N441 CARE PLAN #1

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Lakeview College of Nursing

N441: Adult Health 3

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Demographics

Date of Admission	Client Initials	Age	Biological Gender
4-11-25	**D.T.**	**68**	**Female**
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American	**retired**	**single**	**none**
Code Status	**Height**	**Weight**	
Full code	**64.9 kg (143 lbs)**	**152.4cm (5'0)**	

Medical History

Past Medical History: hypertension, hyperlipidemia, COPD (no oxygen), peripheral artery disease, post-right BKA, anemia, cellulitis of left leg, deep vein thrombosis, liver disorder.

Past Surgical History: 7/26/22 peripheral atherectomy

5/17/22 & 9/15/22 cardiac catheterization

3/11/24 right leg amputation

5/17/22 & 9/15/22 & 7/26/22 & 10/4/23 peripheral angioplasty

5/17/22 & 9/15/22 peripheral stent

10/6/23 & 3/21/24 & 4/18/24 upper gastrointestinal endoscopy

Family History: no known family history

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

Said she drinks alcohol and smokes "here and there".

Did not report the use of any other drugs.

Education: did not finish high school

Living Situation: lives alone in an apartment

Assistive devices: right leg prosthetic, walker

Admission History

Chief Complaint: Presented to the hospital for a scheduled left carotid endarterectomy

History of Present Illness (HPI)– OLD CARTS

This patient presented to the hospital on April 9th for a scheduled left carotid endarterectomy. Her post-op recovery was complicated by her being unable to meet the oxygen requirements that would have allowed her to be discharged. Since she was not improving, she was transferred to the CVICU. Her oxygenation problem is still an issue because she has been diagnosed with acute hypoxic respiratory failure. On top of that, she is on CPAP and Optiflow for oxygenation. Her respiratory failure can be seen with her diminished lung sounds and crackles on inspiration. She also struggles to catch her breath. Being on Optiflow slowly caused her to have an altered level of consciousness because she was retaining CO2. Once she got back on the CPAP, she was back to baseline. This has been an ongoing issue since her admission, and it is somewhat severe, but it seems like she has been improving**.**

History of present illness was difficult to complete due to the patient herself not being sure why she was admitted to the hospital when all she was having was a carotid endarterectomy.

Admission Diagnosis

Primary Diagnosis: acute hypoxic respiratory failure

Secondary Diagnosis (if applicable): N/A

Pathophysiology

Introduction

Respiratory failure is not something that occurs out of nowhere. Respiratory failure results from the pulmonary system no longer being able to oxygenate the blood properly or eliminate carbon dioxide from the body (Capriotti, 2020). There are two different types of respiratory failure: hypoxemic and hypercapnic (Capriotti, 2020). My patient presented with hypoxic respiratory failure.

Disease Process

Hypoxemic respiratory failure develops when the pressure of the oxygen in arterial blood (PaO2) is lower than 60 mmHg and the level of arterial carbon dioxide (PaCO2) remains normal. This client's lab revealed a PaO2 of 72.4 mmHg, which is abnormal at the healthcare facility, but their PaCO2 remained stable. The patient's PaO2 may have been even lower when they first got admitted, but the value of 72.4 mmHg was the most recent value. Hypoxemic respiratory failure can develop after pulmonary embolism, pneumonia, or pulmonary edema. The patient had been getting treated for pneumonia.

Signs and Symptoms

Early signs or symptoms that someone is experiencing respiratory failure are restlessness, fatigue, headache, shortness of breath, tachycardia, or increased blood pressure (Hinkle et al, 2021). This patient presented with tachycardia, increased blood pressure, fatigue, and shortness of breath. Decreased breath sounds or the use of accessory muscles are some of the physical findings that occur with respiratory failure.

Diagnosis

After having a left carotid endarterectomy, the patient was unable to meet the oxygen requirements during her post-op for her to be discharged. Even with interventions, her condition was not improving, so she was admitted to the cardiovascular intensive care unit. Her arterial blood gases, other labs, and past medical history all led to her diagnosis of hypoxemic respiratory failure.

