N431 Care Plan 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/20/19	HJ	92	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widow	Morphine – reaction unknown Penicillin – reaction unknown
Code Status	**Height**	**Weight**	
DNR	156cm	87.9kg	

Medical History (5 Points)

Past Medical History: Pneumonia, respiratory failure with hypoxia and hypercapnia, COPD, hyperglycemia, Type 2 Diabetes, hypertension, and lymphedema

Past Surgical History: No past surgical history charted**.**

Family History: Family history is unknown.

Social History (tobacco/alcohol/drugs): Denies use of tobacco, alcohol, and drugs.

Assistive Devices: Walker with gait belt. Denies use of wheelchair and cane.

Living Situation: Lives with son and grandkids.

Education Level: Patient's daughter states she is retired.

Admission Assessment

Chief Complaint (2 points): Difficulty Breathing and productive cough

History of present Illness (10 points): 92-year-old female presents to Sarah Bush Lincoln Hospital with shortness of breath and difficulty breathing on 9/20/20, accompanied by a productive cough. Patient complains of chest pain upon breathing and it has been getting worse since the past week. Patient has past medical history of respiratory failure with hypoxia and hypercapnia, COPD, hyperglycemia, Type 2 Diabetes, hypertension, and lymphedema**.** A chest x-ray was completed on the 22nd showing infiltrate in the left mid and lower lobes confirming community acquired pneumonia. Patient is respiratory protocol with 2 L oxygen via nasal cannula. Antibiotics Azithromycin and ceftriaxone started. Patient has episodes of night time hyperglycemia and morning hypoglycemia. Blood sugar being monitored Q2H, vitals are currently stable. Patient reports no pain at time of assessment.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Community Aquired Pneumonia

Secondary Diagnosis (if applicable):NA

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

Pneumonia can be defined as inflammation of the lung tissue causing purulent, inflammatory cells, and fibrin fill the alveolar air spaces (Capriotti & Frizzell, 2016, p.449). The most common cause of pneumonia is inhalation of droplets that contain bacteria or pathogens, along with inhalation of chemicals, aspiration of contents from the oropharynx or stomach may also cause it (Capriotti & Frizzell, 2016, p.449). Once the droplets travel through the upper airway, they have access to the lung tissue. The pathogens can then adhere to epithelium tissue in the respiratory tract to stimulate an inflammatory reaction, causing vasodilation (Capriotti & Frizzell, 2016, p.450). The vasodilation is accompanied by edema, due to the irritation. This then triggers an excessive stimulation of respiratory goblet cells that secrete mucus, causing it to collect among alveoli and capillaries (Capriotti & Frizzell, 2016, p.450). The result of this compression is auditory crackles or wheezes, as the alveoli attempt to open against the exudative fluid and edema. This poses a concern on gas exchange, limiting the encounter at the pulmonary capillaries and forming an obstruction (Capriotti & Frizzell, 2016, p.450).

The primary test that diagnoses pneumonia is a chest x-ray with differential to reveal the presence of a bacterial or viral infection (Capriotti & Frizzell, 2016, p.450). My patient was ordered a chest x-ray and the results revealed markedly increased ill-defined opacity in left amid and lower lung. Ill cardiomegaly was also noted, along with moderate left pleural effusion and small right pleural effusion noted. The enlargement of central pulmonary arteries was consistent with pulmonary artery hypertension, as stated in the history. Additionally, a thoracentesis can be utilized if pleural effusion is suspected, which the patient also undergone. These results showed negative findings for pneumothorax, persistent left lung opacities, and no definite residual left pleural effusion. Furthermore, labs performed on the patient to support the diagnosis include obtaining arterial blood gases and pulse oximetry to assess oxygenation status of the patient (Capriotti & Frizzell, 2016, p.450). This patient maintained a pulse oximetry reading between 92-94 during my shift and had a blood pH of 7.3 along with a PaO2 of 83.6. More labs that can utilized to diagnose pneumonia are sputum culture and sensitivity tests to investigate if there is an organism present, such as *S. pneumoniae* and Legionella (Capriotti & Frizzell, 2016, p.450). The patient had received the sputum tests and they each came back negative for pneumonia organisms.

