

N311 Care Plan 4

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Lakeview College of Nursing

N311: Foundations of Professional Practice

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3/30/2025

Demographics

Date of Admission 3/17/2025	Client Initials SS	Age 36	Biological Gender Female
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Single	Allergies Adhesive/Latex
Code Status Do not Intub	Height 5'2	Weight 106 lbs	

Medical History

Past Medical History: Amblyopia, Anemia, Cervicitis, Cirrhosis due to cystic fibrosis , Cystic fibrosis with pulmonary manifestations, Depression, Diabetes mellitus due to cystic fibrosis, Deep venous thrombosis, fibromyalgia, hypotension, MRSA (methicillin resistant staph aureus) culture positive in lungs, noncompliance with medication regimen, Osteoporosis due to cystic fibrosis, Pneumonia due to Pseudomonas, Pneumonia due to Staphylococcus Aureus, Seizures last one was 2013.

Past Surgical History: reconstruction surgery on left arm and left leg, appendix removed, gallbladder surgery. 4 surgery on right leg (reconstruction). Reconstruction on right eye.

Family History: ADD/ADHD in her brother, Diabetes maternal grandmother and paternal grandfather. Mental illness in her brother and father.

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

Client was a former smoker from 04/30/1997 to 04/30/2023 used to smoke about a half of a pack a day. Client was a former drinker as well stopped drinking in 2023.

Education: Graduated from Lincoln Challenge

Living Situation: Client lives with their mom and dog at home.

Assistive devices: Implantable Port Single Lumen Left Chest and Oxygen Tank (5Liter).

Admission Assessment

Chief Complaint: Shortness of breath

History of Present Illness (HPI) – OLD CARTS: The client stated that she “started to feel liturgic one morning and didn’t feel like doing anything.” The client started to feel a tightness in her chest. She stated she “coughed up phlegm.” The client feels like physical activity makes it worse, and she hasn’t tried anything to help relieve the pain. The client refused to take any medications.

Primary Diagnosis

Primary Diagnosis on Admission: Cystic fibrosis

Secondary Diagnosis (if applicable): MRSA pneumonia

Pathophysiology

Pathophysiology of the Disease, APA format:

My client came to the hospital due to having shortness of breath. My client also has a history of cystic fibrosis, which “is an autosomal-recessive disease caused by defects in the CF transmembrane conductance regular (CFTR) gene, which encodes for a protein that functions as a chloride channel and regulates the flow of other ions across the surface of epithelial cells” (Capriotti, 2024, pg.41). She was diagnosed with the disease at the age of three. Cystic fibrosis affects most of the respiratory system and pancreas and can also affect other organs. “Pancreatic enzyme insufficiency with associated complications occurs” (Capriotti, 2024, pg.14). The water secreted is reduced and causes thick mucus plugging of the pancreas ductules, preventing the pancreatic enzymes from reaching the intestine. Many complications, such as pancreatitis, cholelithiasis, and cirrhosis of the liver, and “pulmonary involvement occurs in 90% of patients” (Capriotti, 2024, pg.41). The body malabsorption of fats and proteins, which produces poor nutrition and stunted growth. Thickened bile in the liver creates blockages in bile ducts, which cause liver damage and eventually cirrhosis. The gastrointestinal system develops symptoms like

constipation, abdominal pain, and poor nutrient absorption. When cystic fibrosis impacts sweat glands, it causes excessive salt loss during perspiration, which creates electrolyte imbalances and dehydration. The sweat chloride test depends on higher salt loss levels as the principal diagnostic indicator for cystic fibrosis. Pancreatic damage over time leads to diabetes and multiple metabolic disorders. My client presented with abdominal pain upon palpation due to the ascites that were in her abdomen. Also, while listening to her lungs, I could hear wheezing in her right lung. “Signs and symptoms include pulmonary wheezes, rhonchi, excess mucus in sputum, sinusitis, nasal polyps, diarrhea, malabsorption, abdominal pain caused by pancreatitis and cholecystitis, cirrhosis of the liver, and rectal prolapse,” (Capriotti, 2024, pg.41). My client was positive for MRSA pneumonia as well. “Methicillin-resistant *Staphylococcus aureus* (MRSA) is highly prevalent in CF patients and is typically associated with complications” (Voropanov et al., 2022). My patient was encouraged to do some purse lips exercise and to also eat at least 50 percent of her meals throughout the day.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Voropanov, I. A., Comaneci, V. D., & Stan, I. V. (2022, October).

