N431 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/20/19	FS	85	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Single	NKA
Code Status	**Height**	**Weight**	
Full Code	177.8 cm	76.2 kg	

Medical History (5 Points)

Past Medical History:

- Major Cognitive Disorder
- COPD
- Alcohol Dependent
- Alter in comfort
- Anxiety
- MRSA
- Restless Leg Syndrome

Past Surgical History:

- Neck Surgery

Family History:

- Mother- Stroke
- Father- Stomach Cancer

Social History (tobacco/alcohol/drugs): Patient states that he is a current smoker, smoking one pack or more a day. He denies the use of illegal substances; However, it is identified that he was an IV drug user. Patient is a current alcohol user, he is dependent on alcohol, stating that he cannot do without. It has been identified that the use of alcohol is necessary as it has been a major part of his life. Patient can receive 2-3 beers/day while hospitalized to help with his agitation.

Assistive Devices: My patient uses either a cane or walker. Also, a gait belt is available at patient's bedside to aid in assistance.

Living Situation: Currently homeless. Prior upon arrival to the hospital, my patient was living at a homeless center called “the haven”. A court hearing is scheduled tomorrow to determine where my patient will reside after discharge.

Education Level: Patient has no high school diploma as he dropped out his junior year.

Admission Assessment

Chief Complaint (2 points): Patient states that he is experiencing Shortness of Breath

History of present Illness (10 points): Patient was admitted to the hospital on September 20, 2019 with complaints of shortness of breath. Upon examination, provider identified pneumonia as the primary factor, along with COPD exacerbation. Confirming the diagnosis with an X-RAY. Patient had very little pain in his chest, but mostly could not breath. He said his breathing difficulty worsened when he laid down (Orthopnea). Nothing would relieve my patients’ pain and shortness of breath. Therefore, leading him to seek medical treatment. Patient was placed on oxygen following his arrival twelve days prior, but at this point is on room air. Today, patient is in no pain, just gets very aggravated at times. All goals have been met, however we are waiting for further discharge instructions following his court hearing on Thursday in the determination of where he will be discharged to. Patient has a sitter in the room with him due to being confused and lighting up a cigarette in the hospital bathroom last night.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia**.**

Secondary Diagnosis (if applicable):COPD Exacerbation

Pathophysiology of the Disease, APA format (20 points): Parenchyma compromises many of the thin-walled alveoli of the lung, forming a large surface area, promoting the maintenance of gas exchange. When the parenchyma becomes inflamed, it is known as a condition called pneumonia, which is known to be the eighth leading cause of death in the united states (Cheever & Hinkle, 2018). Typically, the cause of pneumonia is an infection. However, other causes of pneumonia may be due to inhalation of noxious fumes or aspirating gastric contents into the respiratory tract. Pneumonia is more common in men, the winter months, African Americans and older adults.

Acquired pneumonia, Ventilator-associated pneumonia, and healthcare-associated pneumonia are three ways to categorize how the infection came about. Hospital-acquired pneumonia is pneumonia that develops 48 hours or more after admission to the hospital. Ventilator-associated pneumonia is when pneumonia develops 48-72 hours post-tracheal intubation. Healthcare-associated pneumonia is pneumonia that develops in individuals who were hospitalized two or more days, developing pneumonia within ninety days (Cheever & Hinkle, 2018).

Before the Streptococcus Pneumonia vaccine and antibiotics to treat the infection, pneumonia was the common cause of death in older adults.

Classification of pneumonia depends solemnly on the location of where the patient had been exposed to the pathogen, the pathogen, or the location of the pathogen within the lung.

Manifestations of pneumonia include chills, a high fever, a productive cough with mucopurulent sputum, and reports of difficulty breathing (Klein, Quinn & Sorenson, 2017).

Diagnosing pneumonia starts with clinical presentation and the physical exam of the infected patient. Such clinical presentation will lead the provider to obtain either a chest x-ray, CT, or sputum analysis or

all three of the following. These tests are done to work towards the confirmation of the diagnosis of pneumonia. A chest x-ray will not confirm if it is viral or bacterial pneumonia. However, it can determine if it is either pneumonia or acute bronchitis. A sputum analysis may help diagnose bacterial pneumonia, which aids in the identification of dominant or unsuspected pathogens. A CT is not routinely done in patients but is known as the "gold standard" diagnosis technique for pneumonia (Cheever & Hinkle, 2018). The diagnosis of pneumonia in my patient was made by obtaining a chest x-ray upon admission.

