N441 Care Plan

Lakeview College of Nursing

Jaclyn Nicasio

Demographics (3 points)

Date of Admission 09/01/2019	Patient Initials EAG	Age 79 y/o	Gender Male
Race/Ethnicity Caucasian	Occupation Retired Marine of about 30 years	Marital Status Widow for 1 year. Married for 60 years.	Allergies NKDA
Code Status DNR	Height 168 cm	Weight 54.6 kg	

Medical History (5 Points)

Past Medical History: squamous cell carcinoma – right lung mass, systemic inflammation respiratory syndrome (SIRS), acute hypoxemic respiratory failure, history of tobacco use, GERD, depression, anxiety

Past Surgical History: Bronchoscopy with biopsy (08/9/19), repair of ventral hernia

Family History: Due to the patient's increasing level of confusion during assessment, he was unable to elaborate on family history. No known family history was listed within the patient chart.

Social History (tobacco/alcohol/drugs): The patient denies any previous or current use of alcohol or drugs. Confirmation of tobacco use is made. The patient states that he had begun smoking "around the age of 30" and smoked less than half a pack per day.

Assistive Devices: utilization of a walker outside of the inpatient setting

Living Situation: lives with daughter and son-in-law in single-family home in Charleston, IL

Education Level: highest level of education is the 12th grade, completion of high school

Admission Assessment

Chief Complaint (2 points): Shortness of breath with right-sided chest pain

History of present Illness (10 points): The patient arrived at Sarah Bush Lincoln Health Center emergency department on 09/01. He arrived with his son-in-law, who drove him, and expressed shortness of breath and chest pain on the right-hand side. The patient was also fever, dyspnea, and hypoxic. Chest pain was described as "constant" and non-radiating. Collecting an accurate history of symptoms, including pain level, onset, duration, relieving factors, and aggravating factors, were unreliable due to the patient having an increased level of confusion. The son-in-law stated that this confusion began to increase over the last few days with the development of a productive cough two days ago, in addition to dyspnea and pleuritic pain. The patient was admitted on 09/01.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia/Pneumonitis

Secondary Diagnosis (if applicable): Squamous cell carcinoma within the lungs

Pathophysiology of the Disease, APA format (20 points):

Along with the flu, pneumonia is a commonly discussed respiratory infection. Pneumonia is best explained as, "an inflammation of the lung parenchyma caused by various microorganisms, including bacteria, mycobacteria, fungi, and viruses" (Hinkle & Cheever, 2018, p.591). However, pneumonitis is more of a general term describing the inflammatory process that occurs within the lung that may allow microorganisms to invade and flourish. There are four types of pneumonia. These being community-acquired, healthcare-associated, hospital-acquired, and ventilator-associated pneumonia. However, there are risk factors that will increase the odds that a patient will present with this respiratory infection. These risk factors include being at an age older than 65, alcoholism,

immunosuppressive disorders, multiple medical comorbidities, structural lung disease, or residency in a long-term care facility/daycare facility. The patient that was in the critical care unit possessed a few of those qualities. These were older than 65 years of age, multiple comorbidities, and structural lung disease.

Pneumonia occurs when the upper airway does not prevent particles from reaching the lower respiratory tract. As a result, the inflammatory reaction occurs within the lungs producing exudate (Hinkle & Cheever, 2018). This results in the potential to affect both ventilation and diffusion. As a result, the body has to work harder to compensate for decreased access to oxygen for the body. So, symptoms that may appear may include chest pain, confusion, a productive or non-productive cough, fever, diaphoresis, nausea, vomiting, and shortness of breath (Mayo Clinic, 2018). Therefore, as a result of shortness of breath, it would be common to see an increased respiratory rate in those patients with pneumonia. Symptoms exhibited by the patient upon arrival to the emergency department included chest pain, shortness of breath, previous vomiting at his residence, and ongoing confusion.

Diagnostic tests that can be performed to assist in the diagnosis of pneumonia include assessing the patient accurately upon arrival. This goes from the patient's history to the physical exam. In addition to this, a chest x-ray, blood cultures, and sputum cultures may be collected to diagnose and identify the infectious organism positively. More invasive diagnostic procedures include a nasotracheal or orotracheal suction or a bronchoscopy (Hinkle & Cheever, 2018). Labs and diagnostic tests that were performed on the patient included a blood culture and x-ray to assess for the presence of pneumonia. Lab draws for a CBC and CMP to indicate the presence of infection due to an increased presence of white

blood cells and neutrophils. X-ray results did conclude that the patient does have a positive outcome for pneumonia.

Treatment options include the administration of antibiotics, if the infection is bacterial, but if the infection is viral in nature then the treatment regimen is mostly supportive. This includes hydration, antipyretics, antitussive medications, and inhalation treatments (Hinkle & Cheever, 2018). Antibiotic treatment may include a variety of IV or PO antibiotics. This patient in particular was on a regimen of four antibiotics. These being azithromycin, vancomycin, levofloxacin, and piperacillin-tazobactam.

