N431 Care Plan # 2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/22/2019	J. H.	67 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	Codeine
Code Status	**Height**	**Weight**	
Full code	172.1 cm	115.5 kg	

Medical History (5 Points)

Past Medical History:

- Breast Cancer
- GERD
- HTN
- Hyperlipidemia
- Obesity
- Osteoarthritis

Past Surgical History:

- Mastectomy- 3/28/1998
- Right Total Knee Arthroplasty-9/20/2019

Family History:

- Father- CVD, MI, HTN, Stroke
- Mother- Anemia, Leukemia
- Sister- Thyroid disease

Social History (tobacco/alcohol/drugs):

- Denies substance abuse.
- Past alcohol user.

- Former tobacco smoker. Quit 30+ days ago, 1.5 ppd for 46 years, started at age 17, stopped at age 63.

Assistive Devices: Walker and gait belt

Living Situation: Home w/ husband

Education Level: High school diploma or equivalent

Admission Assessment

Chief Complaint (2 points): Right-sided chest discomfort

History of present Illness (10 points):

Patient is a 67-year-old female that presents to the ED with complaints of right-sided chest discomfort and shortness of breath. Patient states she was awakened at 0300 with right-sided chest pain. Patient rates pain a 3/10 on the numeric pain scale. Patient denies pleuritic pain, nausea, diaphoresis and abdominal pain. Patient denies radiation to the back, neck, or arms. Patient states she had a syncopal episode today at physical therapy. Patient is 4 weeks post-op from a right total knee arthroplasty. Patient denies history of blood clots, numbing, tingling, or calf pain. Review of systems is otherwise negative.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Bilateral pulmonary embolism

Secondary Diagnosis (if applicable): N/A

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

"An embolus is a substance or object that travels via the bloodstream to a blood vessel and subsequently lodges in a vessel, creating a partial or complete obstruction of blood flow through the affected vessel" (Sorenson, Quinn, & Klein, 2017, pg. 487). When an embolus travels and lodges in a blood vessel and creates an obstruction in the blood flow it is then

referred to as an embolism. A pulmonary embolism (PE) occurs when an embolus is pumped from the right heart into smaller arterioles until it becomes wedged in the vessel. This causes an obstruction in blood flow and circulation to the lung (Sorenson, Quinn, & Klein, 2017). Risk factors for developing a pulmonary embolism include prior history of deep vein thrombosis or pulmonary embolism, individuals with prolonged immobilization, individuals that have had recent surgery, women and older adults (Sorenson, Quinn, & Klein, 2017).

Clinical manifestations of a pulmonary embolism include sudden shortness of breath, hemoptysis, and chest pain. The chest pain usually worsens with exertion, but does not relieve after resting (Hinkle & Cheever, 2018). Diagnostic tests used for detecting pulmonary emboli include CT scans, lung ventilation/perfusion scanning, and pulmonary angiography. In addition, a D-dimer blood test may be performed to detect fibrin protein fragments (Sorenson, Quinn, & Klein, 2017). “Treatment of PE includes thrombolytic therapy to dissolve the clot, anticoagulation to prevent further clots, and oxygen supplementation” (Sorenson, Quinn, & Klein, 2017, pg. 488). Prevention is an important teaching topic for these patients. Nurses should educate clients on the importance of wearing compression stockings, increased activity, and early ambulation after surgery (Hinkle & Cheever, 2018).

My patient presented to the ED with complaints of shortness of breath and right-sided chest discomfort. These manifestations coincide with the classic presentation of pulmonary embolism. D-dimer results indicated that the patient had elevated fibrin protein fragments in her blood. In addition, a CT angiogram of the chest and pulmonary vessels was performed. Results showed extensive bilateral emboli. Treatment modality for this patient included subcutaneous Lovenox injections and close monitoring by healthcare personnel. Patient was discharged on 10/23/2019.