Treatment of pneumonia depends on many factors. Factors that determine the kind of treatment are the severity, causative pathogen, and the health status of the patient. Other factors include the cause of pneumonia and any other underlying diseases in association with the diagnosis (Klein, Quinn & Sorenson, 2017). Supplemental oxygen serves as a supportive measure in the treatment of viral pneumonia. Antibiotics specific to the bacteria may be beneficial and show dramatic improvements. However, there is no antibiotic available for viral pneumonia. Acyclovir is a medication available in treating a patient with severe viral pneumonia (Klein, Quinn & Sorenson, 2017).

My patient was on an antibiotic called levofloxacin, due to his diagnosis of bacterial pneumonia.

Pathophysiology References (2) (APA):

Cheever, K. & Hinkle, J., (2018) *Brunner and Suddarth's Textbook of Medical-Surgical Nursing.* (Fourteenth Edition.) Philadelphia, PA: Wolters Kluwer.

Klein, D., Quinn, L., & Sorenson, M. (2017). *Pathophysiology: Concepts of Human Disease.* New York, NY. Pearson.

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	3.80-5.41	4.67	5.54	NA
Hgb	11.3-15.2	14.1	16.3	NA
Hct	33.2-45.3	43.0	42.3	NA
Platelets	149-493	250	298	NA
WBC	4.0-11.7	7.2	8.7	NA
Neutrophils	45.3-79	92.6	90.9	My patient is diagnosed with pneumonia, which is when part of the lung becomes inflamed due to an infection. Neutrophils are the primary white blood cells that respond to a bacterial infection. Also, Neutrophils will be increased in any acute inflammation (Cheever & Hinkle, 2018).
Lymphocytes	11.8-45.9	7.0	3.9	Lymphocytes are a special kind of WBC that tends to decrease when there is an infection present in the body (Cheever & Hinkle, 2018). My patient has pneumonia which is an infection of the lung resulting in inflammation (Cheever & Hinkle, 2018). Therefore, it makes sense that this level is decreased.
Monocytes	4.4-12.0	5.6	2.8	NA
Eosinophils	0.0-6.3	0.1	1.0	NA
Bands	1-5	NA	NA	NA

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	136	139	NA
K+	2.5-5.1	4.3	3.8	NA
Cl-	98-107	100	102	NA
CO2	22-29	24	29	NA
Glucose	70-99	80	91	NA

BUN	6-20	16	17	NA
Creatinine	0.5-0.9	0.98	0.9	NA
Albumin	3.5-5.2	3.5	3.9	NA
Calcium	8.6-10.4	9.0	8.8	NA
Mag	1.6-2.4	NA	NA	NA
Phosphate	2.5-4.5	NA	NA	NA
Bilirubin	0.3-1	0.6	0.6	NA
Alk Phos	35-105	35	39	NA
AST	0-32	19	13	NA
ALT	0-33	61	19	A common reason for ALT to be elevated is alcohol abuse (Cheever & Hinkle, 2018). As mentioned above, my patient is alcohol dependent and has been drinking alcohol daily for many years, which is a big indication of why his ALT is elevated.
Amylase	50-150	NA	NA	NA
Lipase	10-160	NA	NA	NA
Lactic Acid	0-150	1.6	1.0	NA
Troponin	0.5-2.4	0.1	0.1	NA
CK-MB	0.0-0.04	1.42	1.32	NA
Total CK	20-100	24	29	NA

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

Lab Test	**Normal**	**Value on**	**Today's**	**Reason for Abnormal**

	Range	Admission	Value	
INR	0.86-1.14	NA	NA	NA
PT	11.9-15	NA	NA	NA
PTT	22.6-35.3	NA	NA	NA
D-Dimer	0.00-0.62	NA	NA	NA
BNP	0.5-30	NA	NA	NA
HDL	>60	NA	NA	NA
LDL	<100	NA	NA	NA
Cholesterol	<200	NA	NA	NA
Triglycerides	0-150	NA	NA	NA
Hgb A1c	4-5.6%	NA	NA	NA
TSH	0.4-4.0	NA	NA	NA

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**	**Straw, clear**	**NA**	NA
pH	5.0-8.0	6.0	NA	NA
Specific Gravity	1.005-1.034	1.008	NA	NA
Glucose	Normal	Normal	NA	NA
Protein	Negative	Negative	NA	NA
Ketones	Negative	Negative	NA	NA
WBC	<5	NA	NA	NA
RBC	0-3	NA	NA	NA

Leukoesterase	Negative	Negative	NA	NA

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	7.35-7.45	7.38	7.42	NA
PaO2	80-100 mmhg	82.9	85.4	NA
PaCO2	35-45mmhg	39.4	39.6	NA
HCO3	21-28mEq/L	23.1	25.6	NA
SaO2	60-75	72	56.3	Individuals who have chronic health conditions will see a decrease in their SaO2 (Cheever & Hinkle, 2018). My patient has COPD, which is a chronic health condition resulting in a decrease in his SaO2 levels.