Antibiotic therapy and oxygenation are the primary treatments of pneumonia (Pneumonia, 2018). The patient was prescribed Azithromycin and Ceftriaxone, along with 2L oxygen via nasal cannula, following the chest x-ray and confirmation of pneumonia. To encourage sufficient breathing, the patient was positioned in fowlers position and had assistance from respiratory therapy. In addition to this, antipyretics and analgesics may be prescribed for discomfort and body aches associated with the disease (Pneumonia, 2018). To prevent further pneumonia outbreaks, the patient was informed on the pneumococcal vaccination.

On physical exam and assessment, the patient had given a past medical history of COPD and respiratory failure, only further exacerbating the irritation. The patient is experiencing shortness of breath, decreased oxygen saturation, wheezes on expiration, and weakness. These symptoms are all associated with community acquired pneumonia and the abnormal labs align with this finding. The book states that a productive cough and dyspnea are the initial manifestations of pneumonia, which the patient exhibited on admission (Capriotti & Frizzell, 2016, p.450). Further symptoms include decreased exercise tolerance, pleuritic chest pain, hemoptysis, tachycardia, and wheezes (Capriotti & Frizzell, 2016, p.450).

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

Pneumonia. (2018, March 13). Retrieved from https://www.mayoclinic.org/diseases-conditions/pneumonia/diagnosis-treatment/drc-20354210

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	3.80-4.41	4.28	3.72	Red blood cells are decreased in patients with chronic inflammatory

				diseases. This patient has a history of COPD and the pneumonia is causing more inflammation of the airways, resulting in decreased red blood cells (Van Leeuwen & Bladh, 2017, p.384).
Hgb	11.3-15.2	13.3	11.4	Values within normal limits
Hct	33.2-45.3%	42	36.4	Values within normal limits
Platelets	149-493k	152	110	The decrease in platelets is associated with the medication the patient is receiving. Lovenox injections are given daily to decrease the chances of clotting. Since the patient is not taking these at home, it is lowering the platelet count in result of preventing a DVT (Van Leeuwen & Bladh, 2017, p. 814, 364).
WBC	4-11.7K	12.3	8.7	The increase of white blood cells is associated with the presence of infection, which is congruent with the diagnosis of pneumonia. The inflammatory or infectious response increases the white blood cell count (Van Leeuwen & Bladh, 2017, p. 369).
Neutrophils	45.3-79	79	NA	Values within normal limits
Lymphocytes	11.8-45.9	13.7	1.0	Values within normal limits
Monocytes	4.4-12.0	6.7	2.0	Values within normal limits
Eosinophils	0.0-6.3	NA	NA	Values absent from chart.
Bands	<1 x 10^9 L	NA	NA	Values absent from chart.

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-	135-145	137	146	Sodium is increased in patients who have diabetes. It is a result of dehydration related to frequent urination (Van Leeuwen & Bladh,

				2017, p. 1064).
K+	3.5-5.1	3.4	4.2	Potassium is decreased in result of hypertension medications, furosemide and amlodipine, which release potassium in the urine. It is also related to diabetes, which affect cellular retention and renal excretion of potassium respectively (Van Leeuwen & Bladh, 2017, p. 980).
Cl-	98-107	99	99	Values within normal limits
CO2	22-29	25	42	CO2 is increased because the patient has a history of COPD, causing the body to retain CO2. Also associated with the buildup of ketoacids in diabetics, which this patient is (Van Leeuwen & Bladh, 2017, p. 400).
Glucose	70-99	411	78	Increased glucose is seen in this patient because of the history of diabetes, along with the presence of infection. This relates to the feedback loop in response to stress (Van Leeuwen & Bladh, 2017, p. 655).
BUN	6-20	NA	39	Increased BUN is seen in this patient, because she has chronic kidney disease, causing BUN to be retained (Van Leeuwen & Bladh, 2017, p. 1177).
Creatinine	0.5-0.9	NA	1.49	Creatine is increased from high levels of glucose in the blood and chronic kidney disease. The patient has stage 3 kidney disease (Van Leeuwen & Bladh, 2017, p. 476).
Albumin	3.4-5.2	NA	NA	Values within normal limits
Calcium	8.6-10.4	8.8	8.0	Calcium is decreased due to the loop diuretic the patient is taking and the lack of calcium being absorbed (Van Leeuwen & Bladh, 2017, p. 269).
Mag	1.6-2.4	NA	NA	Values within normal limits

