

N431 Care Plan #1

Lakeview College of Nursing

Bailey Roth

**Demographics (3 points)**

<b>Date of Admission</b> 9/20/2019	<b>Patient Initials</b> H.J.	<b>Age</b> 92	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> Retired	<b>Marital Status</b> Widowed	<b>Allergies</b> Morphine, penicillins
<b>Code Status</b> DNR	<b>Height</b> 156 cm	<b>Weight</b> 88.9 kg	

**Medical History (5 Points)**

**Past Medical History:** arthritis, hypertension, impaired gas exchange, lymphedema of lower extremities, CHF, CKD stage 3, type 2 diabetes, DVT, increased risk for skin tears, unstageable pressure ulcer.

**Past Surgical History:** Thoracentesis – 500mL drained

**Family History:** No known family history

**Social History (tobacco/alcohol/drugs):** Never a smoker, doesn't drink and has never used drugs

**Assistive Devices:** Patient used to use a walker at home but since she has been here so long and has lost her strength she has been using a Hoyer to be lifted.

**Living Situation:** Lives at home with her son and her grandson, is thinking about heading to Odd Fellows on Friday for rehabilitation.

**Education Level:** High School education

**Admission Assessment**

**Chief Complaint (2 points):** “Having trouble breathing and coughing a lot”

**History of present Illness (10 points):** Patient came from home with her son and her grandson and was admitted to the second floor on the 20<sup>th</sup> from the emergency room. After 5 days of being on the second floor she was moved to the fourth floor. Patient has a past medical history of

chronic diastolic CHF, chronic hypoxic respiratory failure on 2L of oxygen at home, diabetes, hypertension, chronic kidney disease stage 3, morbid obesity. Patient was admitted with a diagnosis of community-acquired pneumonia and acute on chronic hypoxic respiratory failure with hypercapnia.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** Community-acquired pneumonia and acute on chronic hypoxic respiratory failure with hypercapnia.

**Secondary Diagnosis (if applicable):** N/A

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

Pneumonia is a type of lung infection that occurs because of bacteria, viruses or fungi (Cheever & Hinkle, 2017). In community-acquired pneumonia can occur in any community setting not just the hospital, nursing home or any other health care setting. The respiratory system supplies your body and blood with fresh oxygen and removes carbon dioxide, which is known as a waste product. Many germs and bacteria can get into your respiratory tract when you breath in and out, causing infection. Bacteria can reach the lungs causing infection, which make the lungs work poorly. Infection in your lungs cause your respiratory system to work poorly (Cheever & Hinkle, 2017). For example, oxygen may not be able to get into your blood easily, causing a decrease in oxygen saturation, which upsets respirations. Community-acquired pneumonia spreads from person to person through one person's sneezing or coughing in any public setting. Worldwide, streptococcus pneumonia is the most common source of pneumonia but some of the other common bacteria causing CAP are; haemophilus influenza, mycoplasma pneumonia, chlamydia pneumonia, legionella, gram-negative bacilli and staphylococcus aureus

(Cheever & Hinkle, 2017). Those who are most at risk for community-acquired pneumonia are smokers, those who have a weak immune system such as those with HIV, those with COPD, those with other comorbidities such as diabetes mellitus or kidney disease, use of certain medications such as PPI's and those who are heavy alcohol users. All of these risks lead a person to have a weaker immune system, making it easier for a bacteria or a virus to enter the most and cause an infection. Symptoms of CAP can occur quickly, these symptoms may include; shortness of breath, low oxygen saturation, coughing consistently, heavy mucous, fevers and chills, chest pain that is worse when you breathe or cough and nausea or vomiting. Community-acquired pneumonia is diagnosed mainly by a chest x-ray looking for white spots, also known as infiltrates (Cheever & Hinkle, 2017). Other ways to diagnose CAP can be done by blood tests, blood smears and sputum tests. Community-acquired pneumonia is treated mainly by antibiotics as a first line treatment. You may need extra support such as supplemental oxygen, increased oral fluids or intravenous fluids, breathing treatments and if severe enough respiratory support with a ventilator. To help the spread of CAP, you can get the pneumococcal vaccine which helps protect against S. Pneumoniae, which is recommended for those who are 65 years or older. For those who are younger than 65 and have pneumonia, they need to stay home and out of the community as much as possible to prevent the spread of infection (Cheever & Hinkle, 2017).

**Pathophysiology References (2) (APA):** Cheever, K., & Hinkle, J. (Eds). (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Pneumonia: Contagiousness, Causes, Treatment, Recovery Time. (2018). Retrieved October 4, 2019, from <https://www.webmd.com/lung/understanding-pneumonia-basics>.