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	NA	Negative	NA
Blood Culture	Negative	NA	Negative	NA
Sputum Culture	Negative	NA	NA	NA
Stool Culture	Negative	NA	NA	NA

Lab Correlations Reference (APA):

Cheever, K. & Hinkle, J., (2018) *Brunner and Suddarth's Textbook of Medical-Surgical Nursing.*

(Fourteenth Edition.) Philadelphia, PA: Wolters Kluwer.

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Diagnostic Imaging

All Other Diagnostic Tests (5 points): In my patients' case, a positive chest x-ray was performed to aide in the diagnosis of Pneumonia. My patient's chest x-ray results showed small left pleural effusion airspace disease, infection, inflammation and mild basal atelectasis.

Diagnostic Test Correlation (5 points):

An x-ray was done on my patient to determine the cause of his shortness of breath and chest pain. An x-ray is a digital image of the internal composition of the chosen body part which is produced by x-ray passing through it and being absorbed to different degrees (Cheever & Hinkle, 2018). A chest x-ray is one of the many diagnosis factors that aids in the diagnosis of pneumonia (Klein, Quinn & Sorenson, 2017). Also, an x-ray can be used in this situation to rule out acute bronchitis, which has similar symptoms to pneumonia (Cheever & Hinkle, 2018). Therefore, an x-ray of the chest confirmed the diagnosis of pneumonia in my patient.

Diagnostic Test Reference (APA):

Cheever, K. & Hinkle, J., (2018) *Brunner and Suddarth's Textbook of Medical-Surgical Nursing.* (Fourteenth Edition.) Philadelphia, PA: Wolters Kluwer.

Klein, D., Quinn, L., & Sorenson, M. (2017). *Pathophysiology: Concepts of Human Disease.* New York, NY. Pearson.

Current Medications (10 points, 1 point per completed med)

10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	**Albuterol (Proair)**	**Acetaminophen (Tylenol)**	**Nicotine Transdermal (Nicotine)**	**Ipratropium-albuterol (DuoNeb)**	**Rayos (Prednisone)**
Dose	180 mcg/ 2 puffs	650 mg/ 2 tablets	1 patch	3ml	40mg/ 2 tablets
Frequency	Daily (PRN)	Q4H	Daily	Q4H	Daily
Route	Inhalation PO	PO	Transdermal	Inhalation PO	PO
Classification	Bronchodilators, Adrenergic	Antipyretic, non-opioid analgesic	Opioid Analgesics	Adrenergic, Bronchodilator	Corticosteroids
Mechanism of Action	Binds to h2 receptors in airway smooth muscle resulting in a decrease intracellular reflex, relaxing the muscle airway	Blocks prostaglandin production which interferes with the pain generation in the PNS. It acts on the temperature regulation center in the hypothalamus.	Provides source of nicotine during controlled withdrawal.	Relaxation of airway smooth muscle with subsequent bronchodilation	Suppresses inflammation and the normal immune response.
Reason PT. Taking	Wheezing	Fever	Nicotine WD	SOB	Inflammation
Contraindications (2)	1.Hypersensitivity to medication. 2. Hypertension.	1.Severe active liver disease 2.Hepatic Impairment	1.Arrythmias Sever 2.Cardiovascular disease.	1.Cardiac disease 2.Hypersensitivity to medication.	1.Known alcohol intolerance 2.Active untreated infections.
Side Effects/Adverse Reactions (2)	1.Chest Pain 2.Palpitations	1.Hemolytic Anemia 2.Abdominal Pain	1.Headache 2.Insomnia	1.Palpitations 2.Tremor	1.Peptic ulcerations 2.Depression
Nursing Considerations (2)	1.Monitor vitals throughout therapy, frequently. 2. Observe for any excess wheezing.	1.Use cautiously in patient with alcoholism. 2. Monitor patients for hepatic impairment S/S.	1.Monitor for n/v, dizziness or confusion. 2. Assess/Monitor Vitals	1.Shake inhaler well prior to administering. 2. Use cautiously in patient with DM.	1.Monitor I & O 2. Asses for weakness and confusion.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain an EKG prior to administering.	Obtain LFT and baseline vitals.	Assess smoking history prior to administration. Obtain baseline vs	Assess/ Obtain baseline vitals.	Obtain baseline vitals and do an assessment prior to starting.
Client Teaching needs (2)	1.Take albuterol as directed. 2. Do not exceed the recommended dose. Notify provider if they feel SOB.	1.Education that patient should take medicine as a whole. 2. Take Medication as prescribed with a full glass of water	1.Education on joining a smoking cessation program. 2. Instruct patient on how to apply TD patch.	1.Notify provider if they feel any shortness of breath. 2. Education on how to prime prior to use.	1.Educate on taking the medication as directed. 2. Education on the need to avoid alcohol.