Treatment

The main goal of treating respiratory failure is to correct the underlying cause and to restore adequate gas exchange (Hinkle et al, 2021). For this patient, she is using an Opti Flow and a CPAP to restore her oxygenation.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

Hinkle, J. L., & Cheever, K. H. (2021). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
tHb	**11.8 g/dL**	**N/A**	**12-18 g/dl**	**This lab measures the total amount of hemoglobin in the blood. The low amount is expected for this anemic patient.**
Hct	**35%**	**N/A**	**37-50%**	**The patient has a past medical history of anemia so it would be normal for her Hct to be slightly decreased**
pO2	**72.4 mmHg**	**n/a**	**80-100 mmhg**	**This low level of pO2 could be because of pneumonia. She has a diagnosis of respiratory failure, so this is consistent with this diagnosis.**
CoHb	**0.3%**	**N/a**	**0.5-1.5%**	**This patient has been exposed to carbon monoxide in some form (Pagana et al., 2023).**

HCO3	**20.2 mmol/L**	**N/A**	**22-26 mmol/L**	**This lab could be low because of her diuretic use (Pagana et al., 2023)**
BE	**-4.2 mmol/L**	**N/A**	**-2 to 2 mmol/L**	**An abnormal barium enema could indicate many things wrong with the gastrointestinal tract like fistulas, diverticula, hernias, or inflammatory bowel diseases (Pagana et al., 2023. Patient's abdomen is distended.**
Glucose	**132 mg/dL**	**142 mg/dL**	**74 – 100 mg/dL**	**The patient's glucose could be abnormal because they had just eaten or if they had not taken their insulin yet.**
Chloride	**112mmol/L**	**115 mmol/L**	**98-107 mmol/L**	**High levels of chloride could be caused by the patient's anemia (Pagana et al., 2023).**
BUN	**28 mg/dL**	**48 mg/dL**	**10-20 mg/dL**	**Elevated BUN could be caused because of dehydration (Pagana et al., 2023). This patient had poor skin turgor and is on Lasix.**
Magnesium	**3.2 mg/dl**	**2.3 mg/dl**	**1.6-2.6 mg/dl**	**High magnesium could be caused by uncontrolled diabetes, it doesn't seem like this patient took anything for blood sugar at home (Pagana et al., 2023).**
Troponin	**1,049 ng/L**	**N/A**	**0.4 ng/L**	**It seems like this patient was in the process of determining if she had heart failure because no other labs indicate a myocardial infarction (Pagana et al., 2023).**
WBC	**26.25 10^3 u/L**	**26.27 10^3 u/L**	**4-11 10^3 u/L**	**The patient is suspected to have pneumonia, which would elevate her**

				WBC.
HGB	**10.6 g/dl**	**7.6 g/dl**	**11-16 g/dl**	**A low HGB would correlate with this patient's anemia.**
MCV	**76.4 fL**	**74.4 fL**	**80-100 fL**	**Low MCV could be caused by anemia (Pagana et al., 2023).**
MCH	**24.3 pg**	**24.3 pg**	**26-33 pg**	**Low MCH can be caused by the patient's anemia (Pagana et al., 2023).**
Absolute neutrophil	**23.78 10^3 u/L**	**N/A**	**1.6-7.7 10^3 u/L**	**Increased neutrophils could be caused by her pneumonia (Pagana et al., 2023).**
Absolute lymphocytes	**0.63 10^3 u/L**	**N/A**	**1-4.9 10^3 u/L**	**Decreased lymphocytes could be caused by some of the medications she is taking (Pagana et al., 2023).**
RBC	**4.36 10^6 u/L**	**3.13 10^6 u/L**	**3.5-5.20 10^6 u/L**	**Low red blood cell could be caused by her anemia (Pagana et al., 2023).**