Overall, generalized deterioration can occur in the elderly population regarding pneumonia. This can be seen through subjective data, like confusion, chest pain, shortness of breath, and also through objective data, like tachypnea, decreased oxygen saturation, or decreasing level of consciousness or orientation. As a result, this patient exhibited substantial clinical data that correlated to his diagnosis of pneumonia secondary to a structural lung mass from previously diagnoses squamous cell carcinoma.

Pathophysiology References (2) (APA):

Hinkle, J.L., & Cheever, K. H. (2018). ***Brunner & Suddarth's Textbook of Medical-Surgical Nursing*** **(14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.**

Mayo Clinic. (2018, March 13). Pneumonia. Retrieved from https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes/syc-20354204

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.38-5.56	3.85 (L)	3.62 (L)	Decreased red blood cell count as a result of an increased blood volume from intravenous fluid administration (Van Leeuwen & Bladh, 2017, p.475).
Hgb	13-17	13.2	12.4 (L)	Decreased hemoglobin as a result of dilution as evidenced by an increased level of fluid intake orally and intravenously (Van Leeuwen & Bladh, 2017, p.475).
Hct	38.1-48.9	39.4	36.7 (L)	Decreased hematocrit as a result an increased level of fluid intake orally and intravenously (Van Leeuwen & Bladh, 2017, p.475).
Platelets	149-393	296	270	N/A
WBC	4-11.7	11.7	11.9 (H)	Increased white blood cell count related to the infectious response of the body in the presence of pneumonia (Van Leeuwen & Bladh, 2017, p.516).
Neutrophils	45.3-79	89.7 (H)	86.3 (H)	Increased neutrophil count related to the infectious response of the body in the presence of pneumonia (Van Leeuwen & Bladh, 2017, p.516).
Lymphocytes	11.8-45.9	5.1 (L)	7.0 (L)	Decreased lymphocyte count related to the presence of an infection (Van Leeuwen & Bladh, 2017, p.516).
Monocytes	4.4-12	5.1	5.7	N/A
Eosinophils	0-6.3	0.1	N/A	N/A
Bands	0-5	N/A	N/A	N/A

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	137	136	N/A
K+	3.5-5.1	4.1	4.1	N/A
Cl-	98-107	102	102	N/A
CO2	21-31	28	29	N/A
Glucose	74-109	152 (H)	92	Increased glucose results on day of admission as a result of an increased stress level due to shortness of breath (Van Leeuwen & Bladh, 2017, p.856).
BUN	7-25	16	10	N/A
Creatinine	0.7-1.2	0.83	0.68 (L)	Decreased creatinine levels as a result of an increased intake of fluids orally and intravenously (Van Leeuwen & Bladh, 2017, p.644).
Albumin	3.5-5.2	3.1 (L)	N/A	Decreased albumin as a result of a chronic disease process, cancer, and inflammation caused by the presence of pneumonia (Van Leeuwen & Bladh, 2017, p.26).
Calcium	8.6-10.3	9	8.3 (L)	Decreased calcium level due to hypoalbuminemia related to insufficient levels of albumin (Van Leeuwen & Bladh, 2017, p.340).
Mag	1.8-2.6	N/A	N/A	N/A
Phosphate	2.5-4.5	N/A	N/A	N/A
Bilirubin	0.3-1	0.7	N/A	N/A
Alk Phos	40-130	68	N/A	N/A
AST	0-40	15	N/A	N/A

ALT	**0-41**	**13**	**N/A**	**N/A**
Amylase	**23-85**	**N/A**	**N/A**	**N/A**
Lipase	**0-160**	**N/A**	**NA**	**N/A**
Lactic Acid	**0.5-2**	**0.8**	**N/A**	**N/A**
Troponin	**< 0.04**	**N/A**	**N/A**	**N/A**
CK-MB	**5-25**	**N/A**	**N/A**	**N/A**
Total CK	**22-198**	**N/A**	**N/A**	**N/A**

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**< 1.1**	**N/A**	**N/A**	**N/A**
PT	**11-12.5**	**N/A**	**N/A**	**N/A**
PTT	**30-40**	**N/A**	**N/A**	**N/A**
D-Dimer	**< or equal to 500**	**N/A**	**N/A**	**N/A**
BNP	**< 125**	**N/A**	**N/A**	**N/A**
HDL	**>45 male**	**N/A**	**N/A**	**N/A**
LDL	**< 130**	**N/A**	**N/A**	**N/A**
Cholesterol	**< 200**	**N/A**	**N/A**	**N/A**
Triglycerides	**< 150**	**N/A**	**N/A**	**N/A**
Hgb A1c	**< 7**	**N/A**	**N/A**	**N/A**
TSH	**0.4-4**	**N/A**	**N/A**	**N/A**