COMPLICATED PNEUMONIA IN A PATIENT WITH CYSTIC FIBROSIS AND METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS INFECTION. ProQuest.

<https://www.proquest.com/openview/4e0fe374d1fdab84cc1675aa1fcae932/1?cbl=4585458&pq-origsite=gscholar>

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
WBC	20.53	9.38	4.00-11.00 10*3/uL	Shows a sign of infection. in the lungs.
HGB	9.4	8.0	11-16 g/dL	This may be because of her nutrition.
RDW	16.4	17.8	12-15%	This may be because of her nutrition.
HCT	29.4	25.9	34-47 %	This can be caused by an infection or lung problems, making it difficult for the body to make enough red blood cells.
Absolute Neutr	15.62	5.83	1.60-7.70 10*3/uL	Infections in lungs
Absolute Mono	1.70	1.19	0.00-1.10 10*3u/L	These are higher due to the body trying to fight off infections.
Sodium	125	132	136-145 mmol/L	It can be due to dehydration.
Chloride	88	95	98-107	Chloride is low due to the

			mmol/L	sodium.
Prothrombin Time	18.9	N/A	12.1-14.9 sec	Blood might take longer to clot.
INR	1.6	N/A	0.9-1.1	Takes the blood longer to clot.
Glucose	280	197	74-100	The pancreas isn't working properly.
Albumin	1.9	1.7	3.5-5.0 g/dL	liver disease.

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
X-RAY KUB	The client had distention, and upon palpation, the abdomen was hard.	Shows distention, no obstructive bowel sounds
X-ray of the chest	Coughing up mucus and shortness of breath.	Chest X-Ray showed pneumonia.
Sono (Abdomen)	The client has distention, and the abdomen is hard upon palpation.	Ascites in the abdomen.

Diagnostic Test Reference (1) (APA):

Current Medications

Brand/Generic	Hydromorphone (Dilaudid)	Lactulose	Ursodio L (Urso 250)	Pancrelipase (Creon 24)	Bupropion HCL (Wellbutrin XL)
Dosage, Route, Frequency given	4mg tablet by mouth every 4 hours.	10g/15mL oral solution Take 15mLs by mouth 2(two) times daily as	Tablet 250mg, oral	Takes 3-5 capsule by mouth	XL tablet 150 mg oral every morning.

		needed			
Reason Client Taking	Dyspnea related to her cystic fibrosis	Helps flush her lower intestines out, so she wants get stopped up.	For the liver.	To break down protein and fat	Depression

Other References (APA):

Nurse's Drug Handbook Jones & Bartlett Learning. (2024a). . Jones & Bartlett Learning.

Assessment

Physical Exam – **HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS**

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

The student and instructor may complete these assessments together.

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Client is oriented x4 well groomed. No sign of distress is shown. No acute distress.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Yes due to the insulin patients takes. Wounds: No Braden Score: 20 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Skin is dry and warm upon palpation. Skin is the color is pink. Skin turgor is normal mobility.. No rashes, a few bruises due to the patient taking insulin. No wounds. Client does have clubbing of the nail and toes. Capillary refill is equal to 3 seconds fingers and toes bilaterally.
HEENT:	Head and neck are symmetrical with no signs of