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
CTA chest and Ct abdomen pelvis w/out contrast	The patient was unable to meet oxygen requirements after her surgery which caused her to be admitted into the CVICU.	CT results showed pulmonary emphysema and a small pleural effusion in the right of the chest. This diagnostic test is used create an image of the lungs and heart, in this case to see if there were any infiltrates.
Xr chest Ap or Pa only	The patient wasn't able to meet oxygen requirements or wean of the oxygen, so she was admitted into the CVICU.	X ray showed the right pleural effusion to be increasing in size. The heart is also increased in size and

		alveolar opacities are present.
Echo with contrast	Since the chest Xray and CT scan showed an increase in heart size the echocardiogram was used to capture the image of her heart.	Results had not been released yet but the diagnostic exam is used to create an image of the heart and its ejection fraction.
Bilateral lower extremity venous duplex	The client has history of deep vein thrombosis, and her veins are difficult to palpate.	This was used to determine if the patient had any formation of blood clots.
12 lead EKG	The patient had very high levels of troponin in her cardiac labs.	EKG showed normal sinus rhythm, but the ST segment and T wave were abnormal. An EKG is used to see what the rhythm of the heart is.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's diagnostic and laboratory test reference* (Sixteenth edition). Elsevier.

Active Orders

Active Orders	Rationale
Nursing communication	**This outlines how and when the nurses should be communicating about their patients.**
Neuro check Q4H	**Neuro checks are used to assess if the patient's condition is worsening or not.**
Blood glucose sliding scale	**This order is to treat blood glucose appropriately depending on the result.**
Vital signs	**The vital sign order is used to make sure the client is stable.**
Intake and output	**An intake and output order can be used to**

	see if the kidneys are functioning properly to see if they're producing the amount of urine that should be coming out.
Cardiac monitoring	**Continuous cardiac monitoring to figure out if there's any cardiac abnormalities.**
CCT/CVICU insulin instructions	**Orders to follow the insulin protocol that is followed in the unit.**
Electrolyte replacement order set 750 if early morning magnesium is </= 1.6 mg/dL and GFR or CrCl > 30 mls/min	**If the patient's magnesium is too low, then it needs to be replaced.**
Electrolyte replacement order set 750 if early morning potassium is </= 3.6 mmol/L and if GFR CrCl is > 30 mls/min	**If the patient's potassium is too low, then it needs to be replaced because it can lead to cardiac issues.**
Initiate hospital CCU mobility protocol	**Mobility protocol allows for the patient to move as much as possible.**
Delirium daytime interventions	**If delirium happens during the daytime there is a set order of interventions that the nurse can apply.**
Delirium nighttime interventions	**If delirium happens during the nighttime there is a set order of interventions that the nurse can apply.**
Assess for delirium	**Assessing for delirium can help figure out if the patient has worsening condition.**
Increase activity as tolerated	**The patient should remain as mobile as it is physically possible for them.**
Delirium notify provider	**If the patient is experiencing delirium some factor is worsening their condition, and the provider should be notified.**
Notify physician at: HR >130 or <50 SBP >160 or <100 Temp >39C or <36 C RR >30 or <8 Urine < 60 q2hrs	**If the vital signs are out of the normal range, then there is something probably wrong with the patient and some type of intervention must happen.**
Universal decolonization	**The protocol to remove contaminants.**
Incentive spirometer q1 while awake	**This decreases the risk of pneumonia and atelectasis after surgery**
Hospitalized patient PRN pain med substitution	**If there isn't the pain medication that it is requested, it may be able to be replaced with something else.**
Pneumatic compression stocking	**Reduces the chance of developing deep vein thrombosis**
Float heels off bed	**Reduces the chance of developing pressure ulcers on heels**

Medications

Home Medications (Must List ALL)

Medication	Reason for taking
acetaminophen	**For pain**
Albuterol sulfate	**For bronchospasm or shortness of breath**
Bupropion	**This medication is used for depressive disorders**
carbamazepine	**This medication can be used to relieve pain**
lisinopril	**This is a hypertensive medication for hypertension**
Ferrosol	**This is a iron supplement for anemia**
methocarbamol	**this medication relieves discomfort caused by muscle conditions**
metoprolol	**This is a hypertensive medication**
Multivitamin mineral	**this is taken for any vitamin deficits**
sucralfate	**This medication is used to prevent duodenal ulcers**
pantoprazole	**Used for heartburn**
Symbicort	**This is to prevent asthma or COPD exacerbations**

Hospital Medications (Must List ALL)

