

N311 Care Plan1

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Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Merriweather

9/14/2025

Demographics

Date of Admission 9/9/2025	Client Initials GD	Age 65	Biological Gender Male
Race/Ethnicity White/Caucasian	Occupation Unemployed	Marital Status Single	Allergies None Known
Code Status Full Code	Height 70.5"	Weight 136 lb	

Medical History

Past Medical History: Chronic Obstructive Pulmonary Disease (COPD), Type II Diabetes Mellitus (DM), severe anemia, altered mental status, alcohol withdrawal, toxic encephalopathy, cerebrovascular accident (CVA)

Past Surgical History: Upper gastrointestinal endoscopy (8/30/2025), colonoscopy (8/31/2025)

Family History: None on file

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

Former smoker: quit 1/1/2025, currently 0 packs/day. There was no record of length of time pt smoked or packs/day history. Patient (pt) has never used smokeless tobacco.

Alcohol – not currently. Drugs – not currently.

Education: Not on file

Living Situation: Pt lives in a nursing home (The Waters in Covington, Indiana). Pt previously lived in a group home with his 80 year old landlord/caretaker. Pt wishes to return to old living arrangement, however his landlord states that she is unable to provide the care he requires.

Assistive devices: Pt states that he can get up and ambulate by himself, and initially refused physical therapy evaluation. However, he requires assistance from the nursing staff with all

activities of daily living (ADLs). After agreeing to a physical therapy evaluation, it was recommended that he use a front-wheeled walker, gait belt, and have a 1-person assist.

Admission Assessment

Chief Complaint: Shortness of breath (SOB)

History of Present Illness(HPI)– OLD CARTS: Pt was unable to provide a significant history due to being in respiratory distress. The pt was found slumped over and without oxygen being delivered through his nasal cannula. Note that he usually uses a nasal cannula that delivers oxygen at 2L/min. The staff was unable to determine for how long he had been without his oxygen. The onset of his SOB is also difficult to determine, but he has chronic COPD so it is likely he is continually struggling to properly ventilate his lungs. Upon arrival to the emergency department (ED) he was tachypneic with responses only to loud noises and painful stimuli. During ambulance transportation to the hospital his oxygen was increased through use of a non-rebreather mask, which alleviated his symptoms. His shortness of breath was directly related to his COPD. It is unclear what his oxygen saturation was at the nursing home, but it worsened enough to require treatment in the ED.

Primary Diagnosis

Primary Diagnosis on Admission: Respiratory failure with hypercapnia

Secondary Diagnosis (if applicable): N/A

Pathophysiology

Pathophysiology of the Disease, APA format:

According to *Davis Advantage for Pathophysiology, 3rd Edition* (Capriotti, 2024), the respiratory tract is broken up into upper and lower portions. Capriotti (2024) states that “The upper respiratory tract conducts air to the lower airways; protects the lungs from foreign matter; and warms, filters, and humidifies air as it enters the lungs. The lower respiratory tract participates in gas exchange by oxygenating blood and excreting carbon dioxide at the alveoli.” (p. 476). She goes on to say, “Respiratory failure occurs when the pulmonary system fails to oxygenate the blood or fails to sufficiently eliminate carbon dioxide. It is classified as either hypoxemic or hypercapnic respiratory failure... Hypercapnic respiratory failure occurs when carbon dioxide in arterial blood (PaCO₂) is greater than 50 mm Hg. Common causes of hypercapnia include COPD and asthma.” (p. 481).

It is important to oxygenate the blood for cellular respiration, a process by which the body produces its main energy source adenosine triphosphate (ATP). ATP is the “currency” of energy used for many bodily processes, including DNA synthesis, neurotransmission, and muscle contraction. All of these processes and many more, are necessary to support and maintain life in the human body (Dunn & Grider, 2023). In the case of this patient, his respiratory failure caused insufficient oxygenation of his blood which began to interrupt ATP production.

“Dyspnea is the sensation of being short of breath; it is a common symptom of pulmonary or cardiovascular disease... Acute episodes of dyspnea are most often caused by bronchospasm of asthma, whereas chronic, persistent dyspnea is commonly caused by COPD.” (Capriotti, p. 479). In the case of respiratory failure, Table 20-1 in *Davis Advantage for Pathophysiology, 3rd Edition* indicates that when the pCO₂ reaches 65 mm Hg a person has hypercapnia. It also indicates that when the pCO₂ reaches 60 mm Hg a person has entered

respiratory failure (Capriotti, 2024, p. 481). An arterial blood gas (ABG) was performed on this pt which revealed an arterial pCO₂ of 110 mm Hg, indicating respiratory failure with hypercapnia.

Pathophysiology References (2) (APA):

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

Dunn, J., & Grider, M. H. (2023, February 13). Physiology, Adenosine Triphosphate. <https://www.ncbi.nlm.nih.gov/books/NBK553175/>

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen SAT	Oxygen Delivery Method
1118 on 9/11	78 bpm	123/68 mm Hg	20 breaths/min	98.6	100	3L/min nasal cannula

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
0838 on 9/11	0/0	N/A	N/A	N/A	N/A