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	3.8 – 5.4x10 <sup>6</sup>	3.75	3.72	
Hgb	11 – 15 g/dL	11.7	11.4	
Hct	34 – 45%	36.2 %	36.4 %	
Platelets	150-400,000	<b>119,000</b>	N/A	Thrombocytopenia can be caused by infection, since this patient has pneumonia that could be why her her platelet count is low (Cheever & Hinkle, 2017)
WBC	4-11,000	7,500	8,700	
Neutrophils	45 – 80%	<b>89.1 %</b>	<b>90.0 %</b>	Neutrophil count is high because she is fighting an infection (Cheever & Hinkle, 2017)
Lymphocytes	11.8- 45.9%	<b>6.4%</b>	<b>3.8%</b>	Low lymphocytes are the cause of your body fighting an infection (Cheever & Hinkle, 2017)
Monocytes	4.3- 12%	4.3%	6.0%	
Eosinophils	1-6%	N/A	N/A	
Bands	0-6%	2.0%	1.0%	

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	<b>146</b>	<b>146</b>	A slight elevation of sodium could mean that the patient was dehydrated. Since she has been sick, her PICC was d/c'd and she's not getting fluids that could be the cause of dehydration

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				causing the elevation of sodium (Cheever & Hinkle, 2017)
<b>K+</b>	<b>3.5 – 5.1</b>	<b>3.5</b>	<b>4.2</b>	
<b>Cl-</b>	<b>98 – 108</b>	<b>100</b>	<b>99</b>	
<b>CO2</b>	<b>21 – 31</b>	<b>41</b>	<b>42</b>	Conditions such as pneumonia can cause an increase in blood CO2 because gas exchange isn't working properly (Cheever & Hinkler, 2017)
<b>Glucose</b>	<b>70 -110</b>	<b>230</b>	<b>78</b>	Patient's glucose elevates because she is a type two diabetic (Cheever & Hinkle, 2017).
<b>BUN</b>	<b>7-25</b>	<b>35</b>	<b>39</b>	Patient has decreased kidney function from chronic kidney disease (Cheever & Hinkle, 2017).
<b>Creatinine</b>	<b>0.5-0.9</b>	<b>1.34</b>	<b>1.49</b>	Patient has decreased kidney function from chronic kidney disease (Cheever & Hinkle, 2017).
<b>Albumin</b>	<b>3.5-5.5</b>	<b>N/A</b>	<b>2.9</b>	An elevation in BUN (that this patient has as well) can cause a decrease in Albumin. This is also seen in patient's who have community acquired pneumonia (Cheever & Hinkle, 2017)
<b>Calcium</b>	<b>8.0 – 10.0</b>	<b>8.0</b>	<b>N/A</b>	
<b>Mag</b>	<b>1.6 – 6.4</b>	<b>2.1</b>	<b>2.1</b>	
<b>Phosphate</b>	<b>2.5 – 4.5 mg/dL</b>	<b>N/A</b>	<b>N/A</b>	
<b>Bilirubin</b>	<b>0.3 – 1</b>	<b>1.2</b>	<b>N/A</b>	
<b>Alk Phos</b>	<b>35 – 105</b>	<b>99</b>	<b>N/A</b>	
<b>AST</b>	<b>0-32</b>	<b>35</b>	<b>N/A</b>	Elevation in AST is in correlation to the elevation in the patient's BUN (Cheever & Hinkle, 2017)
<b>ALT</b>	<b>0-33</b>	<b>18</b>	<b>N/A</b>	
<b>Amylase</b>	<b>40 – 140 U/L</b>	<b>N/A</b>	<b>N/A</b>	

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<b>Lipase</b>	<b>0-160 U/L</b>	<b>N/A</b>	<b>N/A</b>	
<b>Lactic Acid</b>	<b>0.5 – 2.2 mmol/L</b>	<b>1.9</b>	<b>N/A</b>	
<b>Troponin</b>	<b>0 – 0.03</b>	<b>0.024</b>	<b>N/A</b>	
<b>CK-MB</b>	<b>0 – 4.3</b>	<b>2.01</b>	<b>N/A</b>	
<b>Total CK</b>	<b>20 – 180</b>	<b>133</b>	<b>N/A</b>	

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

<b>Lab Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>INR</b>	<b>0.86 – 1.14</b>	<b>0.98</b>	<b>N/A</b>	
<b>PT</b>	<b>11.9-15</b>	<b>13.2</b>	<b>N/A</b>	
<b>PTT</b>	<b>25 – 35 second</b>	<b>N/A</b>	<b>N/A</b>	
<b>D-Dimer</b>	<b>Less than 500</b>	<b>N/A</b>	<b>N/A</b>	
<b>BNP</b>	<b>Less than 100 pg/mL</b>	<b>N/A</b>	<b>N/A</b>	
<b>HDL</b>	<b>&gt;60</b>	<b>N/A</b>	<b>N/A</b>	
<b>LDL</b>	<b>&lt;160</b>	<b>N/A</b>	<b>N/A</b>	
<b>Cholesterol</b>	<b>Less than 200</b>	<b>N/A</b>	<b>N/A</b>	
<b>Triglycerides</b>	<b>&lt;150</b>	<b>N/A</b>	<b>N/A</b>	
<b>Hgb A1c</b>	<b>&lt;5.0 for non-diabetics &lt;7.5 for controlled diabetics</b>	<b>7.5</b>	<b>N/A</b>	
<b>TSH</b>	<b>0.4 – 4.0 U/L</b>	<b>N/A</b>	<b>N/A</b>	