Phosphate	44-147	99	NA	Values within normal limits.
Bilirubin	0.0-1.2	1.2	NA	Values within normal limits.
Alk Phos	35-105	99	NA	Values within normal limits
AST	0-32	25	NA	Values within normal limits
ALT	0-33	18	NA	Values within normal limits
Amylase	23-85	NA	NA	Values absent from chart.
Lipase	23-85	NA	NA	Values absent from chart.
Lactic Acid	0.5-2.4	384	NA	Lactic acid is increased in diabetes due to inefficient aerobic glycolysis and decreased blood flow caused by diabetes result in accumulation of lactic acid from anaerobic glycolysis. It also is increased in pulmonary failure due to decreased blood flow (Van Leeuwen & Bladh, 2017, p. 777).
Troponin	0-0.4	0.024	NA	Values within normal limits
CK-MB	3-5%	2.01	NA	Values within normal limits
Total CK	22-198	133	NA	Values within normal limits

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	0.86-1.14	0.98	NA	Values within normal limits
PT	11.9-15	13.2	NA	Values within normal limits
PTT	23-37	NA	NA	Values absent from chart.

D-Dimer	<0.4	NA	NA	Values absent from chart.
BNP	<100	NA	NA	Values absent from chart.
HDL	>40	NA	NA	Values absent from chart.
LDL	<100	NA	NA	Values absent from chart.
Cholesterol	<200	NA	NA	Values absent from chart.
Triglycerides	<150	NA	NA	Values absent from chart.
Hgb A1c	0.5-7	NA	7.5	Hemoglobin A1c is elevated in my patient due to diabetes, as glucose intolerance and elevated glucose levels define this (Van Leeuwen & Bladh, 2017, p. 400).
TSH	0.4-4.0 M	NA	NA	Values absent from chart.

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	NA	Values within normal limits
pH	5.0-8.0	5.0	NA	Values within normal limits
Specific Gravity	1.005-1.034	1.013	NA	Values within normal limits
Glucose	Normal	150	NA	Values within normal limits
Protein	Negative-Normal	Normal	NA	Values within normal limits
Ketones	Negative	Negative	NA	Values within normal limits
WBC	<5	3	NA	Values within normal limits
RBC	0-3	<1	NA	Values within normal limits
Leukoesterase	Negative	Negative	NA	Values within normal limits

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	7.38-7.42	7.30	NA	The decrease in blood pH is related to respiratory conditions and respiratory acidosis. This is seen in patient with pneumonia, respiratory failure, and COPD, which my patient has (Van Leeuwen & Bladh, 2017, p. 368).
PaO2	80-100	82.6	NA	Values absent from chart.
PaCO2	35-45	59.6	NA	Values within normal limits
HCO3	22-28	24.9	NA	Values within normal limits
SaO2	93-100%	NA	NA	Values absent from chart.

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	NA	Values within normal limits
Blood Culture	Negative	Negative	NA	Values within normal limits
Sputum Culture	Negative	Negative	NA	Values within normal limits
Stool Culture	Negative	Negative	NA	Values within normal limits

Lab Correlations Reference (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest x-ray without contrast, Chest x-ray, and Thoracentesis were completed.

Diagnostic Test Correlation (5 points):

Patient presented to the hospital with shortness of breath and productive cough. Chest X-Ray was ordered to aid in the diagnosis of pneumonia (Van Leeuwen & Bladh, 2017, p. 388). Per the radiologist's note, the heart was slightly enlarged in size and there was evidence of pneumonia in the left lobe. The lungs showed a pleural effusion, and presence of cardiomegaly.

Chest x-ray without contrast ordered to assess fluid overload due to crackles in patient's lungs upon auscultation (Capriotti & Frizzell, 2016, p.450). This was also ordered due to complaints from patient regarding difficulty breathing. Results revealed markedly increased ill-defined opacity in left amid and lower lung, ill cardiomegaly, moderate left pleural effusion and small right pleural effusion. It also displayed an enlargement of the central pulmonary arteries, which are consistent with pulmonary artery hypertension.

Thoracentesis ordered to assess the presence of pneumothorax or pleural effusion, as patient's status has not improved with medication (Capriotti & Frizzell, 2016, p.450). Evidence showed negative findings for pneumothorax, persistent left lung opacities, no definite residual left pleural effusion, and a presence of cardiomegaly.