<p>Head/Neck:</p> <p>Ears:</p> <p>Eyes:</p> <p>Nose:</p> <p>Teeth:</p>	<p>bruises. Trachea is midline with no deviation. Ear canal are clear. No palpable deformities on the ears. Client did get 8 of their teeth pulled. Teeth are yellow and have plaque on them. Nose is midline, no visible bleeding or polyps.</p>
<p>CARDIOVASCULAR:</p> <p>Heart sounds:</p> <p>S1, S2, S3, S4, murmur etc.</p> <p>Cardiac rhythm (if applicable):</p> <p>Peripheral Pulses:</p> <p>Capillary refill:</p> <p>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Location of Edema:</p>	<p>Heart sounds are S1 and S2, regular heart beat. All extremities pink warm and dry bilaterally. Capillary refills are equal to 3 seconds. No Edema is presented.</p>
<p>RESPIRATORY:</p> <p>Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Breath Sounds: Location, character</p>	<p>Client didnt use accessory muscle. Wheezing in the right lung.</p>
<p>GASTROINTESTINAL:</p> <p>Diet at home: don't eat much but drinks a lot of milk. Maybe one meal a day at home. High fats and high proteins.</p> <p>Current Diet: Soft food diets.</p> <p>Height:</p> <p>Weight:</p> <p>Auscultation Bowel sounds:</p> <p>Last BM: 03/26/2025</p> <p>Palpation: Pain, Mass etc.:</p> <p>Inspection:</p>	<p>Client stated "I don't eat much at home". Diet consists of milk and maybe one meal a day at home. While at Carle her diet is soft foods. Client is 5'2 and weighs 106 lbs. Whooshing of the bowel sounds, Ascites can be heard. Last Bowel movement was 03/26/2025. During the palpation the abdomen is tender and distention, masses during palpation.</p>

<p>Distention: Yes</p> <p>Incisions: No</p> <p>Scars: No</p> <p>Drains: No</p> <p>Wounds: No</p> <p>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Size:</p> <p>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p>	
<p>GENITOURINARY:</p> <p>Color:</p> <p>Character:</p> <p>Quantity of urine:</p> <p>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Inspection of genitals:</p> <p>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p> <p>Size:</p>	<p>Client was independent when voiding. Client was real stern on the nurse not looking at her output.</p>
<p>MUSCULOSKELETAL:</p> <p>Neurovascular status:</p> <p>ROM:</p> <p>Supportive devices:</p> <p>Strength:</p> <p>ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score: 6</p> <p>Activity/Mobility Status:</p>	<p>All extremities have full range of motion. Hand grips and pedal pushes are normal and equal strength on both sides. Client is orient to place time and person. Client does use an oxygen tank at home (5L). At the hospital client is on 6 L. Client has a Implantable Port Single Lumen Left Chest. Client is active and independent.</p>

<p>Independent (up ad lib) <input type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p>	
<p>NEUROLOGICAL:</p> <p>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p> <p>Sensory:</p> <p>LOC:</p>	<p>Mental status for the patient is ok, client did talk about having suicidal thoughts when she was younger. She is aware of her disease and health. She speaks well. Client level of consciousness is 15. All senses are intact. No sign of depression appropriate for her age.</p>
<p>PSYCHOSOCIAL/CULTURAL:</p> <p>Coping method(s):</p> <p>Developmental level:</p> <p>Religion & what it means to pt.:</p> <p>Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Client takes pictures in her free time. Client development level integrity and despair. Client doesn't have a religion. Client stays at home with mom who does her laundry and helps with her daily living.</p>

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800AM	96 radial	110/58 on the right arm, sitting.	20	98.5 F oral	7 Liters of Oxygen (Nasal Canel)

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
1100	1-10	Head	6	Stabbing	I asked the nurse if she could provide the patient with medication to help with the pain.

Intake and Output

Intake (in mL)	Output (in mL)
480 mL	Client is independent but voided 1 time while in my care.

Nursing Diagnosis

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? <ul style="list-style-type: none"> ● Client response, status of goals and outcomes, modifications to plan.
<ol style="list-style-type: none"> 1. Impaired gas exchange related (Phelps, 202 pg.277) to Ineffective 	The reason I picked this diagnosis is because the airway is the top	<ol style="list-style-type: none"> 1. Monitor oxygen saturation 2. Position for optimal 	1. The goal is to improve oxygen saturation by the end of the by keeping the client in a high	The client sat up at a high Fowler position but refused to do the pursed lips activity.

airway clearance evidenced by shortness of breath.	priority when it comes to caring for a client.	breathing.	Fowler position and offering breathing techniques such as pursed lips.	
2. Imbalanced Nutrition less than body requirements (Phelps, 2023, pg.444) related to inadequate knowledge of nutrient requirements evidenced by patient weight and labs results.	The reason I picked this diagnosis is because nutrition is very important when it comes to patients' health.	1. Assess and monitor food intake. 2. Promote Adequate Oral Intake.	1. The goal is to encourage the client to intake 50 percent of her meal before the end of the shift.	The client only took a bite of her pudding and drank 480 mL of tea with milk.

Other References (APA):

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