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/ straw colored; clear	Yellow; clear	N/A	
pH	4.5 – 7.0	5.0	N/A	
Specific Gravity	1.005-1.034	1.013	N/A	
Glucose	0 – 15 mg/dL	<b>150</b>	N/A	Patient has type two diabetes (Cheever & Hinkle, 2017).
Protein	<20	1+	N/A	
Ketones	<20	Neg	N/A	
WBC	0-5	3	N/A	
RBC	0-3	<1	N/A	
Leukoesterase	Either positive or negative	Neg	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	7.35 – 7.45	7.32	N/A	
PaO2	80 - 100	<b>103.0</b>	N/A	Patient's PaO2 is elevated at this time because patient was on BiPap causing her levels to be slightly elevated (Cheever & Hinkle, 2017)
PaCO2	35 – 45	<b>55.5</b>	N/A	Elevated PaCO2 is due to the poor exchange of O2 and CO2 in the

				<b>blood from decreased work in the lungs from pneumonia (Cheever &amp; Hinkle, 2017)</b>
<b>HCO3</b>	<b>22 - 26</b>	<b>25.3</b>	<b>N/A</b>	
<b>SaO2</b>	<b>95 – 100%</b>	<b>97.6</b>	<b>N/A</b>	

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

<b>Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Explanation of Findings</b>
<b>Urine Culture</b>	<b>Should be negative in the absence of infection</b>	<b>N/A</b>	<b>N/A</b>	
<b>Blood Culture</b>	<b>Should be negative in the absence of infection</b>	<b>N/A</b>	<b>N/A</b>	
<b>Sputum Culture</b>	<b>Should be negative in the absence of infection</b>	<b>N/A</b>	<b>N/A</b>	
<b>Stool Culture</b>	<b>Should be negative in the absence of infection</b>	<b>N/A</b>	<b>N/A</b>	

**Lab Correlations Reference (APA):** Cheever, K., & Hinkle, J. (Eds). (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):** Chest x-ray

**Diagnostic Test Correlation (5 points):** Chest x-ray showed cloudy white patches (infiltrates) in both lungs.

**Diagnostic Test Reference (APA):** Cheever, K., & Hinkle, J. (Eds). (2017). *Brunner’s & Suddarth’s Textbook of Medical-Surgical Nursing*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

**Current Medications (10 points, 1 point per completed med)  
\*10 different medications must be completed\***

**Hospital Medications (5 required)**

Brand/Generic	amLODIPi ne (Norvasc)	Cefidini r (Omnicef)	Enoxaparin (lovenox)	Ipratropium -albuterol (DuoNeb)	Bisocodyl (ducolax)
Dose	5 mg = 1 tab	300 mg = 1 tab	30 mg = 0.3 mL	3 mL	10 mg = 2 tabs
Frequency	Once per day	Once every 24 hours	Once daily	Twice a day	As needed
Route	Orally	Orally	SubQ	Inhaled	Orally
Classification	Calcium Channel Blocker	Antibacteri al (cephalospo rin)	Anticoagulant	Bronchodil ator	Stimulant laxative
Mechanism of Action	Inhibits the movement of calcium ions into vascular smooth muscle cells and cardiac muscle cells which inhibits calcium ion influx across cell membranes causing vasodilatio n, lowering blood	Cefidini r is a beta- lactam antibiotic like the penicillins and is mainly bactericidal. Inhibits the third and final stage of the bacterial wall. It has been proven to be effective for the	Lovenox binds to and potentiates antithrombin to form a complex that irreversibly inactivates the factor Xa.	Ipratropium and albuterol work together to decrease the amount of bronchospas ms that occur with allergic reactions or respiratory distress	Bisocodyl works by stimulatin g enteric nerves to cause colonic contractio ns and increase bulk of the stool.