Hospital Medications (5 required)

Brand/Generic	**Levofloxacin (Levaquin)**	**Ondansetron (Zofran)**	**Naloxone (Narcan)**	**Polyethylene Glycol (MiraLAX)**	**Promethazine (Phenergan)**
Dose	750 mg	4 mg	0.4 mg	17 g/8 ozh20	12.5 mg
Frequency	HS	Q6H (PRN)	Q2H (PRN)	Daily	Q4H (PRN)
Route	PO	IV push	IV push	PO	IM
Classification	Anti-infective, antibiotic	Antiemetic	Antidotes, opioid antagonists.	Laxative, osmotic.	Antiemetic, antihistamine, sedative/hypnotics
Mechanism of Action	Inhibits bacteria synthesis by inhibiting DNA synthesis	Blocks the effects of serotonin in the vagal nerve terminals results in decreased n/v	Blocks the effects of opioids without producing agonists effects.	Acts as an osmotic agent, drawing water into the GI Tract.	Blocks the effects of histamine, altering effects of dopamine in CNS.
Reason Client Taking	Pneumonia	Nausea	Opioid OD	Constipation	Nausea/ Vomiting
Contraindications (2)	1.Prolonged QT interval, 2.Hypomagnesia	1.Hypersensitivity to medication. 2. Prolonged QT	1.Hypersensitivity to medication. 2. Cardiovascular Disease.	1.GI Obstruction 2. Gastric Retention.	1.Hypersensitivity to medication. 2. Prostatic Hypertrophy.
Side Effects/Adverse Reactions (2)	1.Confusion 2. Nausea	1.Constipation 2. Headache	1.Hypertension 2. Hypotension	1.Nausea 2. Flatulence	1.Confusion 2. Constipation
Nursing Considerations (2)	1.Assess for rash 2. Monitor Bowel function	1.Monitor bowel sounds. 2. Assess patient for EPS (Involuntary movements, etc.)	1.Use cautiously in patients who are dependent on opioids. 2.Monitor blood pressure.	1.Use cautiously in patient who has abdominal pain with a fever. 2. Assess bowel sounds and function.	1.Assist in ADL's to prevent injury in patient. 2. Monitor vitals throughout therapy and LOC.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess bowel sounds	Obtain baseline EKG	Assess/ Obtain baseline vitals (RR)	Assess usual bowel functioning, bowel sounds and electrolytes.	Obtain baseline vitals and assess LOC prior to starting medication.
Client Teaching needs (2)	1.Increase fluid intake (1500-2000 ml/day) 2. Wear protective clothing (Phototoxicity)	1.Notify immediately if irregular heartbeat. 2. Take medicine as prescribed.	1.Take Medicine as directed. 2. Educate on medication regimen.	1.Do not use for more than two weeks. 2. Notify doctor of any unusual cramps or bloating.	1.Take missed dose as soon as remembered. 2. Notify provider of sore throat, jaundice, or involuntary movements.

Medications Reference (APA):

Jones & Bartlett Learning. Nurse's Drug Handbook. (2018) n.a. n.a.

