

N311 Care Plan 3

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Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Merriweather

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Demographics

Date of Admission 09/24/2025	Client Initials P.J.S	Age 90	Biological Gender Female
Race/Ethnicity White	Occupation Green Meadow Girl Scout Council	Marital Status Widowed	Allergies Dogs, Horses
Code Status Full (has ACP docs)	Height 5'7" (170.2 cm)	Weight 230 lbs (104.3 kg)	

Medical History

Past Medical History: Hyperlipidemia, Hypertension, Measles, Mumps, Stroke (HCC),

Incontinence

Past Surgical History: Wide Excision Basal Cell Carcinoma Right Leg and Excision Lesion

Left Leg, Right Wrist Surgery, Hysterectomy

Family History: Mother (deceased): Stroke, Father (deceased): Alcohol Abuse, Paternal

Grandmother (deceased): Dementia

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

Never smoked or used smokeless tobacco, No alcohol currently, Never used drugs or vaped

Education: Highest education level was 12th grade

Living Situation: House

Assistive devices: No assistive devices

Admission Assessment

Chief Complaint: Trouble Breathing/Pain in chest

History of Present Illness (HPI) – OLD CARTS:

Patient started having trouble breathing and chest pain on the 23rd of September, and checked herself into the hospital on the 24th. Along with the chest pain, and troubled breathing

she has not been able to keep any liquids or food down and has been vomiting. The patient has been seeing a respiratory therapist and is on one of the highest settings of oxygen possible.

Patient rated her pain on a scale from 1 to 10 an 8.

Primary Diagnosis

Primary Diagnosis on Admission: Aspiration Pneumonia

Secondary Diagnosis (if applicable): No secondary diagnosis for this patient.

Pathophysiology

Pathophysiology of the Disease, APA format:

Pneumonia is described as., “An infection and inflammation process in the lobes or the lungs caused by bacteria, viruses, fungi, parasites, mycoplasma or chemicals.” (Capriotti and Frizzell 2016). In this case, the patient developed Aspiration Pneumonia due to swallowing a foreign object. Aspiration Pneumonia most commonly happens in the right lung, more specifically the middle lobe. According to Capriotti and Frizzell, “Aspiration pneumonia is caused by anaerobic bacteria swallowed from the oropharynx.”. Some of the pathogens, but most specifically Staph species can spread from the bloodstream to the lungs. Aspiration pneumonia can also be developed from accidental inhalation of stomach reflux. “One of the major risk factors for pneumonia is infleunza infection.” (Capriotii and Frizzell 2016).

Pneumonia can cause the immune system to be severely weakened, which then leads to the lungs being weak as well. This was obvious in my patient since she not only was on oxygen, but also could not keep any food down and was vomiting. Pneumonia can be detected by having difficulty breathing, chest pain while taking deep breaths, fever, coughing, or chills. On the physical aspect, it is deciphered by diminished breath sounds, crackles, and tachycardia. Out of these factors I have included, it seems as though this patient was facing issues with all of these.

Also stated was the fact that if a patient has had a stroke before, they are higher risk to developing pneumonia. (Capriotti and Frizzell 2016). The patient has had a stroke before as well as it being in her family history, and also has high blood pressure.

Some diagnostics tests used to diagnose pneumonia include a chest x-ray, CBC tests, and in this patient's case doing a chest CT to see what is causing the infection and where exactly it is at.

Treatment for pneumonia includes, antibiotic therapy, oxygenation, and Fowler's position. The patient was sitting up (not in her bed, but in a chair), and as I already stated was on one of the highest settings of oxygenation.

It is unsure as to how the patient has developed aspiration pneumonia exactly, but she had been seeing a respiratory therapist and seemed to be doing the things she should be to get herself healed.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016a). *Pathophysiology: Introductory concepts and clinical perspectives* (3rd ed.). F.A. Davis Company.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's Diagnostic & Laboratory Test Reference* (17th ed.). Elsevier.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
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CMP (Sodium)	134 - low	active	136-145 mmol/L	
CMP (Glucose)	164 – high	active	70 – 99 mg/dL	
CMP (BUN)	32 – high	active	10 – 20 mg/dL	
CMP (BUN/Creatine Ratio)	38 - high	active	12-20	
CBC (WBC)	3.00 - low	11.0 - high	4.00 – 12.00 10(3)/mcL	
CBC (MPV)	6.6 - low	6.9 - low	9.7 – 12.4 fL	
CBC (Absolute Lymphocytes)	0.80 - low	0.40 - low	1.30 – 3.20 10(3)/mcL	
CBC (Absolute Monocytes)	0.10 - low	0.80 - normal	0.20 – 1.00 10(3)/mcL	
CBC (Neutrophils)	88.5% – high	active	47.0 – 73.0 %	
CBC (Lymphocytes)	4.0% - low	active	18.0 – 42.0%	
Prothrombin Time (PT) (Prottime Patient)	29.9 - high	39.1 - high	10.1 – 13.1 seconds	
Prothrombin Time (PT) (INR)	2.6 - high	3.5 - high	0.8 – 1.1 seconds	