	<b>pressure.</b>	<b>treatment of common bacterial infections in the ear, sinus, throat, lungs and skin.</b>			
<b>Reason Client Taking</b>	<b>Client is taking this medication because she has hypertension.</b>	<b>Client is taking medication because she has community acquired pneumonia.</b>	<b>Client is taking this medication as a prophylaxis to a hospital acquired DVT.</b>	<b>Patient is taking this medication as treatment of respiratory distress from pneumonia</b>	<b>Client is taking this medication as a prophylaxis to consitpation.</b>
<b>Contraindications (2)</b>	<b>Patient's with heart failure should only be taking this medication as a last resort ; Those with impaired liver function should not be taking medication as it reduces the effects of the medication.</b>	<b>Patient's who have renal impairment or failure should use this medication as a last resort ; Patient's with diabetes should be notified if the oral suspension contain sucrose in it.</b>	<b>Do not give this medication is PTT and PT are already low, this will cause them to become lower and cause internal bleeding ; Do not give to patient if they have history of immune-mediated heparin-induced thrombocytopenia</b>	<b>Patient's who have high blood pressure should not be administered this medication ; Patient's who have diabetes mellitus should not be administered this medication especially if they are uncontrolled .</b>	<b>Do not take this medication if experiencing low electrolyte such as sodium, potassium and magnesium ; don't take this medication if experiencing diarrhea.</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>Hypotension can occur ; vasodilatory effects such as</b>	<b>Elevated blood sugars in the suspension contains</b>	<b>This medication may cause severe bruising and internal</b>	<b>Effects such as dry mouth and shakiness (tremors) may occur</b>	<b>Side effects of this medication include increased</b>

	dizziness, palpitations, peripheral edema and flushing	sucrose in it ; Renal failure may occur if patient already has renal impairment.	bleeding ; location irritation and pain at the injection sites		or persistent vomiting, diarrhea and nausea ; this medication can lead to decreased urination
<b>Nursing Considerations (2)</b>	Before administering medication, make sure to check patient's pulse and blood pressure ; continue to monitor blood pressure after the administration of amlodipine.	Check last dose given before administering, this medication should only be given once in a 24 hour period ; Be careful in those with renal failure, if levels are too high or too low before administering notify physician	Rotate injection sites on the stomach, never do two spots two days in a row ; administration of medication may cause thrombocytopenia	Before administering this medication to assess patients blood pressure ; after administration of this medication make sure that patient has enough water with them if they start to experience dry mouth.	Before administering assess patient's last stool and the looks of it; know not to administer if this medication is causing diarrhea
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	Assessment of blood pressure before administering medication ; assessment of liver function tests before administering	Assessment of kidney function before administering ; Assessment of blood glucose in diabetics	Before administering double check platelets, PTT and PT ; Assess for excessive bleeding	Assess blood pressure ; assessment of patient's knowledge of the drug and how it is administered.	Assessment of key electrolyte and fluid volume ; assess patient's knowledge of the medication and how it works

<p><b>Client Teaching needs (2)</b></p>	<p><b>Report irregular heartbeat, shortness of breath, swelling of hands or feet and pronounced dizziness ; Don't take this medication if blood pressure is under 120 systolic.</b></p>	<p><b>Take this drug with meals or a full glass of water as it may cause upset stomach; complete the full course of this medication even if you are feeling better</b></p>	<p><b>This medication may make blood thinner, if that happens be careful doing daily activities such as shaving, brushing teeth and retuning to normal activities ; don't use ibuprofen on this medication</b></p>	<p><b>Know how to administer this medication – this medication is usually given 4 times a day, open the foil pouch and remove one vial, squeeze all of the medicine out into the chamber, attach the mouth piece or facemask, breathe all of the medication in and hold your breath ; this medication is not to be used as a rescue inhaler.</b></p>	<p><b>Teach client that this medication should be taken when constipated or when in need of better formed stools ; make sure they know that if they continue to experience diarrhea that this medication needs to be stopped.</b></p>
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**Home Medications (5 required)**