Brand/ Generic	**Acetaminophen / Febrol**	**Aspirin/ acetylsalicylic acid**	**Atorvastatin/ Lipitor**	**Bisacodyl/ Dulcolax**
Classification	**Nonsalicylate/ antipyretic**	**Salicylate/ anti-inflammatory**	**HMG-CoA reductase inhibitor/ Antihyperlipidemic**	**Stimulant laxative Organic compound**
Reason Client Taking	**The patient takes this medication whenever she has a mild pain.**	**The control pain**	**This is taken for high levels of cholesterol**	**To promote bowel movements**
List two teaching needs for the	**-the patient should not be taking more than the daily**	**-The patient should not ingest alcohol while taking**	**-The drug should be taken at the same time each day to maintain its effects**	**-The patient should know that taking this**

medication pertinent to the client	**dose recommender because it can cause hepatotoxicity. - the nurse should teach the patient signs of hepatotoxicity.**	**this medication because it can increase the chance of gastric ulcers forming (NDH, 2023). -The patient should take aspirin with food to lessen the chance of gastric upset (NDH, 2023.**	**(NDH, 2023). - Patient should notify their provider if they develop unexplained muscle pain (NDH, 2023).**	**medication every day or regularly can cause constipation. -The patient should also know that this medication could cause electrolyte loss.**
Key nursing assessment(s) prior to administration	**The nurse should do a pain assessment prior to administration to determine if this pain medication will be enough for the pain that is being experienced.**	**The nurse should do a pain assessment prior to giving this medication to ensure that the medication will be effective for the pain.**	**-Since this patient is taking insulin, their blood sugar should be measured because atorvastatin can mess with blood glucose (NDH, 2023).**	**The nurse should assess when the patient's last bowel movement was.**

Brand/ Generic	**Cefepime injection/ Maxipime**	**Duloxetine/ Cymbalta**	**Fluticasone furoate vilanterol/ breo ellipta**
Classification	**Cephalosporin/ antibiotic**	**Selective serotonin and norepinephrine reuptake inhibitor/ antidepressant**	**Corticosteroid/ antiasthmatic**
Reason Client Taking	**This patient is suspected to have pneumonia.**	**This helps treat peripheral neuropathy**	**To prevent asthma attacks.**
List two teaching needs for the	**-The patient needs to report to their provider if they**	**-The medication should be taken whole**	**-The nurse should teach the patient how to properly take the medication**

medication pertinent to the client	**develop severe diarrhea even if it's months after the antibiotic therapy (NDH, 2023). -The patient should also notify their provider if they notice mental health changes (NDH, 2023).**	**and not be crushed or chewed (NDH, 2023). -This medication should not be stopped abruptly (NDH, 2023).**	**(NDH, 2023). - The patient should rinse their mouth after using the inhaler (NDH, 2023).**	
Key nursing assessment(s) prior to administration	**-Bowel movements should be assessed every day (NDH**	**Orthostatic hypotension can happen while taking this medication, so blood pressure should be taken (NDH, 2023).**	**The nurse should do a respiratory assessment before and after the administration.**	
Brand/ Generic	**Furosemide/ Lasix**	**Hydralazine/ apresoline**	**Insulin lispro/ Humalog**	**Ipratropium/ albuterol**
Classification	**Loop diuretic/ antihypertensive**	**Vasodilator/ antihypertensive**	rapid-acting insulin analogue	Adrenergic Bronchodilator
Reason Client Taking	**For hypertension**	**To manage hypertension**	**For elevated blood glucose**	**Albuterol can help open the airways during bronchospasm. Client is currently in respiratory failure**
List two teaching needs for the medication pertinent to	**-The patient should be recommender to increase their potassium intake because**	**-This medication should not be taken with food because it can increase**	**-The patient should know to rotate injections sites to prevent scar tissue formation. --Do not use the**	**-The client should be taught on how to properly use the inhaler.**