Diagnostic Test Reference (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 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	Norvasc (Amlodipine)	Cefdinir (Omnicef)	Enoxaparin (Lovenox)	Furosemide (Lasix)	Levemir (Insulin Detemir)
Dose	5mg = 1 tab	300mg = 1 cap	30mg = 0.3mL	20mg=1 tablet	100=0.7 ml
Frequency	Daily	Q24H	Daily	Daily	BID
Route	PO	PO	SQ	PO	SQ
Classification	Calcium Channel Blocker	Cephalosporin Antibiotic	Low Molecular Weight Heparin	Loop Diuretic	Recombinant Human Insulin Analog
Mechanism of Action	Inhibits influx of extra cellular calcium into vascular smooth muscle and myocardial cells, resulting in decreased peripheral vascular resistance and a reduction	Inhibition of cell wall synthesis. Activity against gram positive organisms (Staphylococcus aureus, staphylococcus pneumoniae, staphylococcus pyrenes. Activity against gram negative organisms	Binds antithrombin II which leads to inhibition of coagulation factors IIa and XA (Ciccone, 2018).	Inhibits sodium and chlorine reabsorption at proximal and distal tubules and loop of Henle (Ciccone, 2018).	Regulates glucose metabolism, stimulates peripheral glucose up rake by skeletal muscle and fat, inhibits glucose production. Prolong action works by having albumin binds with fatty acyl side

	of heart rate pressure (Ciccone, 2018).	Haemophilus influenza, Haemophilus parainfluenza (Ciccone, 2018).			chin and distributes to peripheral targets (Ciccone, 2018).
Reason Client Taking	Hypertensi on	Pneumonia	Thromboemb olic	Edema, Hypertensi on	Diabetes Type 2
Contraindication s (2)	Bradycardi a Hypotensio n	Hypersensitiv ity to Cephalospori n antibiotics Renal impairment	Active Bleed Ulcer disease	Hypokalem ia Hypovolem ia Use of other sulfonamid es	Hypersensitiv ity Hypoglycemi a
Side Effects/Adverse Reactions (2)	Edema Palpitation s	C. Diff Seizures	Bleeding Anemia	Hyponatre mia Hypokalem ia	Pruritus Injection reaction
Nursing Considerations (2)	Monitor intake and output and daily weights Monitor for angina or arrhythmia s on EKG (Ciccone, 2018).	Seizure precautions Assess patient for skin rash frequently during therapy. Discontinue at first sign of rash; may be life-threateni ng. Stevens-John son syndrome may develop. Observe for signs of anaphylaxis	Assess for signs of bleeding and hemorrhage (bleeding gums, nosebleed, tarry stools, hematuria) Needle safety while injecting patient and use of standard precautions (Ciccone, 2018).	Assess for tinnitus or ear pain for ototoxicity Assess fluid status throughout therapy via daily weights, intake and output, edema, lung sounds, skin turgor and membrane (Ciccone, 2018).	Assess for symptoms of hypoglycemi a (anxiety, restlessness, tingling in hands, feet, cold sweats, confusion, cool, pale, skin, drowsiness, irritable, tachycardia) Monitor blood glucose every 4-6 hours to assess for hyperglycemi

		(rash, pruritus, wheezing) (Ciccone, 2018).			a or hypoglycemia (Ciccone, 2018).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver enzymes Monitor blood pressure and pulse Assess for jaundice (Ciccone, 2018).	Monitor Kidney Labs Monitor bowel function, asses for bloody stool (Ciccone, 2018).	Monitor coagulation labs (PT. INT, PTT) Assess for excessive clotting (Ciccone, 2018).	Monitor blood pressure and pulse before administering Assess neurologic status and intraocular pressure (Ciccone, 2018).	Monitor blood glucose prior to administration Double nurse verification before administering (Ciccone, 2018).
Client Teaching needs (2)	Change position slowly to minimize orthostatic hypotension. Continue taking medication even if feeling well, consult physician before stopping. (Ciccone, 2018).	Report signs of superinfection (furry overgrowth on the tongue, vaginal itching or discharge, loose or foul-smelling stools) and allergy. Notify health care professional if fever and diarrhea develop, especially if stool contains blood, pus, or mucus.	Caution patient to avoid activities leading to injury, to use a soft toothbrush and electric razor, and to report any symptoms of unusual bleeding Do not take OTC medications, especially those containing aspirin, NSAIDs, or alcohol, without advice of health care	If you miss a dose, do not double up, take as soon as remembered Take first thing in the morning, everyday Make position changes slowly to minimize orthostatic hypotension (Ciccone, 2018).	Instruct patient on proper technique for administration. Discuss the rotation of injection sites Educate on signs and symptoms of hypoglycemia and hyperglycemia and to call the doctor if they occur (Ciccone, 2018).