Pathophysiology References (2) (APA):

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

Sorenson, M., Quinn, L., & Klein, D. (2017). *Pathophysiology Concepts of Human Disease*. Hoboken, NJ: 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	3.8-5.41	4.13	3.90	N/A
Hgb	11.3-15.2	11.9	11.5	N/A
Hct	33.2-45.3	36.2	34.5	N/A
Platelets	149-393	393	373	N/A
WBC	4.0-11.7	11.5	9.6	N/A
Neutrophils	45.3-79.0	62.3	62.6	N/A
Lymphocytes	11.8-45.9	25.9	25.9	N/A
Monocytes	4.4-12.0	9.2	8.6	N/A
Eosinophils	0.0-6.3	2.0	1.9	N/A
Bands	N/A	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal
Na-	136-145	138	140	N/A

K+	3.5-5.1	3.9	3.9	N/A
Cl-	98-107	103	107	N/A
CO2	21-31	24	23	N/A
Glucose	74-109	98	102	N/A
BUN	7-25	14	12	N/A
Creatinine	0.5-0.9	0.81	0.75	N/A
Albumin	3.5-5.2	3.7	N/A	N/A
Calcium	8.6-10.3	9.5	9.0	N/A
Mag	1.6-2.4	2.0	N/A	N/A
Phosphate	N/A	N/A	N/A	N/A
Bilirubin	0.3-1.0	0.4	N/A	N/A
Alk Phos	35-105	99	N/A	N/A
AST	0-32	15	N/A	N/A
ALT	0-33	14	N/A	N/A
Amylase	N/A	N/A	N/A	N/A
Lipase	N/A	N/A	N/A	N/A
Lactic Acid	N/A	N/A	N/A	N/A
Troponin	0.000-0.030	<0.010	N/A	N/A
CK-MB	0.00-0.08	0.00	N/A	N/A
Total CK	N/A	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.86-1.14	1.04	N/A	N/A
PT	11.9-15.0	13.8	N/A	N/A
PTT	22.6-35.3	32.0	N/A	N/A
D-Dimer	0.00-0.62	10.38	N/A	"A positive D-dimer test indicates the presence of abnormally high amounts of fibrin degradation products in the blood. This suggests that a high level of clot-formation and breakdown is occurring" (Sorenson, Quinn, & Klein, 2017, pg. 562). This result and the results of the CT scan is indicative of a pulmonary embolism.
BNP	N/A	N/A	N/A	N/A
HDL	N/A	N/A	N/A	N/A
LDL	N/A	N/A	N/A	N/A
Cholesterol	N/A	N/A	N/A	N/A
Triglycerides	N/A	N/A	N/A	N/A
Hgb A1c	N/A	N/A	N/A	N/A
TSH	0.45-5.33	1.02	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	N/A	N/A	N/A	N/A
pH	N/A	N/A	N/A	N/A

Specific Gravity	N/A	N/A	N/A	N/A
Glucose	N/A	N/A	N/A	N/A
Protein	N/A	N/A	N/A	N/A
Ketones	N/A	N/A	N/A	N/A
WBC	N/A	N/A	N/A	N/A
RBC	N/A	N/A	N/A	N/A
Leukoesterase	N/A	N/A	N/A	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	N/A	N/A	N/A	N/A
PaO2	N/A	N/A	N/A	N/A
PaCO2	N/A	N/A	N/A	N/A
HCO3	N/A	N/A	N/A	N/A
SaO2	N/A	N/A	N/A	N/A

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	N/A	N/A	N/A	N/A
Blood Culture	N/A	N/A	N/A	N/A
Sputum Culture	N/A	N/A	N/A	N/A
Stool Culture	N/A	N/A	N/A	N/A

<u>Lab Correlations Reference (APA):</u>

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- EKG: Measures the electrical activity of the heart
- CXR: Imaging test that uses small amounts of radiation to produce pictures of the organs, tissues, and bones of the body
- US Venous Duplex: High frequency waves that produce views of the veins that return blood to the heart
- CT Angiogram Chest/Pulmonary: Test that uses x-rays to provide pictures of the heart and the vessels that go to the heart and lungs

Diagnostic Test Correlation (5 points):

- EKG: Sinus tachycardia
- CXR: Heart size is normal, surgical clips overlie the right chest, lungs are clear, no visualized pneumothorax or pleural effusion, osseous structures are intact
- US Venous Duplex: Lower extremity venous ultrasound demonstrates normal flow and compressibility in the common femoral vein, saphenofemoral junction, popliteal vein, and posterior tibial vein. No evidence of intraluminal filling defect.
- CT angiogram chest/pulmonary: Extensive bilateral pulmonary emboli, emphysema, and a 4 mm noncalcified left lower lobe nodule.