<p><b>Brand/Generic</b></p>	<p><b>Nystatin Topical (Mycostatin )</b></p>	<p><b>Furosemide (Lasix)</b></p>	<p><b>Aspirin</b></p>	<p><b>Insulin Aspart (NovoLOG )</b></p>	<p><b>Melatonin</b></p>
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<b>Dose</b>	<b>100,000 U</b>	<b>20 mg = 1 tab</b>	<b>81 mg = 1 tab</b>	<b>Per the sliding scale</b>	<b>3 mg = 1 tab</b>
<b>Frequency</b>	<b>Twice daily</b>	<b>Once daily</b>	<b>As needed</b>	<b>At least 3 times a day and as needed</b>	<b>As needed at bedtime</b>
<b>Route</b>	<b>Topical</b>	<b>Orally</b>	<b>Orally</b>	<b>SubQ</b>	<b>Orally</b>
<b>Classification</b>	<b>Polyene antifungal</b>	<b>Loop diuretic</b>	<b>Antiplatelet / analgesic / antipyretic</b>	<b>Fast – acting insulin</b>	
<b>Mechanism of Action</b>	<b>Exerts antifungal activity by binding to ergosterol found in fungal cell membranes .</b>	<b>Acts by inhibiting the luminal Na – K – Cl cotransporter in the thick ascending limb of the loop of Henle, by binding to the chloride transport, thus causing sodium, chloride and potassium loss in the urine.</b>	<b>This medication works in many different ways and is classified in multiple categories. For example it decreases pain, inflammation and fever, as well as helps platelets to not clot.</b>	<b>NovoLOG is a fast acting insulin that starts to work 15 minutes to an hour after administered and keeps working for 2-4 hours. Insulin is a hormone that works by lowering levels of glucose in the blood.</b>	<b>Melatonin binds to receptor SCN of the hypothalamus and specifically acts on MT1 and MT2. When melatonin binds, it sends signals to other receptors that start a cascade of actions ultimately resulting in effects of the drug, making the patient sleepy.</b>
<b>Reason Client Taking</b>	<b>Patient is taking this medication because she has a candida infection under her</b>	<b>Patient is taking this medication because she has significant swelling in her lower extremities</b>	<b>Patient is taking this medication for her pain</b>	<b>Patient is taking this medication because she is a type 2 diabetic.</b>	<b>Patient is taking this medication because she has trouble sleeping and getting to sleep at</b>

	<b>breasts.</b>				<b>night.</b>
<b>Contraindications (2)</b>	<b>Do not give to patient who has hypersensitivity to any of the components of this medication ; not to be used for systemic or vaginal infections.</b>	<b>Not for patients who have renal impairment ; not intended for patients with hypokalemia</b>	<b>Not to be given to a patient who has low platelets ; not to be administered if actively on lovenox.</b>	<b>Do not take this medication if not blood sugar is below 110 ; Do not take this medication if you are not planning on eating in the next 15-30 minutes.</b>	<b>Don't take this medication if you have a severe reaction such as an allergic reaction or hallucinations ; Do not administer medicine if patient is taking sedative medication such benzodiazepines.</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>This medication may cause skin irritation such as eczema or rashes ; This medication may cause pain or burning at the place of application</b>	<b>GI effects such as nausea/vomiting , hepatic encephalopathy, anorexia and diarrhea/constipation may occur ; CNS effects such as dizziness and blurred vision may occur</b>	<b>Side effects include increased bleeding or internal bleeding ; this medication may interact with other medication this patient is taking such as anti-diabetic medication or antibiotics</b>	<b>This medication may cause blood sugar to become too low and cause the patient to become hypoglycemic ; this medication may cause a decrease in kidney function</b>	<b>This medication can cause hallucinations ; This medication may cause the adverse reaction of insomnia.</b>
<b>Nursing Considerations (2)</b>	<b>If there is a lack of response</b>	<b>Observe patients reaction to drug</b>	<b>Before administering this</b>	<b>Perform a physical assessment</b>	<b>Double check patients</b>

	<p>from this medication a KOH smear can be done to determine the type of bacteria ; Older adults may respond differently to this medication than those who are younger, start with a smaller dose</p>	<p>carefully as this could cause cardiac and other systemic reactions that are deadly ; Monitor blood glucose carefully in diabetic patients</p>	<p>medication the nurse should assess the patient for a history of excessive bleeding ; the nurse should assess the cranial nerve 8 function before administering</p>	<p>on your patient to get a baseline of what their normal is before beginning ; obtain blood glucose checks to monitor the effects of insulin</p>	<p>medication list to make sure that they are not on any benzodiazepines ; Watch out for increased hallucinations, dizziness, increased awakeness, high blood pressure or increased blood sugar.</p>
<p><b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b></p>	<p>Assess patient's reaction to this medication ; assess patient's allergies to see if any of them reside in this medication</p>	<p>Before administering assess the patients BUN, potassium, sodium, creatinine, CO2 and uric acid; Monitor patients blood pressure as this could cause alterations in BP</p>	<p>Assess patients pain levels before administering ; assess patients platelets before administering</p>	<p>Assess patients blood glucose ; assess patients for ketones in their urine if they are hyperglycemic</p>	<p>Assessment of patients sleep-awake cycle ; Assessment of patients blood pressure before administering</p>
<p><b>Client Teaching needs (2)</b></p>	<p>Teach the patient the proper application to this medication ; if relief occurs within the first few days before treatment is</p>	<p>Monitor blood glucose multiple times a day if diabetic ; education patient on the type of foods they can and cannot eat (for example teach them the allowable salts</p>	<p>Patient should not go over 4000mg in a 24 hour period it will have serious effects to your liver ; you may take</p>	<p>Insulin is only part of the treatment, make sure to educate the patient on different diets and exercise regimens</p>	<p>Teach patient the correct dosing and correct timing before giving medication (30 minutes before desired</p>

	over, don't stop the treatment continue with full course	they should be consuming) ; teach patients to sit up and stand slowly.	this drug with food in GI upset occurs	to go along with insulin ; Teach patient to do frequent blood sugar checks when they are sick or not feeling well	sleep) ; teach patient's to work on other techniques to sleep instead of relying heavily on melatonin.
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- **Medications Reference (APA):** J. (2018). *Nurse's Drug Handbook* (17<sup>th</sup> Ed.). Burlington, MA.