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow Clear	Yellow Clear	Yellow Clear	N/A
pH	5-8	7	7	N/A
Specific Gravity	1.005-1.034	1.013	1.005	N/A
Glucose	Normal	Normal	Normal	N/A
Protein	Negative	Negative	Negative	N/A
Ketones	Negative	Negative	Negative	N/A
WBC	Negative	Negative	Negative	N/A
RBC	Negative	2+	1+	Presence of red blood cells within the urine as a result of the placement of a 16F coude indwelling catheter (Van Leeuwen & Bladh, 2017, p.1584).
Leukoesterase	Negative	Negative	Negative	N/A

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	Arterial: 7.35-7.45 Venous: 7.31-7.41	Arterial: 7.46 (H)	Venous: 7.38	High pH is a result of an increased respiratory rate as evidenced by objective data collected through respiratory rate (Van Leeuwen & Bladh, 2017, p.294).
PaO2	Arterial: 75-85	Arterial: 79	Venous: 26.1 (L)	Decreased PaO2, upon arrival, as a result of pathophysiological

	Venous: **40-50**			**processes of lung cancer and pneumonia exhibited by shortness of breath (Van Leeuwen & Bladh, 2017, p.296).**
PaCO2	**Arterial:** **35-45** **Venous:** **40-50**	**Arterial:** **34.7 (L)**	**Venous:** **47.1**	**Low PaCO2 as a result of an increased respiratory rate pushing off an increased amount of carbon dioxide (Van Leeuwen & Bladh, 2017, p.294).**
HCO3	**Arterial:** **22-26** **Venous:** **22-26**	**Arterial:** **25.3**	**Venous:** **25.5**	**N/A**
SaO2	**Arterial:** **95-98** **Venous:** **60-75**	**Arterial:** **97**	**Venous:** **51.5 (L)**	**Decreased SaO2 as a result of the pathological process of pneumonia decreasing normal lung function capabilities to oxygenate (Van Leeuwen & Bladh, 2017, p.296).**

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative**	**Negative**	**N/A**	**N/A**
Blood Culture	**Negative**	**Negative**	**N/A**	**N/A**
Sputum Culture	**Negative**	**N/A**	**N/A**	**N/A**

Stool Culture	**Negative**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2017). ***Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications*** **(7th ed.). Philadelphia, PA: F.A. Davis Company**

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- **EKG on 09/01 indicated by SOB – sinus tachycardia w/ occasional SVT**
- **XR Chest 1 view on 09/01 indicated by right-sided chest pain and hypoxia – persistent RUL patchy infiltrate concerning for pneumonia for pneumonitis surrounding area of central consolidation correlating with previously demonstrated mass**
- **MRI brain w/ and w/o contrast on 09/03 indicated by confusion and lung cancer – no significant findings**

Diagnostic Test Correlation (5 points):

- **EKG - The patient has a history of a lung mass, systemic inflammation respiratory syndrome, acute hypoxemia, and a chronic history of tobacco use. ECG was ordered to assess and monitor cardiovascular system and the potential of a myocardial infarction (Hinkle & Cheever, 2018, p.702). Per the cardiologist's notes, a 12-lead ECG was conducted on 09/01. Results were "sinus tachycardia with occasional supraventricular tachycardia."**
- **Chest X-ray – The patient has a history of lung cancer, squamous cell carcinoma. A chest x-ray was ordered as a result of the patient stating, upon arrival, that he was**

experiencing chest pain to rule out potential of a myocardial infarction (Hinkle & Cheever, 2018, p.695). Per the radiologist's notes, results were "persistent right upper lobe patchy infiltrate concerning for pneumonia for pneumonitis surrounding area of central consolidation correlating with previously demonstrated mass."

- **MRI – The patient has a history of lung cancer and a baseline MRI of the brain was no obtained upon diagnosis. The patient was also exhibiting an increasing level of confusion and disorientation. Assessment for the potential of metastasis of the cancer to the brain is indicated (Van Leeuwen & Bladh, 2017, p.1095). Per the radiologist's notes, results were of no significance with no presence of brain metastasis.**

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). ***Brunner & Suddarth's Textbook of Medical-Surgical Nursing*** **(14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.**

Van Leeuwen, A. M., & Bladh, M. L. (2017). ***Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications*** **(7th ed.). Philadelphia, PA: F.A. Davis Company**