		(Ciccone, 2018).	professional. (Ciccone, 2018).		

Hospital Medications (5 required)

Brand/Generic	Lantus (Insulin Glargine)	Ondansetron (Zofran)	Acetaminophen (Tylenol)	Bayer (Aspirin)	Montelukast (Singular)
Dose	15 units	4mg	325mg	81mg	10mg
Frequency	HS	Q8H PRN	Q6HPRN	Daily	Every Night
Route	SQ	PO	PO	PO	PO
Classification	Recombinant Human Insulin Analog	Selective 5-HT3 Receptor Antagonist	Antipyretic	Antipyretic	Bronchodilator, Leukotriene antagonist
Mechanism of Action	Lowers blood glucose by stimulating glucose uptake in skeletal muscle and fat, inhibiting hepatic glucose production. Other actions of insulin: inhibition of lipolysis and proteolysis, enhanced protein synthesis	The antiemetics results from peripheral and central serotonin receptor blocking. (Ciccone, 2018).	Inhibits the synthesis of prostaglandins that may serve as mediators of pain and fever, primarily in the CNS. Has no significant anti-inflammatory properties or GI toxicity (Ciccone, 2018).	Produce analgesia and reduce inflammation and fever by inhibiting the production of prostaglandins. Decreases platelet aggregation (Ciccone, 2018).	Antagonizes the effects of leukotrienes, which mediate the following: Airway edema, Smooth muscle constriction, Altered cellular activity. Result is decreased inflammatory process, which is part of asthma and allergic rhinitis. (Ciccone,

	(Ciccone, 2018).				2018).
Reason Client Taking	Diabetes Type 2	Prevent Nausea	Prevent nausea and mild pain or aches	Reduce inflammation, analgesia	To expand airways and promote breathing, COPD
Contraindications (2)	Hypoglycemia Allergy to insulin glargine	QT Prolongation Use with apomorphine	Products containing alcohol, aspartame, saccharin, sugar, or tartrazine Sever hepatic impairment	Bleeding disorders Thrombocytopenia	Hypersensitive Hepatic impairment
Side Effects/Adverse Reactions (2)	Hypoglycemia Pruritus	Constipation Eye disorders	Headache Neutropenia	Dyspepsia Epigastric distress	Rash Suicidal ideations
Nursing Considerations (2)	Assess for symptoms of hypoglycemia (anxiety, restlessness, tingling in hands, feet, cold sweats, confusion, cool, pale, skin, drowsiness, irritable, tachycardia) Monitor blood glucose every 4-6 hours to assess for hyperglyce	Monitor hydration status and intake and output related to nausea and vomiting Assess patient for syncope or dizziness, assist with ambulating to prevent falls (Ciccone, 2018).	Assess for fever, diaphoresis, tachycardia, or malaise improvement Evaluate hepatic, hepatologic and renal function periodically through usage (Ciccone, 2018).	Assess for fever and associated signs for improvement Monitor for unusual bleeding such as from the gums, nose, or small scrapes (Ciccone, 2018).	Assess lung sounds and respiratory function prior to and periodically during therapy Monitor closely for changes in behavior that could indicate worsening of depression or suicidal thoughts (Ciccone, 2018).

	mia or hypoglycemia (Ciccone, 2018).				
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor blood glucose prior to administration Double nurse verification before administering (Ciccone, 2018).	Monitor ECG Monitor Electrolytes Asses nausea, vomiting, bowel sounds, and abdominal pain before administration (Ciccone, 2018).	Assess overall health status and alcohol usage before administering. Patients who are malnourished or abuse alcohol are at higher risk of developing hepatotoxicity. Assess amount, frequency, and type of drugs taken in patients self-medicating, especially with OTC drugs. Prolonged use may increase the risk of adverse renal affects. (Ciccone, 2018).	Monitor PT/PTT/INR Monitor hepatic function before administration (Ciccone, 2018).	Assess pulmonary function tests Assess patient's chest pain (Ciccone, 2018).
Client Teaching needs (2)	Instruct patient on proper technique for	Report syncope or dizziness to provider	Advise patient to take medication exactly as	Take with a full glass of water and to remain in an upright position for	Do not discontinue or reduce other asthma medications