Diagnostic Test Reference (APA):

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

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

Home Medications (5 required)

Brand/Generic	Norvasc (amlodipine) (Skidmore, 2018, pg. 65)	Aspirin (acetylsalicylic acid) (Skidmore, 2018, pg. 99)	Ultram (tramadol) (Skidmore, 2018, pg. 1167)	Zofran (ondansetron) (Skidmore, 2018, pg. 879)	Colace (docusate sodium) (Skidmore, 2018, pg. 391)
Dose	10 mg = 2 tablets	81 mg = 1 tablet	100 g = 2 tablets	4 mg = 1 tablet	200 mg = 2 tablets
Frequency	Daily	BID	Q6, PRN	Q8, PRN	BID
Route	Oral	Oral	Oral	Oral	Oral
Classification	Antihypertensive; antianginal	Nonsteroidal anti-inflammatory	Analgesic	Antiemetic	Laxative; stool softener
Mechanism of Action	Inhibits the contraction of cardiac muscle and vascular smooth muscle cells	Reduces inflammation by inhibition of prostaglandin synthesis	Binds to opioid receptor; reuptake of norepinephrine and serotonin	Blocks serotonin peripherally, centrally, and in the small intestine	Increases water and fat penetration on the intestine
Reason Client Taking	Hypertension	Osteoarthritis	Moderate to severe pain	Nausea and vomiting	Prevention of dry, hard stools
Contraindications (2)	Severe obstructive CAD Severe aortic stenosis	Bleeding disorders Agranulocytosis	Hypersensitivity Acute intoxication with any CNS depressant	Hypersensitivity Torsades de pointes	Fecal impaction Nausea/ vomiting
Side Effects/Adverse Reactions (2)	Headache Peripheral edema	Nausea Vomiting	Tachycardia Hypertension	Headache Dizziness	Cramps Diarrhea

				Drowsiness	
Nursing Considerations (2)	Assess for peripheral edema, dyspnea, jugular distention, and crackles Assess angina: intensity, location, duration of pain	Monitor salicylate levels Assess pain: character, location, intensity; one hour before and after administration	Assess I & O; monitor for urinary retention Assess for CNS changes	Monitor ECG for signs and symptoms of QT prolongation or torsades de pointes Monitor patient for EPS	Assess the cause of constipation Evaluate the therapeutic response: decrease in constipation
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess cardiac status: B/P, pulse, respirations, ECG	Assess hepatic, renal, and blood studies	Assess pain: location, type, and character Withhold if respirations are less than 12/min	Assess patient for nausea, vomiting, abdominal distention, and bowel sounds prior to administration	Assess for cramping, rectal bleeding, nausea, or vomiting
Client Teaching needs (2)	Use sunscreen and protective clothing to prevent photosensitivity Perform good oral hygiene to prevent gingival disease	Therapeutic response takes up to 2 weeks Take with a full glass of water	Change position slowly to avoid orthostatic hypotension Educate client that dizziness, confusion, and drowsiness may occur	Educate client that a headache is common Report diarrhea, constipation, rash, changes in respirations, serotonin symptoms, or EPS symptoms	Take with a full glass of water Product may take up to 3 days to soften stools