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Lorazepam (Ativan)** **(Jones & Bartlett, 2017, p.641).**	**Paroxetine hydrochloride (Paxil)** **(Jones & Bartlett, 2017, p.862).**	**Acetaminophen-Oxycodone (Percocet)** **(Jones & Bartlett, 2017, p.840).**	**Ranitidine hydro-chloride (Zantac)** **(Jones & Bartlett, 2017, p.971).**	**Docusate-Senna (Senna-Plus)** **(Jones & Bartlett, 2017, p.322).**
Dose	**2mg**	**20mg**	**5/325mg**	**150mg**	**50mg-8.6mg**
Frequency	**TID**	**Daily**	**Q4H**	**BID**	**HS PRN**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Benzo-diazepine**	**Phenyl-piperidine derivative**	**Phenanthrene derivative**	**Aminoaklyl-substituted furan derivative**	**Anionic surfactant**
Mechanism of Action	**Potentiate the effects of GABA and other neuro-transmitters by binding to receptors in limbic and cortical areas of CNS.**	**Exerts effects by potentiating serotonin activity in CNS and inhibiting serotonin reuptake at presynaptic neuronal membrane.**	**Alters perception of and emotional response to pain at spinal cord and higher levels of CNS by blocking release of inhibitory neuro-transmitters.**	**Inhibits basal and nocturnal secretions of gastric acid and pepsin by competitively inhibiting the action of histamine at H2 receptors on gastric parietal cells.**	**Acts as a surfactant that softens stool by decreasing surface tension between oil and water in feces.**
Reason Client Taking	**Anxiety**	**Depression**	**Severe Pain**	**GERD**	**Prophylactic constipation prevention**
Contraindicati	**Acute**	**Hyper-sensit**	**Acute or**	**Acute**	**Fecal**

ons (2)	**angle-closure glaucoma; hyper-sensitivity**	**ivity; use of MAO within 14 days**	**severe bronchial asthma; hyper-sensitivity**	**porphyria; hyper-sensitivity**	**impaction; undiagnosed abdominal pain**
Side Effects/Adverse Reactions (2)	**Chest pain; constipation**	**Ventricular tachycardia; urine retention**	**Anxiety; constipation**	**Insomnia; broncho-spasm**	**Bloating; diarrhea**
Nursing Considerations (2)	**Monitor those patients with impaired respiratory function due to potential for hypoventilation, sedation, and respiratory depression; assess for suicidal ideation and tendencies**	**Monitor for evidence of GI bleeding; Monitor patient for unexplained bone pain, joint tenderness, swelling, or bruising**	**Use extreme caution with patient with hypoxia or respiratory dysfunction; Assess for abdominal pain due to potential to mask GI problems**	**Administer medication with or without food; Monitor for signs of a GI bleed (black, tarry stools, vomiting blood)**	**Assess for electrolyte imbalances, steatorrhea, vitamin or mineral deficiencies if long-term use; assess for laxative abuse syndrome**
Key Nursing Assessment(s) Prior to Administration	**Assess respiratory rate; Ensure patient is already on an additional anti-depressant due to risk for suicidal ideation**	**Assess EKG strip prior to administration to ensure no abnormal rhythms; Assess patient for suicidal ideations**	**Assess respiratory function prior to giving patient the next dose**	**Inform patient not to chew medication but rather swallow whole or allow complete dissolving in mouth**	**Assess for un-diagnosed abdominal pain**
Client Teaching needs (2)	**Avoid alcohol due to the combined increase of CNS depression; Take medication as prescribed and do not**	**Tell patient to notify provider if unexplained bone pain, joint tenderness, or bruising appear; Do not take any**	**Instruct patient to swallow pillow whole, do not crush or chew due to rapid release/ absorption; Notify**	**Take medication at home with or without food; Report any signs of difficulty swallowing,**	**Take docusate with a full glass of water or milk; Increase fiber intake and drink at**

	stop taking without consulting PCP	**OTC NSAIDs without consulting physician first**	**provider if lightheadedness, dizziness, itching, swelling, or trouble breathing occurs**	**vomiting blood, or dark/tarry stools to physician**	**least 6-8 8-oz glasses of water a day**

Hospital Medications (5 required)

Brand/Generic	**Azithromycin (Zithromax)** **(Jones & Bartlett, 2017, p.104).**	**Levofloxacin (Levaquin)** **(Jones & Bartlett, 2017, p.608).**	**Piperacillin-Tazobactam (Zosyn)** **(Mayo Clinic, 2019).**	**Vancomycin (Vancocin)** **(Jones & Bartlett, 2017, p.1175).**	**Nicotine trans-dermal system (Nico-derm)** **(Jones & Bartlett, 2017, p.791).**
Dose	**500mg**	**750mg**	**3.375mg**	**1000mg**	**14mg**
Frequency	**Daily**	**Q48H**	**Q6H**	**Q8H**	**Daily**
Route	**PO**	**IVPB**	**IVPB**	**IVPB**	**Trans-dermal**
Classification	**Azalide**	**Fluoro-quinolone**	**Penicillin and betalactamase inhibitors**	**Tricyclic glycopeptide**	**Pyridine alkaloid**
Mechanism of Action	**Binds to ribosomal subunit of susceptible bacteria, blocking peptide trans-location and inhibiting RNA-dependent protein synthesis.**	**Interferes with bacterial cell replication by inhibiting the bacterial enzyme DNA gyrase.**	**Inhibits the synthesis of bacterial cell walls by binding preferentially to specific PBPs located within the cell walls.**	**Inhibits bacterial RNA and cell wall synthesis; alters permeability of bacterial membranes, causing cell wall lysis and cell death.**	**Binds selectively to nicotinic-cholinergic receptors at autonomic ganglia, in eh adrenal medulla, at the neuro-muscular junctions, and in the brain.**
Reason Client	**HAP/VAP**	**HAP/VAP**	**HAP/VAP**	**HAP/VAP**	**Chronic**