### Assessment

#### Physical Exam (18 points)

<b>GENERAL (1 point):</b> <b>Alertness:</b> <b>Orientation:</b> <b>Distress:</b> <b>Overall appearance:</b>	<b>Awake, alert and oriented X3, cooperative, well-nourished, no apparent distress at this time, patient has bruising all over her body with the largest one being at her flank.</b>
<b>INTEGUMENTARY (2 points):</b> <b>Skin color:</b> <b>Character:</b> <b>Temperature:</b> <b>Turgor:</b> <b>Rashes:</b> <b>Bruises:</b> <b>Wounds: .</b> <b>Braden Score: 14</b> <b>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b> <b>Type:</b>	<b>Pale with multiple bruising over body, skin is warm and dry, decreased skin turgor, temperature is 36.7, patient has no rashes or wounds, bruising over belly, flank, legs and arms.</b> <b>Braden score is 14.</b>
<b>HEENT (1 point):</b> <b>Head/Neck:</b> <b>Ears:</b> <b>Eyes:</b>	<b>Head is normocephalic, neck is supple and nontender, no JVD present, no lymphadenopathy</b> <b>Patient is hard of hearing, ears are parallel to</b>

<p><b>Nose:</b> <b>Teeth:</b></p>	<p><b>eyes.</b> <b>Patient has PERLLA, normal conjunctiva and sclera, no scleral icterus.</b> <b>No sinus tenderness, no deviated septum, no leaking of fluids or mucous.</b> <b>Moist oral mucosa.</b></p>
<p><b>CARDIOVASCULAR (2 points):</b> <b>Heart sounds:</b> <b>S1, S2, S3, S4, murmur etc.</b> <b>Cardiac rhythm (if applicable):</b> <b>Peripheral Pulses:</b> <b>Capillary refill:</b> <b>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b> <b>Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b> <b>Location of Edema: Lower extremities</b></p>	<p><b>S1 and S2 sounds, no murmur detectable, patient is in a normal sinus rhythm.</b> <b>Peripheral pulses are palpable. Capillary refill is less than 2 seconds.</b></p>
<p><b>RESPIRATORY (2 points):</b> <b>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b> <b>Breath Sounds: Location, character</b></p>	<p><b>No labored respirations. Coarse crackles in upper lobes.</b></p>
<p><b>GASTROINTESTINAL (2 points):</b> <b>Diet at home: regular</b> <b>Current Diet: Consistent Carbs</b> <b>Height: 156 cm</b> <b>Weight: 88.9 kg</b> <b>Auscultation Bowel sounds:</b> <b>Last BM: 10/2/2019</b> <b>Palpation: Pain, Mass etc.:</b> <b>Inspection:</b> <b>Distention:</b> <b>Incisions:</b> <b>Scars:</b> <b>Drains:</b> <b>Wounds:</b> <b>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b> <b>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b> <b>Size:</b> <b>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/></b> <b>Type:</b></p>	<p><b>Bowel sounds are within normal limits, can heard gurgles and movement in each quadrant. Patients last bowel movement was today (10/2/2019).</b> <b>Patients abdomen is non-distended, no incisions, scars or drains.</b> <b>Patient does have an adequate amount of bruising over her stomach from lovenox and insulin injections.</b></p>
<p><b>GENITOURINARY (2 Points):</b> <b>Color:</b> <b>Character:</b> <b>Quantity of urine:</b> <b>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b></p>	<p><b>Urine is yellow and clear (non-hazy), patient urinated 500 mL today.</b></p>