	administration. Discuss the rotation of injection sites Educate on signs and symptoms of hypoglycemia and hyperglycemia and to call the doctor if they occur (Ciccone, 2018).	No heavy lifting or operating machinery, call for assistance when ambulating or extra activities. (Ciccone, 2018).	directed and not to take more than the recommended amount. Avoid alcohol (2 or less glasses per day) ((Ciccone, 2018).	15– 30 min after administration Avoid alcohol use to avoid gastric irritation (Ciccone, 2018).	without consulting health care professional. Educate family to assess for worsening of depression and suicidal ideation (Ciccone, 2018).

Medications Reference (APA):

Ciccone, C. D. (2018). Davis's Drug Guide for Rehabilitation Professionals. Retrieved from

https://fadavispt.mhmedical.com/book.aspx?bookid=1873.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented x3. Patient is well nourished and displays no acute distress.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** .	Patient is Caucasian and presents with a fair skin tone. Skin has decreased elasticity, warm to touch. No abnormal texture. Hair is grey in color. No notable skin turgor. No rashes. Slight bruising on right upper extremity due to PICC line insertion.

Braden Score: **Drains present: Y☐ N ☐** **Type:**	Braden scale: 14
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is midline with no deviations. Hair is grey in color. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. PEERLA is noted. Nose shows no deviated septum, turbinate equal bilaterally. Oral mucosa is pink and moist with no notable abnormalities. Patient's teeth present in yellow to white in color.
CARDIOVASCULAR (2 points): **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:**	Patient is not currently being monitored by telemetry. Patient was noted to be in normal sinus rhythm. Heart sound auscultated x5. S1, S2 heart sounds noted. Radial and pedal pulses assessed. Pulses graded 3+ at radial and pedal. Capillary refill average at <3 seconds. Patient shows signs of lower extremity edema bilaterally.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No accessory muscle use when breathing. Trachea midline. No deviations. Patient was not short of breath on admission. Anterior and posterior lung sounds auscultated. Lung sounds present bilaterally. Coarse breath sounds and mild wheeze on expiration noted. NC in place. Patient currently breathing 2L oxygen. Patient states use of oxygen at home.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐**	Patient's current diet is medium – 1500-1700 calories and typically has a normal diet at home. Patient weighs 87.9 kg and is 156 cm tall. Bowel sounds present in all four quadrants. Patient denies pain on palpation. No masses present. No ostomy, nasogastric tubes, PEG tubes. PICC line inserted on the 22nd and dressing last changed on the 29th. No drains. Last bowel movement was on September 29th.

Size: **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Patient is incontinent and uses bedpan. Urine is yellow in color without an odor. Patient denies pain and urgency on urination. Patient is not on dialysis and genitals are normal upon assessment. The patient did not have a catheter.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	Patient exhibits passive range of motion bilaterally. Patient shows no sign of neurovascular deficit. Patient is a fall risk. Patient is up with a Hoyer lift. Patient benefits from the assistance of glasses for vision. Patient uses a walker to assist her. Fall Score: 50
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient slept most of the day. She is A&O x3. Patient speaks English at a slower pace. Patient MAEW for current age and condition. Patient's strength is bilaterally equal. Patient shows no signs of neurological damage. Patient experienced hypoglycemic episode at 0830, which resulted in unresponsiveness. Patient was ANO x0 at the time, interventions included 10% Dextrose and orange juice. Patient returned to ANO x3 by 0900.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	Patient presents alert and oriented x3. Patient has a normal sleep pattern. Patient denies current or past tobacco use. Patient denies alcohol use. Support is daughter and son. She is retired and a

Personal/Family Data (Think about home environment, family structure, and available family support):	widow.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	**88**	**111/54**	**20**	**36.7**	**92**
1000	**78**	**132/62**	**18**	**36.5**	**94**

Vital Sign Trends: Vital sign trends are stable. The first set of vitals was taken a half hour after hypoglycemic reaction. The second set of vitals were taken after patient finished breakfast and was relaxing in bed. Patient is stable and resting in room most of the day.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numeric Scale 0/10	Patient denies pain	Patient denies pain	Patient denies pain	No interventions implemented
1000	Numeric Scale 0/10	Patient denies pain	Patient denies pain	Patient denies pain	No interventions implemented