Taking					**tobacco use**
Contraindications (2)	**History of hepatic dysfunction; hyper-sensitivity**	**Myasthenia gravis; Hyper-sensitivity**	**Hypokalemia; Increased bleeding risk from prolonged PT/INR or PTT**	**Allergy to corn; hyper-sensitivity**	**Life-threatening arrhythmias; severe angina pectoris**
Side Effects/Adverse Reactions (2)	**Chest pain; edema**	**Arrythmias; acute renal failure or in-sufficiency**	**Diarrhea; confusion**	**Back pain; wheezing**	**Hypertension; confusion**
Nursing Considerations (2)	**Monitor elderly patients closely for arrhythmias; Obtain culture and sensitivity prior to administration**	**Monitor renal function prior too giving; Obtain culture and sensitivity before giving**	**Assess medications to ensure there is no drug interactions with the rest of the regimen; Monitor for low potassium**	**Assess for ototoxicity; Infused medication over at least 1 hour per gram**	**Do not open until just before application due to nicotine evaporation; rotate applications site every day**
Key Nursing Assessment(s) Prior to Administration	**Electrolyte levels; Assess telemetry for arrhythmias**	**Culture and sensitivity collection before beginning medication; Assess tendon dignity, or past injuries, especially in elderly patients**	**Assess allergies to any foods, dyes, preservatives, or animals**	**Ensure this medication delivery rate is at least over 1 hour; Monitor serum concentrations and BUN**	**Remove patch prior to MRI to avoid burns; do not use the same application site for seven days**
Client Teaching needs (2)	**Take oral pills 1 hour before or 2-3hours after food;**	**Advice patient to increase fluid intake to prevent**	**Notify PCP immediately if serious allergic reactions**	**If tinnitus or diarrhea occurs notify PCP; Instruct**	**Must stop smoking as soon as nicotine treatment**

	abdominal pain and loose, watery stools may occur	**crystalluria ; tell patient to stop medication and call your PCP if allergic reaction or tendon pain occur**	**occur; if diarrhea occurs and persists notify PCP (may last up to 2 months after stopping regimen)**	**patient to complete full course of medication**	**begins to avoid toxicity; Seek medical attention if difficulty breathing occurs**

Medications Reference (APA):

Mayo Clinic. (2019, August 1). Piperacillin And Tazobactam (Intravenous Route) Before Using. Retrieved from https://www.mayoclinic.org/drugs-supplements/piperacillin-and-tazobactam-intravenous-route/before-using/drg-20072716

Jones, & Bartlett. (2017). *Nurse's Drug Handbook* (16th ed.). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: alert** **Orientation: unoriented** **Distress: no distress** **Overall appearance: comfortable**	**The patient appeared to be comfortable. He is A&Ox2, not orientated to time or place. There was no distress being physically or verbally expressed.**
INTEGUMENTARY (2 points): **Skin color: Caucasian** **Character: intact** **Temperature: cool** **Turgor: WNL – not tenting** **Rashes: not present** **Bruises: not present** **Wounds: not present** **Braden Score: 17**	**Braden Scale: 17** **Patient is a Caucasian male with a fair complexion. Skin was cool to the touch, dry and pink. Good skin turgor with no abnormal textures or tenting. No observation of rashes, lesions, bruises, or wounds. No drains or observed wounds are present.**

