what I was able to record during the shift.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	**The patient's neurovascular status is intact. The patient's ROM is intact; However, it is limited due to her age. Supportive devices include a wheelchair mainly, with using a walker and a staff occasionally. The patient does assistance with ADLs and is a fall risk with a score of 95. Activity and mobility status is limited with a minimum activity tolerance. This is mostly due to age, but with current diagnosis exertion during activities causes coughing episodes. The patient is not independent by needing assistance with equipment and needing support to stand and walk.**
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The patient has the ability to move all extremities, yet movement is limited due to age. The patient's PERRLA is intact. Strength is equal in arms and legs with both being weak. The patient is only oriented to person and place, this is from patient's pre-diagnoses of dementia. The patient's speech is clear and spontaneous. When asked a question she often lost train of thought and began to talk about something else. The patient's sensory is appropriate for age, she is fully conscious and is aware of her surroundings.**
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home**	**The patient's coping method has been watching television and talking with her daughter. The daughter has been visiting often. The patient's developmental level is The patient has another daughter, making two**

environment, family structure, and available family support):	**children in total. The patient currently lives in a nursing home and has expressed concern about not being able to have a room for herself when she goes back. She seems to have reliable support from her family, and she is religious.**

Discharge Planning

Discharge location: Hawthorne Assisted Living

Home health needs: The patient needs assistance with ADLs

Equipment needs: The patient needs to have home oxygen therapy to help with maintaining O2 saturations.

Follow up plan: The patient should continue oxygen therapy as well as PT to help with decrease in activity tolerance due to age.

Education needs: The patient should be educated on controlling glucose levels as much as possible. Hyperglycemia can lead to diabetes which the patient has yet to be diagnosed with. This means it can still be corrected.

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**
1. Risk for thrombosis related to impaired physical mobility as evidence by patient's generalized weakness.	**The patient is experiencing generalized weakness due to impaired gas exchange caused by her pneumonia. The weakness being experienced will most likely make the patient less active. It is important to educate the patient on active ROM techniques so even if she feels she cannot get out of bed, she is able to stimulate blood flow in the legs to prevent thrombosis.**	**The patient will be able to perform active ROM techniques or be able to educate a family member on passive ROM to help ensure patient's blood circulation in the legs by time of discharge.**	**1.Educate the patient through demonstrations and discussion how to perform active ROM and how to teach others to perform passive ROM.** **2.Educate the patient through discussion and handouts on the importance of keeping blood circulating within the legs and the possibilities of formation of air embolisms if this is not achieved.**	**I will have the patient perform active ROM to demonstrate she understands. I will also have her pretend like she is teaching me how to do passive ROM to ensure that if she cannot perform it herself, someone will be able to help her once out of the hospital. Lastly, I will have her explain back to me why is it important to maintain activity and the risk of air embolisms if not maintained. The patient**

				will be determined to maintain activity to prevent thrombosis. Patient's family will be supportive and want to help is performing passive ROM.
2. Decreased activity tolerance related malnutrition as evidence by patient's Vitamin D deficiency.	**The patient was diagnosed with Vitamin D deficiency which can decrease activity tolerance. It is important to educate the patient on ways to increase vitamin D in order to help maintain their levels.**	**The patient will be able to recognize what foods are rich in vitamin D in order to receive a proper intake by time of discharge.**	**1. I will educate the patient through handouts and discussion on which foods will help increase the patient's vitamin D intake.** **2.I will educate through discussion on other ways to increase vitamin D intake. For example, exposure to sunlight can help the body produce vitamin D.**	**The patient will be able to tell me which foods have high vitamin D value. The patient will understand there are other ways to increase vitamin D in the body such as exposure to sunlight. Patient will be happy to know there are many ways to help with her deficiency. She will be confident in adding rich vitamin D foods into her daily meals.**
3. Risk for falls related to decreased lower extremity strength as evidence by prioritized use	**The patient is mostly wheelchair bound, which could mean a possibility of decreased leg**	**The patient will be able to identify fall risks within her**	**1. I will educate the patient through demonstration and discussion on exercises**	**The patient will be able to demonstrate and explain to me exercises that she can complete to**

of wheelchair.	**strength. This could lead to the patient falling when maneuvering in and out of her wheelchair. It is important for the patient to understand fall risks and ways to strengthen her lower body strength in order to prevent falls.**	**home and will be able to perform exercises such as ROM to increase muscle strength.**	**she can complete to help increase her lower body strength.** **2. I will educate the patient through discussion and handouts on fall risks within the home to where they can be removed to help prevent falls.**	**help with lower body strength. She will also be able to identify fall risks within the home and remove them. She will be happy and determined to strengthen her legs through these exercises. The patient will also be determined to attempt to use a walker or staff for often. She will feel more confident uses assistive devices other than her wheelchair due to the lack of fall risks in her home.**

Other References (APA):

Phelps, L. L. (2022). *Nursing Diagnosis Reference Manual: Twelfth Edition*. Wolters Kluwer.