<u>Hospital Medications (5 required)</u>

Brand/Generic	Phenergan	Tylenol	Pepcid	Lovenox	Colace

	(promethazine) (Skidmore, 2018, pg. 972)	(acetaminophen) (Skidmore, 2018, pg. 9)	(famotidine) (Skidmore, 2018, pg. 499)	(enoxaparin) (Skidmore, 2018, pg. 435)	(docusate sodium) (Skidmore, 2018, pg. 391)
Dose	0.5 mL	650 mg = 2 tablets	20 mg = 1 tablet	0.8 mL	200 mg = 2 tablets
Frequency	Q4, PRN	Q6, PRN	Q12, PRN	Q12	BID
Route	IM injection	Oral	Oral	Subcutaneous injection	Oral
Classification	Antiemetic	Nonopioid analgesic	H2 histamine receptor antagonist	Anticoagulant; antithrombotic	Laxative; stool softener
Mechanism of Action	Acts on blood vessels, GI, respiratory system by competing with histamine for H-receptor sites	Block pain impulses peripherally in response to inhibition of prostaglandin synthesis	Decreases gastric secretions	Binds to antithrombin III, inactivating factors Xa/IIa	Increases water and fat penetration on the intestine
Reason Client Taking	Nausea and vomiting	Mild to moderate pain	GERD	Pulmonary embolism	Prevention of dry, hard stools
Contraindications (2)	Bone marrow suppression Jaundice	Hypersensitivity Severe hepatic impairment/disease	Hypersensitivity Hepatic disease	Thrombocytopenic purpura Active major bleeding	Fecal impaction Nausea/ vomiting
Side Effects/Adverse Reactions (2)	Constipation Urinary retention Dizziness	Nausea Vomiting Abdominal pain	Headache Dizziness Constipation	Hemorrhage from any site Ecchymosis	Cramps Diarrhea
Nursing Considerations (2)	Monitor I & O: watch for urinary retention,	Assess pain: type, location, intensity, and duration	Assess for bleeding: hematuria; hematemesi	Monitor for bleeding: gums; petechiae;	Assess the cause of constipation

	frequency, or dysuria Monitor cardiac status: palpitations, increased pulse, hypo/hypertension, B/P	Monitor I & O: decreased output could indicate renal failure	s; occult blood in stools; abdominal pain Monitor patient for constipation	ecchymosis; black, tarry stools; hematuria Monitor for signs and symptoms of anaphylaxis or angioedema	Evaluate the therapeutic response: decrease in constipation
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess respiratory status: rate and rhythm	Assess hepatic, renal and blood studies	Monitor CBC periodically Assess for epigastric abdominal pain, prank or occult blood, emesis, or gastric aspirate	Monitor blood studies prior to administration Monitor renal studies periodically	Assess for cramping, rectal bleeding, nausea, or vomiting
Client Teaching needs (2)	Product may cause photosensitivity Avoid concurrent use of alcohol and other CNS depressants Take frequent sips of water to avoid dry mouth	Educate client on signs of chronic overdose: bleeding, bruising, malaise, fever, and sore throat Do not exceed maximum daily amount	Avoid irritating foods, NSAIDS, alcohol, ASA, and extreme-temperature foods Smoking diminishes the effectiveness of Pepcid	Use soft bristled toothbrush Report any signs of bleeding	Take with a full glass of water Product may take up to 3 days to soften stools

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Medications Reference (APA):

L. Skidmore. (2018). *Mosby's 2018 Nursing Drug Reference*, (31st ed.). St. Louis, MO:

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Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client is a very pleasant sixty-seven year old woman. Patient is alert and oriented x 4. No signs of distress present. Attitude is appropriate, calm and cooperative.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Client states she is Caucasian and presents with a normal skin tone. Skin has normal elasticity with no abnormal texture. Skin is pink, warm, and dry. No rashes, bruises, or wounds visible. No drains present. Client has a peripheral IV in the left antecubital fossa used for medication administration. Patient's Braden scale is 19.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head is rounded, normocephalic and symmetrical. Hair is gray in color and distributed evenly. Neck lymph nodes not palpable. Ears are symmetrical and have the same color as client's facial skin. No drainage present. PERRLA is noted. EOMI. Nose is straight and shows no signs of deviation. No noted drainage or flaring. Oral mucosa is pink and moist. Uvula is midline. No discoloration noted.
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:**	Client is being continuously monitored by telemetry and exhibiting sinus tachycardia. Heart sounds auscultated x 5. S1 and S2 heart sounds noted. No noted murmurs or rubs. Radial and pedal pulses assessed. Pulses graded at +3 bilaterally. Capillary refill is less than 3 seconds. No noted edema. Negative for neck vein distention.
RESPIRATORY (2 points):	No accessory muscle use. Trachea midline with