<p><b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Inspection of genitals:</b></p> <p><b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Type:</b></p> <p><b>Size:</b></p>	
<p><b>MUSCULOSKELETAL (2 points):</b></p> <p><b>Neurovascular status:</b></p> <p><b>ROM:</b></p> <p><b>Supportive devices:</b></p> <p><b>Strength:</b></p> <p><b>ADL Assistance:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Risk:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Score:</b> 65</p> <p><b>Activity/Mobility Status:</b></p> <p><b>Independent (up ad lib)</b> <input type="checkbox"/></p> <p><b>Needs assistance with equipment</b> <input type="checkbox"/></p> <p><b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p><b>Patients sensations are intact, cranial nerves are intact.</b></p> <p><b>Range of motion is grossly within normal limits for this patient. She has improved in range of motion since her stay at Sarah Bush. Patient uses a Hoyer to be transferred.</b></p>
<p><b>NEUROLOGICAL (2 points):</b></p> <p><b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p><b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -</p> <p><b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/></p> <p><b>Orientation:</b></p> <p><b>Mental Status:</b></p> <p><b>Speech:</b></p> <p><b>Sensory:</b></p> <p><b>LOC:</b></p>	<p><b>Patient is alert and oriented x3, she knows her name, where she is staying, why she in the hospital but can't tell me who the president is. Patient is alert, cooperative and awake There are no deficits in her speech, she can talk to me and make complete sense Patient has no deficits in her sensory status.</b></p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b></p> <p><b>Coping method(s):</b></p> <p><b>Developmental level:</b></p> <p><b>Religion &amp; what it means to pt.:</b></p> <p><b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p><b>Patient seems to not be handling her situation well and keeps repeating that she wishes she wants to go home rather than stay for any more treatments.</b></p> <p><b>Patient is full developed for age.</b></p> <p><b>Patient does not have a certain religion.</b></p> <p><b>Patient and family dynamics are a little all over the place. The POAs want the patient to go to a nursing home so she can get stronger and rehab before she goes back home. The son and the grandson want the patient to come home right away and keep promising that they will be able to take care of her all by their selves. The patient states that she wants to go home.</b></p>

**Vital Signs, 2 sets (5 points)**

<b>Time</b>	<b>Pulse</b>	<b>B/P</b>	<b>Resp Rate</b>	<b>Temp</b>	<b>Oxygen</b>
<b>0730</b>	<b>86</b>	<b>118/58</b>	<b>20</b>	<b>36.7</b>	<b>95</b>
<b>1030</b>	<b>80</b>	<b>120/60</b>	<b>18</b>	<b>36.5</b>	<b>96</b>

**Vital Sign Trends: Patient’s vitals have not changed very much from 0730 to 1030 and she is staying within the normal ranges.**

**Pain Assessment, 2 sets (2 points)**

<b>Time</b>	<b>Scale</b>	<b>Location</b>	<b>Severity</b>	<b>Characteristics</b>	<b>Interventions</b>
<b>0730</b>	<b>Numeric</b>	<b>No pain</b>	<b>0/10</b>	<b>No pain</b>	<b>No pain</b>
<b>1030</b>	<b>Numeric</b>	<b>No pain</b>	<b>0/10</b>	<b>No pain</b>	<b>No pain</b>

**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b> <b>Signs of erythema, drainage, etc.:</b> <b>IV dressing assessment:</b>	IV was d/c because they decided a PICC would be more beneficial, PICC d/c because they thought it has gotten infected. No infection to be detected still.

**Intake and Output (2 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
<b>900</b>	<b>500</b>

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care:**

**Procedures/testing done:** Thoracentesis (500 mL), chest X-ray

**Complaints/Issues:** Crackles in lungs, trouble breathing, trouble keeping glucose stable,

**Vital signs (stable/unstable):** Vital signs are stable

**Tolerating diet, activity, etc.:** Tolerating diet well, patient is a Hoyer lift and a bed rest turn, patient is occasionally getting out of bed to sit in her chair.

**Physician notifications:**

**Future plans for patient:**

**Discharge Planning (2 points)**

**Discharge location:**

**Home health needs (if applicable):**

**Equipment needs (if applicable):**

**Follow up plan:**

**Education needs:**

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

<b>Nursing Diagnosis</b> <ul style="list-style-type: none"><li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li></ul>	<b>Rational</b> <ul style="list-style-type: none"><li>• Explain why the nursing diagnosis was chosen</li></ul>	<b>Intervention (2 per dx)</b>	<b>Evaluation</b> <ul style="list-style-type: none"><li>• How did the patient/family respond to the nurse’s actions?<ul style="list-style-type: none"><li>• Client response, status of goals and outcomes, modifications to plan.</li></ul></li></ul>
1. Ineffective airway clearance related to	This was a nursing diagnosis chosen because the patient has	1. Assessment of patients rate, rhythm and	Patient understood her need to coughing, and deep-breathing exercises to help