Drains present: Y☐ N ☒ **Type: N/A**	
HEENT (1 point): **Head/Neck: midline with hair present** **Ears: no hearing aids** **Eyes: glasses utilized** **Nose: no NG tube** **Teeth: present**	**Head is midline with no deviations. Patient has partial head of grey hair with a receding hairline. Patient can hear and occasionally comprehend questions with no need to raise volume or change tone of voice. Due to disorientation, redirection of time and place is required. PERLA is present. Conjunctiva and sclera are normal. Patient utilized glasses. Nose does not present with any external or internal swelling or discomfort. Teeth are maintained and oral mucosa is moist and pink.**
CARDIOVASCULAR (2 points): **Heart sounds: regular** **S1, S2, S3, S4, murmur etc: S1 S2** **Cardiac rhythm (if applicable): NSR** **Peripheral Pulses: 3+ normal (pedal and brachial)** **Capillary refill: < 3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	**Completion of a cardiac rhythm strip analysis and interpretation was complete. Patient was in normal sinus rhythm with PR interval, QT interval, and QRS complex all within normal limits. Upon auscultation, S1 and S2 was heard. No present of murmurs, palpitations, bruits, or abnormalities. Peripheral pulses were palpable, 3+, for pedal and radial locations. Capillary refill was less than 3 seconds. No neck vein distention or edema was present.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	**No observed use of accessory muscles during breathing was noted. Patient was not intubated but was receiving supplemental oxygen at 2L/min via a nasal cannula. After application SaO2 was within normal limits at 99%. Auscultation of lung sounds were overall diminished in all five lobes bilaterally, significantly in the right lobe. Knowledge of a mass in the right lung is due to previous diagnosis. Patient was not short of breath or displaying any labored breathing, coughing, or wheezing. Baseline respiratory rate is high as a result of the squamous cell carcinoma. Trachea resides midline and the patient does appear comfortable.**

GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet: Heart healthy** **Height: 168cm** **Weight: 54.6 kg** **Auscultation Bowel sounds: active** **Last BM: 09/03/19** **Palpation: Pain, Mass etc.: N/A** **Inspection: within normal limits** **Distention: N/A** **Incisions: N/A** **Scars: N/A** **Drains: N/A** **Wounds: N/A** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size: N/A** **Feeding tubes/PEG tube Y ☐ N ☒** **Type: N/A**	**Patient is eating and tolerating heart healthy diet well. Auscultation of abdomen presented with active bowel sounds in all four quadrants. Palpation of abdomen did not present with tenderness, masses, distention, incisions, or scars. No drains are present. No wounds are present. The patient also does not have an ostomy, nasogastric tube, or feeding tube. No pain is stated or demonstrated during assessment. Last bowel movement was during clinical on 09/03.**
GENITOURINARY (2 Points): **Color: yellow** **Character: clear** **Quantity of urine: 925 mL** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: WNL** **Catheter: Y ☒ N ☐** **Type: coude** **Size: 16F** **CAUTI prevention measures: pericare**	**The patient is continent with urinary urges. However, due to frequent urination needs on top of high fall risk with the patient's confusion, a 16F coude catheter was placed on 09/02. Sterile technique is used with insertion and peri-care is provided frequently to prevent a CAUTI. Urine is yellow and clear. No sediment was within the collection apparatus or catheter tubing. Patient is on I&O. Input of 425mL. Output of 925mL.**
MUSCULOSKELETAL (2 points): **Neurovascular status: intact** **ROM:** **Supportive devices: walker/gait belt** **Strength: bilateral, overall weakness** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 85** **Activity/Mobility Status: with assistance** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	**Fall Score: 85** **Patient is able to feel and reaction to sensation on all four limb and trunk of body. Due to age and health conditions, patient is frail and unable to support himself well while shifting in bed or sitting forward for auscultation. ROM is adequate for age and health conditions. Despite this he has the ability to have a mind-muscle reaction. The patient uses a walker and gait belt as assistive devices. Patient's ability to balance and walk was not assessed due to history of falls, which required a sitter to ensure compliance.**

NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The patient can move all extremities but not well. He is unable to support himself to be considered adequately safe. However, all strength is equal. PERLA is present. Patient is not orientated to time and place. He is overall confused. Speech is clear but expressed thoughts and ideas with word salad. Sight, touch, hearing, taste, and smell are intact. Patient is awake and alert.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**The patient does not have effect coping skills. After the death of his wife, of 60 years, last year he has been accepting of death stating that it is "his time" and that he "is ready to go." He does have the support of his daughter and don-in-law during this period of time. He currently lives with them in their single-family home in Charleston, IL. Practiced religion of the patient is Baptist, however meaning of this religion is unable to be investigated due to confusion. Developmental level is appropriate for the age of this patient.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**93 bpm**	**130/74mmHg** **R. brachial**	**22** **breath/min**	**37.6** **Tympanic**	**100%** **NC 2L**
0837	**89 bpm**	**113/65 mmHg** **R. brachial**	**33** **breath/min**	**37.5** **Tympanic**	**99%** **NC 2L**

Vital Sign Trends/Correlation:

- **According to Cerner, systolic BP is from 91-140 mmHg. However, normal respiratory rate is from 12-20 breaths per minute. There is a consistent trend of a high respiratory rate. This is a result of the patient's medical history of lung cancer, acute hypoxia, SIRS, and pneumonia. All of these conditions result in an increased respiratory rate.**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**Numeric**	**No location described**	**0/10**	**No characteristics described**	**No nursing interventions required**
0837	**Numeric**	**Overall general body**	**5/10**	**General, ache, constant**	**Oxycodone-acetaminophen 5/325mg PRN Q4H for severe pain. Re-assessment at 1012. Pain 0/10 with patient sleeping comfortably.**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Peripheral IV: 20g left antecubital placed on 09/01. IV patency tested with a saline flush and remains patent since placement. No signs of erythema, drainage, infiltration, or irritation. IV dressing is clean, intact, and dry. Saline lock is in place. Peripheral IV: 20g right forearm placed on 09/01. IV patency tested with a saline flush and remains patent since placement. No signs of erythema, drainage, infiltration, or irritation. IV dressing is clean, intact, and dry. Saline lock is in place.
Other Lines (PICC, Port, central line, etc.)	N/A
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:**	N/A

Date on dressing: **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
425 mL	925 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Care was provided to the patient from 0700 to 1300. Overall, the patient was quiet and did not require extensive attention. The presence of a sitter aided in keeping the patient safe and fall-free during his stay.

Procedures/testing done: The patient left the floor for an MRI of the brain. He was off the unit for about an hour and returned promptly at 1100. No additional lab work was ordered or completed.

Complaints/Issues: The patient did not have any complaints or issues during the clinical day.

Vital signs (stable/unstable): Vital signs remained stable from 0700 to 1300. Respiratory rate was not within normal range; however, he was stable and oxygen saturation remained between 95-100%.

Tolerating diet, activity, etc.: The patient was tolerating his diet, and liquids, well without experiencing any difficulties. Activity was limited due to his fragility, confusion, and fall risk.

Physician notifications: The physician did not require any notifications. He did his rounds on the patient and briefly discussed the hospice care consult with the family upon their arrival. Nurse was notified and aware of abnormal vital sign.

Future plans for patient: The patient's pending acceptance for a transfer to the telemetry unit within Sarah Bush. From there, a consult for hospice will meet with the patient and his family.

Discharge Planning (2 points)

Discharge location: Once discharge is discussed with the patient and his family, he will be returning to a single-family home with his daughter and son-in-law in Charleston, IL.

Home health needs (if applicable): Home health care will not be needed farther than hospice and palliative care to assistance the patient with comfort during his final stages.

Equipment needs (if applicable): The patient currently has a walker located at his home. Additional equipment needs may include a wheelchair or a hospital bed, depending on family needs.

Follow up plan: No tentative follow-up plans are scheduled. If any difficulties arise regarding his health promptly return to the Sarah Bush Lincoln emergency department.

Education needs: Education regarding end-of-life care is required. Consult for hospice is scheduled once transfer to telemetry unit is complete. Further discussion with provider and hospice care will assistant with education for the family and patient.

Nursing Diagnosis (15 points)
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	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired gas exchange related to	**The top priority to patient care is**	**1. Position the patient in**	**The patient responded well to being placed**

previous diagnosis of lung cancer and currently pneumonia infection as evidenced by diminished lung sounds during respiratory assessment. **(Swearingen, 2016, p.112).**	**the airway. Without a patent airway and proper oxygenation, the patient would not continue to be able to profuse and arrest.**	**high-Fowler's to facilitate breathing and maintain oxygen saturation within 95-100%.** **2. Assess for signs and symptoms of hypoxia, cyanosis or increased respiratory rate, every time there is interaction with the patient and q4h. Report any significant findings to the provider.**	**upright in high-Fowler's position. Further interventions were not required. O2 saturation remained within acceptable limits for the remainder of his stay. Goal was met, and no modifications were required.**
2. Risk for injury related to fragility and increasing confusion as evidenced by numerous occasions of attempted ambulation without supervision or assistance. **(Swearingen, 2016, p.25).**	**This nursing diagnosis was chosen due to the fact that this patient is no longer orientated enough to completely understand the circumstances regarding his health, current location, or physical abilities.**	**1. Submission of a request for a sitter to stay with the patient in his room. A sitter will stay with the patient during the entire shift, even when the patient is off the floor.** **2.Utilization of bed alarms, verbal instructions, and consistent rounding every hour.**	**The patient has responded well to interventions and remained fall free during the clinical rotation. Further interventions are not required. Goal was met, and no modifications were required.**
3. Acute pain related to the disease process involving lung infiltrate and lung mass as evidenced by assessment with chest x-ray. **(Swearingen, 2016, p.39).**	**This nursing diagnosis was picked due to the patient expressing discomfort during the clinical rotation in addition to his lack of sleep.**	**1. Assess for behavioral and physical indicators of pain during hourly rounds with the numeric pain scale during VS assessments.** **2. Reassess pain levels 30minutes after each**	**The patient has responded well to interventions and remained pain free after nursing interventions during the clinical rotation. Further interventions are not required. Goal was met, and no modifications were required.**