Accessory muscle use: Y☐ N ☐ **Breath Sounds: Location, character**	no deviations. Client exhibits shortness of breath upon exertion. Anterior and posterior lung sounds auscultated. Lung sounds clear bilaterally. Client is currently breathing room air.
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 ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Client is on a regular diet while hospitalized. Client states she does not follow a specific diet while at home. No noted abnormalities noted upon inspection. No ascites present. Bowel sounds auscultated in all four quadrants. Client denies pain or tenderness upon light and deep palpation. No noted distention, incisions, scars, drains, or wounds. No ostomies, PEG tubes, or nasogastric tubes present. Client's last bowel movement was 10/22/2019. Patient is passing flatus. Client denies nausea or vomiting or bloody stools.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Client ambulates to the bathroom with the assistance of a walker. Urine is light yellow in color. No odor or sediments present. Client denies pain or hesitancy with elimination. Client has adequate output. No dialysis or catheter. Client is on I & O's.
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** ☐	Client is up with one assistance and uses a walker to ambulate. Client exhibits a weak/unsteady gait. Client shows full range of motion bilaterally. Clients strength is equal bilaterally and appropriate for age. Client shows no signs of neurological damage or deficits. Morse Fall Score is 60.

NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Client is a pleasant 67-year-old female. Client's attitude is appropriate, calm, and cooperative. Client is alert and oriented to person, place, time and situation. Normal cognition. Client speaks English and does so at a normal pace. MAEW. Client's strength is equal bilaterally. PERRLA noted.
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):**	Client presents calm and cooperative. Husband is at bedside. Client states she lives at home with her husband. Client identifies this individual as her support system. Client shows effective coping skills. Developmental level is appropriate for age. Client identifies as Christian and states that religion and is very important to her.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11: 30	110 BPM	145/90	20/min	36.8 C	98% RA
15: 15	121 BPM	138/86	18/min	36.8 C	97% RA

Vital Sign Trends:

Client is exhibiting sinus tachycardia. This is evidenced by a heart rate over 100 beats per minute. In addition, the patient's blood pressure remains elevated. All other vitals are within defined limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:30	0/10 Numeric pain scale	-	-	-	-
15: 30	0/10				

	Numeric pain scale	-	-	-	-

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** LAC **Date on IV:** 10/22/2019 **Patency of IV:** Catheter patent, flushes easily **Signs of erythema, drainage, etc.:** No signs of erythema, drainage, or phlebitis **IV dressing assessment:** Dry and intact	Saline locked

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600 mL water 50 mL IV bolus **+ 650 mL**	**-350 mL urine**

Nursing Care

Summary of Care (2 points)

Overview of care: Client has complied with all nursing interventions and is progressing. Patient received thrombolytic therapy during hospital stay and tolerated it well. Patient has rated pain a 0/10 for the last six hours. Client still displays shortness of breath upon exertion. Lung sounds are clear bilaterally and respiratory rate is normal. Vital signs remain elevated, but stable. Results of blood studies are all within defined limits. Client is tolerating a regular diet and is consuming adequate amounts of fluids. Client will be discharged from the hospital today.

Procedures/testing done: D-dimer elevated. A computerized tomography coronary angiogram was also performed. Both tests were indicative of a blood clot.

Complaints/Issues: Patient has not expressed any complaints or issues.

Vital signs (stable/unstable): Vital signs remain elevated but stable

Tolerating diet, activity, etc.: Patient is tolerating diet well and consuming adequate amounts of fluid. Client is up with one person with the assistance of a walker.

Physician notifications: Physician discharged patient 10/23/2019.

Future plans for patient: Patient discharged 10/23/2019

Discharge Planning (2 points)

Discharge location: Home w/ husband

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Patient should follow up with primary care provider within 7 days of discharge.