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Right Central Line PICC 5 FR Catheter **Location of IV:** Central Line PICC double right, upper arm 5 FR Catheter **Date on IV:** 9/29/19 **IV dressing assessment:** IV is stable, patent with no complications. Patient denies pain at	Saline Lock

site. No evidence of erythema, drainage or swelling. Flushes easily. Clean, dry, intact.	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL during my shift 250 IV fluids 10% Dextrose Bolus 10 mL Orange Juice	100 mL during my shift 100 mL Urine

Nursing Care

Summary of Care (2 points)

Overview of care: Patient is alert and oriented x3 and slept most of the day. Patient remained on the floor and visited with her daughter while awake. Had no reports of pain during the day. Around 0830, patient's daughter alerted nursing staff she was unresponsive. Patient's blood sugar was <40, physician was informed, and interventions were taken. Dextrose 10% IV bolus and orange juice administered. Patient was stable by 0800 and blood sugar returned to 94. Vital signs are currently stable and abnormal lab values are consistent with diagnosis and past medical history. Discharge plans are initiated and are in contact with Mattoon Health Care.

Procedures/testing done: Chest x-ray and chest CT revealed atelectasis and left lung pneumonia prior to my shift.

Complaints/Issues: No complaints at this time.

Vital signs (stable/unstable): Vital signs are stable at this time.

Tolerating diet, activity, etc.: Patient is tolerating diet, patient remains in the bed most of the day.

Physician notifications: Physician was notified of patient's blood sugar reading of <40 and ordered 10% dextrose IV Bolus Once.

Future plans for patient: Anticipate patient will require long term care facility upon discharge.

Discharge Planning (2 points)

Discharge location: Patient's children are arranging plans for patient to be discharged to Mattoon Health Care.

Home health needs (if applicable): NA

Equipment needs (if applicable): NA

Follow up plan: Patient and family will report with primary care provider or facility to assess blood sugar and absence of infection. Respiratory therapy will consult patient prior to discharge to inform patient and family of medications to relieve vasodilation.

Education needs: Blood sugar and diet education to prevent erratic readings and promote patient health.

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. Decreased gas exchange RT pneumonia AEB need for oxygen and decreased oxygen saturation (Swearingen, 2016, p. 126).	This is in relation to ineffective inspiration and expiration occurring airflow limitations. By providing oxygen to the patient, the SpO2 will remain above 97% and	1. Monitor pulse oximetry every 2 hours and report significant findings. The trend of the SpO2 should increase with interventions such as 2L Oxygen via nasal cannula	The patient's oxygen saturation will increase repositioning and 2 L oxygen. The patient will demonstrate improved perfusion of tissues by assessing the ABGs. The patient will be free of pain. These outcomes are expected to be met by

	assist with breathing and tissue perfusion (Swearingen, 2016, p. 126).	(Swearingen, 2016, p. 126). 2. Administer bronchodilator and oxygen therapy as prescribed to reduce inflammation and improve breathing efforts (Swearingen, 2016, p. 126).	discharge.
2. Ineffective airway clearance related to excessive secretions and fatigue as evidenced nonproductive cough (Swearingen, 2016, p.130).	This is in relation to decline of the productive cough and the patient's need to clear the airways. By promoting deep breathing interventions and fluids, the patient will be able to dispose of secretions (Swearingen, 2016, p.130).	1. Teach and assist patient with deep breathing exercises such as coughing and sitting in the upright position. This facilitates lung expansion and remove secretions (Swearingen, 2016, p.130). 2.Maintain adequate fluid intake of 2-3 L per day. This will help mobilize and thin secretions. By increasing warm liquids, the patient will be able to cough up secretions (Swearingen, 2016, p.130).	The patient's family will identify behaviors to achieve airway clearance and the patient will maintain a patent airway. The patient will demonstrate effective airway clearance and will be absent of dyspnea. Breath sounds will improve. These outcomes are expected to be met by discharge.
3.Erratic Blood Glucose levels related diabetes mellitus as evidenced by increased lab values (Swearingen, 2016, p.369).	This is in relation to a hypoglycemic episode, inadequate blood glucose monitoring, periodic illness, and ineffective medication management. By	1.Assess for changes in mentation, apprehension, erratic behavior, trembling, slurred speech, staggering gait and seizure activity (Swearingen, 2016, p.369).	The patient's family will understand the information provided to them. The patient's blood sugar will remain within normal ranges and the patient's blood sugar will be within normal limits. The patient will also understand what foods