the client	**this medication is not potassium sparring. -Furosemide should be taken hours before bedtime so that the patient does not have to constantly urinate at night (NDH, 2023).**	**the risk of adverse reactions (NDH, 2023). -The patient should know how to measure their blood pressure and heart rate.**	**insulin if it is thickened or discolored. It should be clear and colorless (NDH, 2023).**	**- The client needs to know that the inhaler needs to be cleaned once a week and let air dry (NDH, 2023).**
Key nursing assessment(s) prior to administration	**-The nurse should check the patient's potassium value before administration.**	**-The nurse should assess the patient's vitals before administration.**	**-Blood glucose should be measured before giving this medication.**	**-The nurse needs to do a respiratory assessment before and after use of the inhaler. The nurse also needs to exam if the patient has developed candidiasis.**
Brand/ Generic	**Labetalol**	**Metoprolol/ Lopressor**	**Metronidazole/ Flagyl**	
Classification	**Beta blocker/ antihypertensive**	**Beta blocker/ antianginal**	**Nitroimidazole/ antiprotozoal**	
Reason Client Taking	**For hypertension**	**To treat hypertension**	**To treat some kind of anaerobic infection**	
List two teaching needs for the medication pertinent to the client	**-The patient should know how to take their own blood pressure. - The patient should know to check their pulse for one whole minute**	**-This medication should not be stopped abruptly (NDH, 2023). -This medication should be taken after the same meal**	**-The patient should know that they need to complete the entire antibiotic therapy in full (NDH, 2023). -This medication should be taken with food (NDH, 2023).**	

	before taking the medication.	**every day (NDH, 2023).**		
Key nursing assessment(s) prior to administration	**-The nurse should assess the patient's heart rate before giving this medication.**	**-Blood pressure should be monitored often when taking this medication (NDH, 2023).**	**The nurse should assess for fungal superinfection because this can cause growth of Candidiasis (NDH, 2023).**	
Brand/ Generic	**Nicardipine/ Cardine**	**Polycylene glycol oral poweder/ miralax**	**Prochlorperazine/ Compro**	**Sennosides/ senokot**
Classification	**Calcium channel blocker/ antianginal**	**To promote bowel movements.**	**Piperazine/ antiemetic**	**To promote bowel movements.**
Reason Client Taking	**For stable angina pectoris or hypertension**	**To promote bowel movements**	**If the patient feels nauseas she can take this medication.**	**To promote bowel movements**
List two teaching needs for the medication pertinent to the client	**-The patient should avoid eating any type of grapefruit (NDH, 2023). -This pill should be swallowed whole and not crushed or chewed (NDH, 2023).**	**-The patient should know that they should only take this powder if they are constipated. -The patient should not take more than the required dose.**	**-The patient should avoid alcohol and OTC drugs while taking this medication (NDH, 2023). -The patient should avoid excessive sun and wear sunscreen (NDH, 2023).**	**-This medication should not be taken more than its intended use because it can cause constipation. -This medication should not be taken for more than seven days.**
Key nursing assessment(s) prior to administration	**-The nurse should assess blood pressure and heart rate and also check fluid intake and output (NDH,**	**-The nurse should assess when the patient's last bowel movement was before**	**-The nurse should do a neurological assessment before administration.**	**-The nurse should assess when the patient's last bowel movement was before**

	2023).	**administration.**		**administration.**

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1.Cefepime	**The patient is suspected to have pneumonia. It is important to treat this condition before it progresses, and her condition worsens.**	**1. This medication can cause shortness of breath which can be serious for this client who has respiratory failure (NDH, 2023).** **2. This medication can cause diarrhea. She's been taking laxatives so the diarrhea could be worse.**
2.Heparin	**This medication was chosen because she has past medical history of deep vein thrombosis. She also has limited physical activity so it could increase the risk of blood clots forming.**	**1.Heparin can cause abdominal distention, which could worsen the distention she already has (NDH, 2023).** **2. Heparin can cause excessive bleeding. This is something that should be watched out for every patient.**
3. Furosemide	**The patient has a lot of antihypertensive medications, so it seems like her hypertension is serious. It is important to get her hypertension under control and that she takes these medications daily.**	**1.This medication can cause elevated cholesterol and triglyceride levels which could worsen her hyperlipidemia (NDH, 2023).** **2. This medication can also cause hyperglycemia which could heighten her blood sugar even more (NDH, 2023).**

Medications Reference (1) (APA)