Education needs: Patient should continue home medication regimen as prescribed. Patient should be educated on the importance of wearing compression stockings, avoiding sitting for long periods of time, and attending all follow up lab appointments.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

1. Ineffective breathing pattern related to chest pain as evidenced by dyspnea	Client presented to the ED with right sided chest discomfort and shortness of breath. A CT angiogram indicated bilateral pulmonary emboli. Goal is that patient will maintain an effective breathing pattern during today's 6 hour clinical shift.	1.Assess the patient's respiratory rate, rhythm and depth 2.Assess the characteristics of pain, especially in association with the respiratory cycle	Patient maintained a normal respiratory rate, rhythm and depth for most of the clinical shift. Patient did report shortness of breath upon exertion. Patient rated pain 0/10 on the numeric pain scale. Goal partially met.
2. Impaired gas exchange related to decreased perfusion to lung tissues caused by obstruction in pulmonary vascular bed by embolus as evidenced by dyspnea	Patient has bilateral pulmonary emboli. Goal is that patient will maintain optimal gas exchange during today's 6 hour clinical shift.	1. Assess for signs and symptoms of hypoxia: tachycardia, restlessness, diaphoresis, headache and lethargy or confusion. 2.Use pulse oximetry to continuously monitor oxygen saturation	Patient is alert and oriented x 4. Patient maintained an acceptable oxygen saturation for the entire clinical shift. Patient denies restlessness and diaphoresis. Goal met.
3. Risk for bleeding related to anticoagulant or thrombolytic therapy	Patient has bilateral pulmonary emboli and is taking Lovenox for thrombolytic therapy	1. Monitor platelet counts, coagulation test results, PT, PTT, and H & H 2. Assess for the signs and symptoms of bleeding	Patient displayed no signs or symptoms of bleeding during clinical shift. INR, PT, PTT and H & H were all within defined limits. Goal met.
4. Risk for falls related to the use of assistive devices for mobility	Patient had a right total knee arthroplasty 4 weeks ago. Patient utilizes a	1. Place items used by the patient within easy reach, such as the call light, water, and	Patient remained free from falls during the clinical shift. Staff promptly answered the patient's call light and

	walker for ambulation. Patient exhibits a weak/unsteady gait.	telephone 2. Answer call light immediately	placed personal items within reach. Patient used a walker for safe ambulation. Goal met.

Other References (APA):

Gulanick, M. & Myers, J. L. (2014). *Nursing Care Plans*. (8th ed.). Philadelphia, PA: ELSEVIER

Concept Map (20 Points):

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Subjective Data

Chief complaint: Right-sided chest discomfort and shortness of breath
Patient rates pain 3/10 on numeric pain scale
Patient states she had a syncopal episode at PT
Patient denies pleuritic pain, nausea, diaphoresis and abdominal pain
Patient denies history of blood clots, numbing, tingling, or calf pain

Nursing Diagnosis/Outcomes

1. Ineffective breathing pattern
Outcome: Patient will maintain an effective breathing pattern
2. Impaired gas exchange
Outcome: Patient will maintain optimal gas exchange
3. Risk for bleeding
Outcome: Patient will remain free from bleeding
4. Risk for falls
Outcome: Patient will remain free from falls

Objective Data

D-dimer elevated
CT angiogram chest/pulmonary showed emphysema, extensive bilateral pulmonary emboli, and a 4 mm noncalcified left lower lobe nodule
EKG showed sinus tachycardia
Elevated blood pressure

Patient Information

Patient is a 67-year-old female with a PMHx of breast cancer, HTN, hyperlipidemia, GERD, obesity and osteoarthritis admitted for bilateral pulmonary emboli. The patient's pertinent surgical history includes a right total knee arthroplasty (09/2019)

Nursing Interventions

Assess the patient's respiratory rate, rhythm and depth
Assess the characteristics of pain, especially in association with the respiratory cycle
Assess for signs and symptoms of hypoxia: tachycardia, restlessness, diaphoresis, headache and lethargy or confusion.
Use pulse oximetry to continuously monitor oxygen saturation
Monitor platelet counts, coagulation test results, PT, PTT, and H & H
Assess for the signs and symptoms of bleeding
Place items used by the patient within easy reach, such as the call light, water, and telephone
Answer call lights immediately

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