		intervention for effects and the potential of side effects.	
4. Anxiety as a result of increasing confusion as evidenced by physical demeanor and inquisitive, word-salad questions to the provider. **(Swearingen, 2016, p.198).**	**This nursing diagnosis was picked due to the patient becoming frazzled regarding information about his condition and plans after discharge.**	**1. Assess anxiety levels and administer antianxiety medication as prescribed.** **2. Utilization of nonpharmacological relaxants such as distraction or imagery.**	**The patient has responded well to interventions and continued to have minimal to no anxiety during the clinical rotation. Further interventions are not required. Goal was met, and no modifications were needed.**
5. Deficient knowledge related to inability to retain information as evidenced by continued confusion during reiterated educational sessions. **(Swearingen, 2016, p.188).**	**This nursing diagnosis was picked due to the patient's inability to retain information being relaying to him.**	**1. Utilization of various teaching materials including verbal, written, and tactile delivery methods.** **2. Relaying information to POA, the patient's daughter, and verifying understanding through questions and return demonstration.**	**The patient has responded well to nursing interventions and information was retained by POA during the clinical rotation. Further interventions are not required. Goal was met, and no modifications were required.**

Other References (APA):

Swearingen, P. L. (2016). ***All-In-One Nursing Care Planning Resource*** **(4th ed.). St. Louis, Missouri: ELSEVIER.**

Concept Map (20 Points)

Subjective Data

The patient presented in the Sarah Bush ED on 09/01 with reports of SOB and right-sided CP that is constant and non-radiating. The patient has a productive cough that began two days prior. He presents as hypoxic, febrile, with dyspnea. The patient arrived with his son-in-law who stated that the patient's disorientation has been increasing over the last few days. Onset, duration, relieving factors, and treatments are unattainable due to the patient being an unreliable historian. Patient is admitted on 09/01 to the inpatient setting.

Nursing Diagnosis/Outcomes

Impaired gas exchange related to previous diagnosis of lung cancer and currently pneumonia infection as evidenced by diminished lung sounds during respiratory assessment.
Outcome: Patient's oxygen saturation remains within 95-100% during the entirety of the clinical rotation.
Risk for injury related to fragility and increasing confusion as evidenced by numerous occasions of attempted ambulation without supervision or assistance.
Outcome: The patient remains fall and injury-free during clinical rotation.
Acute pain related to the disease process involving lung infiltrate and lung mass as evidenced by assessment with chest x-ray.
Outcome: The patient will remain pain free, a 0/10 on the numeric scale, for the remained of the stay.
Anxiety as a result of increasing confusion as evidenced by physical demeanor and inquisitive, word-salad questions to the provider.
Outcome: The patient's anxiety will remain managed, within acceptable limits stated by the patient.
Deficient knowledge related to inability to retain information as evidenced by continued confusion during reiterated educational sessions.
Outcome: The patient, or family, will be able retain information delivered by the healthcare team.

Objective Data

Consistent trend of increased respiratory rate (22;33). Low RBC (3.85;3.62), low Hgb (12.4), low PLT (36.7), high WBC (11.9), high neutrophils (84.7;86.3), low lymphocytes (5.1;7), high glucose (152), low Cr (0.68), low albumin (3.1), low calcium (8.3). Decreased venous PaO2 (26.1) and SaO2 (51.5). High arterial pH (7.46) and decreased (34.7). XR chest 1 view results of persistent RUL patchy infiltrate consistent for pneumonia along with previously demonstrated mass.

Patient Information

The patient is a [illegible] complaints of shortness of breath and chest pain. History of lung cancer, SIRS, acute GERD, depression, anxiety, and acute hypoxemic respiratory failure, and chronic tobacco use. Surgical history of a bronchoscopy with biopsy, and ventral hernia repair. No

Nursing Interventions

1. Position the patient in high-Fowler's to facilitate breathing and maintain oxygen saturation within 95-100%.
2. Assess for signs and symptoms of hypoxia, cyanosis or increased respiratory rate, every time there is interaction with the patient and q4h. Report any significant findings to the provider.
1. Submission of a request for a sitter to stay with the patient in his room. A sitter will stay with the patient during the entire shift, even when the patient is off the floor.
2.Utilization of bed alarms, verbal instructions, and consistent rounding every hour.
1. Assess for behavioral and physical indicators of pain during hourly rounds with the numeric pain scale during VS assessments.
2. Reassess pain levels 30minutes after each intervention for effects and the potential of side effects.
1. Assess anxiety levels and administer antianxiety medication as prescribed.
2. Utilization of nonpharmacological relaxants such as distraction or imagery.
1. Utilization of various teaching materials including verbal, written, and tactile delivery methods.
2. Relaying information to POA, the patient's daughter, and verifying understanding through questions and return demonstration.