2023 nurse's drug handbook. (2023). Jones & Bartlett Learning.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance: Slightly confused** **Infection Control precautions: none** **Client Complaints or Concerns: complains of back pain but it is only scored at a three.**	**Patient was A/Ox 4, she was able to answer name, date, location, and what brought her to the hospital. However, she was confused as to why all these problems developed and why she had to stay longer after her surgery.**
VITAL SIGNS: **Temp: 99.3 F** **Resp rate: 35** **Pulse: 81** **B/P: 160/70** **Oxygen: 50 L/Min, 90%** **Delivery Method: opti flow**	
PAIN ASSESSMENT: **Time: 1311** **Scale: 3** **Location: across the abdomen and back** **Severity: not severe** **Characteristics: sharp pain** **Interventions: pain medication**	
IV ASSESSMENT: **Size of IV: 20 g** **Location of IV: right forearm** **Date on IV: 4-13-25** **Patency of IV: patent, easy to flush** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: dry, intact** **Fluid Type/Rate or Saline Lock: none**	**No swelling, erythema, or drainage present on the IV.**
INTEGUMENTARY: **Skin color: appropriate for her race** **Character: dry** **Temperature: warm** **Turgor: slow return to skin** **Rashes: none** **Bruises: A few bruises across her abdomen** **Wounds: she has a wound on the left side of her neck where she had the carotid**	**The patient had dry, warm, thin skin that was an appropriate color for her race. She had slight edema on her right forearm. She also had slow skin turgor and it was difficult to determine her capillary refill since her nail beds were so white. She had a wound from her endarterectomy on the left side of her neck. She also had slight bruising across her abdomen.**

endarterectomy **Braden Score: 19** **Drains present: Y☐ N ☒** **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth: missing a few teeth but no dentures**	**The client had pink moist mucous membranes. Client didn't wear dentures. She was missing a few of her molars but the rest of her teeth were clean and in good condition. Client had difficulty hearing some of my questions, so I had to raise my voice a lot. Head is symmetrical, nose is midline. Carotid pulse on her right side was present and palpable 3+. Trachea was midline and not deviated.**
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: Right Arm**	**S1 and S2 were heard and present with no evidence of murmur. She was tachycardic. She had no neck distention, and her pulses were slightly diminished +1. She had slight edema on her right upper arm.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**No accessary muscle use when breathing. Wheezing and crackles heard across the lung anteriorly and posteriorly bilaterally. Tachypneic.**
GASTROINTESTINAL: **Diet at home: Regular** **Current Diet: heart healthy** **Is Client Tolerating Diet? Yes** **Height: 5'0** **Weight: 143** **Auscultation Bowel sounds: normoactive across all quadrants** **Last BM: 4-12-25** **Palpation: Pain, Mass etc.: slight pain across lower quadrants.** **Inspection:** **Distention: yes** **Incisions: none** **Scars: slight bruising across the lower quadrants.** **Drains: none**	**Patient had abdominal distention. No pain on light palpation but stated she felt pain in deep palpation. Bowel sounds were normoactive across al quadrants. Unknown bruising across the abdomen. No masses or lumps felt upon palpation.**

Wounds: none **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY: **Color: amber** **Character: clear** **Quantity of urine: moderate, but not as much considering she's on Lasix** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: Purewick** **Size:**	Patient states that she feels no pain, frequency, urgency, or burning when urinating.
Intake (in mLs) 360 **Output (in mLs) 400**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM: full range of motion in her remained extremities** **Supportive devices: right leg prosthetic and walker.** **Strength: strong in upper extremities and her left leg.** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 11** **Activity/Mobility Status: slightly hindered** **Activity Tolerance: moderate activity tolerance** **Independent (up ad lib): needs assistance with equipment.** **Needs assistance with equipment** **Needs support to stand and walk**	**Patient had a right below the knee amputation. Her other extremities had full range of motion with strong grips, pushes, and pedal pushes.**
NEUROLOGICAL:	.