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
Blood Culture		No growth within 1 day
Chest X-Ray	Chest X -Ray was taken due to her having Aspiration Pneumonia	Bibasilar Dependent Atelectasis and/or small bilateral Effusions. Cardiomegaly. Nonspecific coarsened pulmonary interstitium can represent pneumonitis, mild fibrosis, or interstitial edema.
Chest CT		Endobronchial debris right mainstem and right lower lobe bronchi with patchy reticular and groundglass airspace opacities predominantly right

		lower lobe.
Swallowing Function Study		Results not including yet, study is active.

Diagnostic Test Reference (1) (APA):

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.

<p>GENERAL:</p> <p>Alertness: Alert</p> <p>Orientation: Oriented</p> <p>Distress: No signs of distress</p> <p>Overall appearance: Well groomed</p>	<p>Patient is A&O x4 well groomed, and no signs of distress.</p>
<p>INTEGUMENTARY:</p> <p>Skin color:</p> <p>Character:</p> <p>Temperature:</p> <p>Turgor:</p> <p>Rashes:</p> <p>Bruises:</p> <p>Wounds: .</p> <p>Braden Score:</p> <p>Drains present: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Type:</p>	
<p>HEENT:</p> <p>Head/Neck:</p>	<p>.</p>

<p>Ears:</p> <p>Eyes:</p> <p>Nose:</p> <p>Teeth:</p>	
<p>CARDIOVASCULAR:</p> <p>Heart sounds: Heard, raspy</p> <p>S1, S2, S3, S4, murmur etc. No murmur, but raspy sounds</p> <p>Cardiac rhythm (if applicable): Rhythm normal</p> <p>Peripheral Pulses: 28 x 2</p> <p>Capillary refill: More than 3 seconds in hands, more than 3 seconds in feet.</p> <p>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Location of Edema: Legs, calf and feet.</p>	<p>Heart sounds were not quiet, but not strong. There were raspy sounds</p>
<p>RESPIRATORY:</p> <p>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Breath Sounds: Location, character</p> <p>Listened to left and right (2) on the front, and on back listened to 4 different locations.</p>	<p>Seemed like her breaths were very forced, coughed after taking deep breaths, and breath sounds were overall just raspy and high pitched.</p>
<p>GASTROINTESTINAL:</p> <p>Diet at home:</p> <p>Current Diet</p> <p>Height:</p> <p>Weight:</p> <p>Auscultation Bowel sounds:</p> <p>Last BM:</p> <p>Palpation: Pain, Mass etc.:</p>	<p>.</p>

<p>Inspection:</p> <p>Distention:</p> <p>Incisions:</p> <p>Scars:</p> <p>Drains:</p> <p>Wounds:</p> <p>Ostomy: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Size:</p> <p>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input 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 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 type="checkbox"/></p> <p>Type:</p> <p>Size:</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 type="checkbox"/> N <input type="checkbox"/></p>	

<p>Fall Score:</p> <p>Activity/Mobility Status:</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 type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p> <p>Sensory:</p> <p>LOC:</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>	

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
12:57	77bpm	117/77	16	97.6 F	97 (on oxygen, 5

					Liters)
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Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions

No pain detected or reported by patient.

Intake and Output

Intake (in mL)	Output (in mL)
100 mL, 4.5 G. Patient is on a thick liquid diet only.	Unmeasurable output – 1 urine occurrence. Patient suffers with incontinence, and also was vomiting all day.

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.
1. Ineffective Breathing Pattern due	This was something she was	1. Being on 5 poz oxygen	1. Breathing pattern returning to normal due to	Patient stated the importance of a stable breathing

to respiratory distress	struggling with due to her aspiration pneumonia.	2.Putting her in Fowler’s position (positioning her upright)	oxygen, and her being able to breath easier because she is sitting upright.	pattern
2. Urge urinary incontinence	Patient has to deal with this everyday	1. Wearing briefs, scheduled toileting 2.Education on fluid intake and not restricting it	1. Patient will identify triggers and achieve intervention goals	Patient will state the understanding of tracking their fluid intake

Other References (APA):

Phelps, L. L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.