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<p>inability to clear secretions from respiratory tract as evidenced by excessive mucous secretions and excessive coughing</p>	<p>had excessive coughing without relief since the patient was admitting to the hospital</p>	<p>depth of each breath and the use of accessory muscles. Tachypnea, shallow respirations and asymmetric movements of the chest may be in response to airway obstruction.</p> <p>2. Teach and asses patient with proper deep-breathing exercises. Deep-breathing exercises facilitate maximum expansion of lungs. Coughing is a reflex and a natural self-cleaning mechanism that helps cilia to maintain airways. Splinting helps reduce pain in patien's abdomen.</p>	<p>facilitate her breathing and help clear out her lungs.</p>
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<p>2. Impaired gas exchange related to retained secretions and inflammation of the pulmonary system as evidenced by increased CO<sub>2</sub> in respiratory system.</p>	<p>Patient has impaired gas exchange due to her pneumonia that is shown in her increased CO<sub>2</sub> in her system.</p>	<ol style="list-style-type: none"> <li>1. Observe skin color and mucous for presence of cyanosis. As oxygenation profusion becomes impaired, peripheral tissues become cyanotic. Cyanosis of nail beds represent vasoconstriction.</li> <li>2. Monitor ABGs and pulse oximetry. This follows the progression of the disease, oxygen saturation should always be above 90%.</li> </ol>	<ol style="list-style-type: none"> <li>1. Teaching patient and family to observe for colors in skin help reduce the severity of ischemia that could happen when pulse oximetry is low and cyanosis occurs.</li> </ol>
<p>3. Ineffective breathing pattern related to compensatory tachypnea as evidenced by inability to meet metabolic demands.</p>	<p>If patient has ineffective breathing pattern any inspiratory or expiratory efforts do not help the patient in providing adequate ventilation.</p>	<ol style="list-style-type: none"> <li>1. Observe for retractions or flaring of nostrils. These are signs of an increase in respiratory efforts.</li> <li>2. Place patient in proper position, sitting upright, to facilitate maximum lung expansion and chest expansion.</li> </ol>	<p>Patient and family understand the need for sitting upright and facilitating proper breathing.</p>

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<p>4. Patient is at risk for acute or increased chest pain related to coughing fits as evidenced by the patient coughing constantly.</p>	<p>1. Coughing an excessive amount of times can cause the patient to be in pain in the muscles that surround the lungs and around the abdomen.</p>	<p>1. Assessment of pain characteristics; sharp, constant or stabbing. Investigate changes in the type of pain and severity of pain. Chest pain is usually presented with pneumonia because the excessive coughing that comes with the disease.</p> <p>2. Instruct pain in chest splinting techniques during coughing episodes. This aids in control of chest discomfort while enhancing the effectiveness of cough effort.</p>	<p>1. Patient and family understand the need for splinting and keep track of the type of pain and the severity of pain.</p>
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**Other References (APA):** Cheever, K., & Hinkle, J. (Eds). (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

**Concept Map (20 Points):**

### Subjective Data

Pain in her chest  
Trouble breathing or trying to catch breath  
Overall pain and not feeling well

### Nursing Diagnosis/Outcomes

Ineffective airway clearance related to inability to clear secretions from respiratory tract as evidenced by excessive mucous secretions and excessive coughing / Patient understood her need to coughing, and deep-breathing exercises to help facilitate her breathing and help clear out her lungs.

Impaired gas exchange related to retained secretions and inflammation of the pulmonary system as evidenced by increased CO2 in respiratory system. / Teaching patient and family to observe for colors in skin help reduce the severity of ischemia that could happen when pulse oximetry is low and cyanosis occurs.

Ineffective breathing pattern related to compensatory tachypnea as evidenced by inability to meet metabolic demands. / Patient and family understand the need for sitting upright and facilitating proper breathing

Patient is at risk for acute or increased chest pain related to coughing fits as evidenced by the patient coughing constantly. / Patient and family understand the need for splinting and keep track of the type of pain and the severity of pain.

### Objective Data

Low oxygen saturation  
Positive Chest X-ray  
High oxygenation and carbon dioxide in ABGs  
Constant coughing coming from patient's room

### Patient Information

Patient is at home with her son and grandson. Her daughters are her POA.  
Thinking about going to Odd Fellows for rehab  
Patient is a 92-year-old, retired, widowed female

### Nursing Interventions

Assessment of the quality and depth of each breath and the use of accessory muscles. Tachypnea, shallow respirations and asymmetric movements of the chest may be in response to airway obstruction. Teach and asses patient with proper deep-breathing exercises. Deep-breathing exercises facilitate maximum expansion of lungs. Coughing is a reflex and a natural self-cleaning mechanism that helps cilia to maintain airways. Splinting helps reduce pain in patien's abdomen.

Observe skin color and mucous for presence of cyanosis. As oxygenation profusion becomes impaired, peripheral tissues become cyanotic. Cyanosis of nail beds represent vasoconstriction

Monitor ABGs and pulse oximetry. This follows the progression of the disease, oxygen saturation should always be above 90%.

Observe for retractions or flaring of nostrils. These are signs of an increase in respiratory efforts.

Place patient in proper position, sitting upright, to facilitate maximum lung expansion and chest expansion.

Assessment of pain characteristics; sharp, constant or stabbing. Investigate changes in the type of pain and severity of pain. Chest pain is usually presented with pneumonia because the excessive coughing that comes with the disease.

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