MAEW: Y ☒ N☐ **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: a/o x4** **Mental Status:** **Speech: difficult to understand what she is saying at times due to voice.** **Sensory:** **LOC: alert and oriented**	
PSYCHOSOCIAL/CULTURAL: **Coping method(s): family support** **Developmental level: integrity vs despair** **Religion & what it means to pt.: patient is not religious** **Personal/Family Data (Think about home environment, family structure, and available family support): the patient had a lot of family visiting her during her stay.**	.

Discharge Planning

Discharge location: Back home

Home health needs: Physical therapy

Equipment needs: She needs oxygen at home.

Follow up plan: No follow-up appointment had been set at the current time.

Education needs: She needs to be educated about the importance of not drinking or smoking anymore and how that can impact her health. If she takes oxygen home, she also needs to know about oxygen safety.

Nursing Process

Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rationale	Outcome	Interventions	Evaluation of

• 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	• Explain why the nursing diagnosis was chosen	**Goal (1 per dx)**	**(2 per goal)**	**interventions**
1.Impaired gas exchange related to COPD as evidenced by low O2 saturation and altered level of consciousness.	**The patient has a past medical history of COPD and was struggling to meet oxygen requirements for her post op. The patient also experienced an altered level of consciousness after being off her CPAP and retaining too much CO2.**	**The patient will have improved oxygenation and improved gas exchange.**	**1.The nurse should position the patient in way that promotes breathing, like high fowler's (Phelps, 2023).** **2.The nurse should encourage the patient to cough and use an incentive spirometer since she still is post-op (Phelps, 2023).**	**By the time the patient is discharged they will be able to maintain and 92% O2 saturation on room air.**
2 Acute confusions related to CO2 retention as evidenced by inability to answer questions that the nurse was asking her (Phelps, 2023).	**The nurse had asked the patient what year it was and the patient was unable to answer the nurse even though she had previously been able to.**	**The goal for this patient would be for her neurological status to remain stable all the time (Phelps, 2023).**	**1. If the patient decides to take a nap then they will put their CPAP back on to prevent CO2 accumulation.**	**By the time the patient is discharged she would have not experienced any more changes in her level of consciousness (Phelps, 2023).**

			2.The nurse will monitor the patient's neurological status frequently to detect any changes (Phelps, 2023).	
3.Decreased activity tolerance related to impaired physical mobility as evidenced by having a below the knee amputation (Phelps, 2023).	**This diagnosis was chosen because the patient is missing her bottom right leg which would cause her to have impaired mobility. The patient is also overweight, so she probably lives a sedentary lifestyle.**	**The goal would be for her to have increased physical activity (Phelps, 2023).**	**1.The nurse can involve the patient in finding physical activities that she would like to be a part of (Phelps, 2023).** **2. The nurse can be helping the patient perform passive range of motion to begin promoting some type of physical activity.**	**Before the patient is discharged the nurse should watch her perform active range of motion exercises to promote physical activity.**
4. Ineffective denial related to her current health condition as evidenced by stating that "the doctors are lying" and that she "… was healthy before she came in for her surgery" (Phelp,	**I chose this diagnosis because it seems like the patient could not accept that her life choice and past medical history**	**The patient will acknowledge and understand her current health problems and how**	**1.The nurse can encourage the patient to express their feelings and what they understand about their**	**By the time the patient is discharged they should be able to explain their current health situation and what they will**

2023).	**could lead her being hospitalized after her surgery. She was in denial that she had something wrong with her.**	**they developed (Phelp, 2023).**	**current situation (Phelps, 2023).** **2.When the patient is ready, the nurse can explain in depth about their health problems and they can be treated (Phelp, 20).**	**be doing to help it (Phelps, 2023).**
5. Sedentary lifestyle related to impaired physical mobility as evidenced by right BKA (Phelps, 2023).	**This nursing diagnosis was chosen because the patient has impaired mobility, and she is currently overweight. This leads to the assumption that she**	**My goal for this patient would be to develop an activity plan that she would be able to do with her prosthetic.**	1.The patient could get physical therapy to see the patient and have them make a physical activity plan for her (Phelps, 2023). 2.I could educate the patient how having a sedentary lifestyle affects her health and could worsen her condition (Phelps, 2023).	**Before the client is discharged, I would want her to have an exercise routine and have her explain to me how she will implement this into her lifestyle.**

Other References (APA)

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