Assessment :

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	My patient was A&O4, being aware to place time and situation. He has been awake and alert most of the day. He appears to be in no distress. Overall appearance is appropriate for age and health condition.
INTEGUMENTARY (2 points): **Skin color: Normal for ethnicity** **Character:PWD** **Temperature: PWD** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 19 **Drains present: Y☐ N ☒** **Type:** NA	Skin is pink, warm and dry. Patient is Caucasian. Normal skin color for ethnicity. No temperature noted. No bruises noted. No rashes or wounds noted. Braden score is a 19. No drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	PERRLA noted bilaterally. Head is midline, no deviations present. Hair is light brown with a little gray in it. No deviated septum or nasal drainage. No glasses. No dentures. Patient has a slight hearing difficulty. .
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** Less than 3 seconds**.** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** NA	. No abnormal heart sounds. S1 and S2 noted in all five areas. Radial and pedal pulses rated 3+, bilaterally. No neck vein distention. Capillary refill less than three seconds, bilaterally. No edema noted.

RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	. No use of accessory muscle. Not adventitious lung sounds. Clear and diminished, bilaterally.
GASTROINTESTINAL (2 points): **Diet at home:** Regular **Current Diet:** Regular **Height:** 177.8 cm **Weight:**76.2 kg **Auscultation Bowel sounds:** Active in all four quadrants. **Last BM:** 9/30/19 **Palpation: Pain, Mass etc.:** NA **Inspection:** **Distention:** NA **Incisions:** NA **Scars:** NA **Drains:** NA **Wounds:** NA **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** NA	. He is on a regular diet at home and in the hospital, tolerating it well. His last BM was on Monday. No mass noted. No pain noted.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** NA **Size:** NA	My patient's urine is slightly cloudy. He complains of no pain during urination. 3oo ml of urine was his output for the afternoon. No dialysis noted. No abnormal findings. No catheter.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** Equal Bilaterally. **Supportive devices:** Walker, cane. **Strength:** MAEW **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 100 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☒ **Needs support to stand and walk**☒	Active ROM in the upper and lower extremities, bilaterally. His strength is equal in all extremities. He uses a walker or a cane, which is present at bedside. One assist with a gait belt present at bedside. Along with a walker and a cane.

NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	There are no signs of neurological damage present in my patient. However, the nurse mentioned he has been going in and out of being confused. For example, he smoked a cigarette in his bathroom, not realizing it was not the right thing to do. However, today he has no recollection of doing so. A sitter is present in the room with him to keep him safe. Speech is appropriate for development. Today he had no visible altered mental status.
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):**	Patient states that he doesn't know of any coping methods he follows. He has no religion preference. His developmental level is appropriate for age and circumstances. Patient has a sitter at bedside, but no family present. He stated that he hasn't seen his son in many years.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1230	90	134/78	20	36.6	95%
1430	97	132/82	18	36.7	95%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1230	Numeric	NA	0	NA	None needed.
1430	Numeric	NA	0	NA	None needed.

IV Assessment (2 Points):

*Patient has no IV as of 9/29/19

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: NA **Location of IV:** NA **Date on IV:** NA	Patient does not have an IV anymore. IV was removed three days prior.

Patency of IV: NA **Signs of erythema, drainage, etc.:** NA **IV dressing assessment:** NA	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600 ml	320 ml

Nursing Care

Summary of Care (2 points)

Overview of care: Care consisted of checking patients' vitals every four hours and keeping him comfortable in his room. Patient had a sitter to watch over him at all times to promote safety.

Procedures/testing done: NA, all tests and procedure are done for this patient and his goals are met. We are waiting for his court hearing tomorrow to find out where he will get discharged to.

Complaints/Issues: No complaints, patient states he is in no pain, he just gets very agitated occasionally, possible d/t altered level of consciousness at times.

Vital signs (stable/unstable): Vitals were stable.

Tolerating diet, activity, etc.: Patient is tolerating his regular diet.

Physician notifications:

No physician notification available besides continue to monitor until discharge.

Future plans for patient: As of right now we are unsure of where patient will be discharged, which is why he is still admitted to the hospital. Patient was homeless prior to admission; therefore, we are waiting for his court hearing to obtain instructions on where patient can reside.

Discharge Planning (2 points)

Discharge location: NA- Will know for sure after his hearing on Thursday.

Home health needs (if applicable): Education on what signs and symptoms to notify the provider of. **(**Shortness of breath, chest pain, etc.**).**

Equipment needs (if applicable): Patient will leave here with his cane and walker that he had prior to admission**.**

Follow up plan: Check-up appointment a week from discharge to monitor well-being.

Education needs: Education on medication regiment and information such as when to notify provider of any abnormalities.