	educating the family and patient on glucose levels and diet, the patient will remain free of hypoglycemic episodes (Swearingen, 2016, p.369).	2.Monitor blood glucose levels before meals and at bedtime, educate family on signs and symptoms of hyperglycemia and hypoglycemia to avoid episodes (Swearingen, 2016, p.369).	should be avoided or included in her diet. A verbal explanation will be given on symptoms of hypoglycemia and hyperglycemia to family and patient. These outcomes are expected to be met by discharge.
4. Potential for impaired skin integrity related to decreased activity as evidenced by immobility (Swearingen, 2016, p. 48)	This is in relation to bed rest and the older adults decreased subcutaneous fat. This patient is at an increased risk for pressure ulcers due to the absent sensation of force against the skin capillaries (Swearingen, 2016, p. 48)	1. Turn patient every 2 hours using pillows or pads around bony prominences to reduce the risk of pressure areas. This reduces skin ischemia from occurring (Swearingen, 2016, p. 48) 2. Prevent soiled linens and use lotions liberally on skin. Moisture can contribute to friction or shearing when moving or lifting the patient by saturating the skin (Swearingen, 2016, p. 48)	Patient's skin will be free of pressure ulcers. After a verbal demonstration on how to prevent pressure ulcers, family teaching will be effective for good skin care techniques. These outcomes are expected to be met by discharge.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

- Weakness, shortness of breath for the past few days
- Home medications and rest did not help alleviate symptoms
- Movement worsened pain and contributed to shortness of breath
- Fatigued easily
- Has not tried any forms of treatment to alleviate chest pain
- Patient occasionally experiences chills, absent at time of admission
- Pain while moving, aches while resting
- Slight nausea, denies at time of admission

Nursing Diagnosis/Outcomes

- Decreased gas exchange RT pneumonia AEB need for oxygen and decreased oxygen saturation
  - Outcome: Client's breathing pattern will improve as evidenced by symptom relief and no reported dyspnea.
- Ineffective airway clearance related to excessive secretions and fatigue as evidenced nonproductive cough
  - Outcome: The patient will demonstrate an effective clearance of the airway and will be absent of dyspnea. Breath sounds will also improve.
- Erratic Blood Glucose levels related diabetes mellitus as evidenced by increased lab values
  - Outcome: Patient will verbalize an understanding of hypoglycemia and hyperglycemia symptoms and interventions if these occur. The patient's blood sugar will also be stable.
- Potential for impaired skin integrity related to decreased activity as evidenced by immobility
  - Outcome: Patient's skin will be free of pressure ulcers and redness. Patient and family will verbalize understanding of how to prevent sores.

Objective Data

- Productive cough on admission
- Non-productive cough currently
- Wheezing and diminished lung sounds are present bilaterally
- X-ray shows infiltrate in left mid and lower lobes
- CBC shows abnormal values consistent with diagnosis
- Mental status change with hypoglycemia
- Increased respiratory rate
- Decreased oxygen saturation

Patient Information

92-year-old female presents to Sarah Bush Lincoln Hospital with shortness of breath and difficulty breathing on 9/20/20, accompanied by a productive cough. Patient complains of chest pain upon breathing and it has been getting worse since the past week. Patient has past medical history of respiratory failure with hypoxia and hypercapnia, COPD, hyperglycemia, Type 2 Diabetes, hypertension, and lymphedema. A chest x-ray was completed on the 22nd showing infiltrate in the left mid and lower lobes confirming community acquired pneumonia. Patient is respiratory protocol with 2 L oxygen via nasal cannula. Antibiotics Azithromycin and ceftriaxone started. Patient has episodes of night time hyperglycemia and morning hypoglycemia. Blood sugar being monitored Q2H, vitals are currently stable.

Nursing Interventions

- Auscultate breath sounds frequently.
- Instruct patient to perform deep breathing and coughing exercises.
- Assess patient's pain
- Increase fluids
- Promote nutrition
- Monitor for signs of hypoglycemia or hyperglycemia
- Monitor blood glucose
- Educate patient and family on medication use and compliance
- Assess vital signs and response to medications
- Administer PRN pain medication, if prescribed.
- Speak in a calm, therapeutic manner
- Establish honest, therapeutic communication
- Explain all interventions, diagnostics and medications