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.At risk for ineffective airway clearance related to	With a new diagnosis of pneumonia and COPD exacerbation,	1.Educate patient on how to splint the chest with a pillow, as it	Patient was able to cough up all the sputum that was affecting his breathing and the

the presence of secretions.	my patient is at an increased risk of secretions aggravating his airway. Pneumonia causes an increase in secretions, making it difficult to maintain a patent airway.	reduces pain associated with it. Assist with position changes every two hours, also. 2.Encourage patient to cough up as much sputum as possible. This will maintain a clear and patent airway. Document the color, quantity, odor and consistency of the sputum.	characteristics of the sputum were documented.
2.At risk for impaired gas exchange related to altered oxygen supply (COPD)	COPD and pneumonia together cause an increase in respiratory failure. Either your body is not getting enough oxygen or it isn't successfully removing CO2.	1. Monitor vitals (rr) vigorously. Along with ABGs 2.Administer rescue inhaler or inhaled steroids to control symptoms.	Patient oxygen levels were monitored and in the normal range when I was present. Measures were on standby if they became abnormal, such as supplemental oxygen. Also, patient is oral steroids and has been getting his prescribed dose regular and on time.
3.At risk for ineffective breathing pattern related to decreased lung expansion.	COPD exacerbation causes an alteration in being able to maintain complete lung expansion.	1.Monitor the client's respiratory rate frequently. 2. Assess patients pain level and administer medication if needed.	Patient remained pain free while I was present at clinical, which lead to effective breathing due to his comfort and overall well-being.
4.At risk for infection related to inadequate primary defenses associated with pneumonia.	I chose this because my patient has bacterial pneumonia is an infection of the lung that could be life-threatening if not treated correctly.	**1.**Take temperature every two-four hours. Documenting results regularly and notifying provider of any abnormal findings. 2.Wear the proper PPE when caring for the patient to protect him. Be sure to perform hand hygiene vigorously!	Patient remained afebrile and provided with safe efficient care with each visit. PPE was worn by everyone who entered the room, providing him with a safe environment.

Other References (APA):

Swearington, P. L. (2016). *All- in- one nursing care planning resource.* (fourth edition).

St. Louis, Missouri. Elsevier.

Concept Map (20 Points):

Subjective Data

Patient was experiencing SOB, weakness and chest pain upon arrival.

Patient stated that lying down did not alleviate the SOB,

but became worse (Orthopnea).
Patient stated that he tried many kinds of treatments

to relieve the chest pain and SOB, but thing worked.

Nursing Diagnosis/Outcomes

At risk for ineffective airway clearance related to the presence of secretions.
measures to done to aide in the education to prevent secretions in the airway. The outcome was successfully maintaining a patent airway throughout the day.

At risk for impaired gas exchange related to altered oxygen supply
Our goal was met, and oxygen levels were monitored vigorously. No supplemental oxygen was needed throughout the day. Also, my patient didn't experience any shortness of breath today (10/2).

At risk for ineffective breathing pattern related to decreased lung expansion
Patient's pain was managed throughout the day and he had experienced no symptoms in association with ineffective breathing.

At risk for infection related to primary defenses associated with pneumonia
Patient is still making progress and taking his antibiotics and assisting measures associated with the prevention of infection.

Objective Data

Patient is febrile upon admission. Upon admission, wheezing was heard upon the auscultation of lung sounds during examination. An x-ray was done, confirming the diagnosis of pneumonia. CBC shows an increase in neutrophils which indicates infection. Also, the CBC showed a decrease in lymphocytes, which indicates infection and acute inflammation.

Patient Information

Patient is an 85 year-old white male with a past medical history of COPD Exacerbation, anxiety, MRSA, and is alcohol dependent. Patient was experiencing SOB, leading him to seek medical treatments in which he was diagnosed with pneumonia.

Nursing Interventions

Monitor vitals every four hours to assess patient's well-being. Does he have a fever? Is his BP high from pain? Also, many of the side effects associated the prescribed medication can be seen in vital signs.
Administer Levofloxacin to my patient on time. He had his last doss ast night before bed (10/1/19 at 2000) He will get his next dose of evofloxacin tonight 10/2/19 @ 2000) .
ducation about finishing the full course of medication mist be aught to the patient. Patient should still finish full course, even if he starts to feel better.
Administer pain medication if the patient is experiencing any pain.
Monitor for any side effects associated with the medications he is prescribed to while at the hospital.