N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10/14/19	**Patient Initials** P.C.	**Age** 72	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Retired; Farmer	**Marital Status** Married	**Allergies** Morphine, Pneumococcal vaccines, Thimerosal topical – Unknown mild reactions
Code Status Full code	**Height** 70 inches	**Weight** 94.4kg	

Medical History (5 Points)

Past Medical History: Diabetes Mellitus type 2, Hypercholesterolemia, Peripheral Vascular disease, MRSA, Coronary Artery disease, COPD, CHF, Hypertension, Pleural plaque w/o asbestos, Obstructive Sleep Apnea, Dementia, and Angina.

Past Surgical History: Above the knee amputation of the right leg, Cholecystectomy, Cardiac catheterization, Right hip replacement.

Family History: Mother – MI, Heart disease. Father – Brain cancer, MI, Heart disease. Three sisters – All with Heart disease. Two brothers – Both with Heart disease.

Social History (tobacco/alcohol/drugs): Former smoker, 1 pack per day, started at age 17, stopped at age 68. Denies alcohol or substance abuse.

Assistive Devices: Wheelchair, Shower chair, and Grab bars.

Living Situation: Lives at home with his wife.

Education Level: Highschool education.

Admission Assessment

Chief Complaint (2 points): Pt sleeping all night and day without waking up.

History of present Illness (10 points): Pt sent to ER by his wife after she noticed he had been sleeping all day and night without waking up, with potential loss of consciousness. Pt noncompliant w/ CPAP at home. Patient reported no aggravating or relieving factors at the time. No treatments were done prior to hospital admission. Chest X-ray showed complete opacification of the left lung. Pt intubated in the ER to protect airway, before being transferred to CCU. CT of chest showed complete atelectasis of left lung and suspected Pneumonia. Cardiology consulted for increased Troponin and an echocardiogram with contrast was done showing an Ejection Fraction of 45%. A Central line was placed in the pts left femoral artery, indicated through expected long-term pt stay along with need for hydration, frequent labs, and medication administrations. Pt started on Amlodipine and Diltiazem for cardiac issues. Pt started on Zosyn to treat the suspected Pneumonia. Pt extubated on 10/23 and placed on BiPAP. On 10/29 pt weaned from BiPAP onto 50% O2 30L/min high flow. Pt was transferred to a 2nd floor step-down unit on 10/29.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Respiratory failure.

Secondary Diagnosis (if applicable): Pneumonia.

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

Respiratory failure is when fluid builds up in the air sacs, or alveoli, that are in the lungs. Alveoli are where the lungs and the bloodstream exchange of carbon dioxide and oxygen. As the fluids fill up the alveoli, the lungs lose the ability to exchange oxygen into the bloodstream. As the oxygen and CO2 in the body buildup, the body begins to lose the ability to function. Respiratory failure can be caused by COPD, ALS, spinal cord injuries, and inhalation injuries.

Signs and symptoms of respiratory failure include rapid breathing and confusion with high CO2 levels. Low oxygen levels will result in cyanosis, restlessness, and anxiety. Patients may also experience the feeling of sleepiness and loss of consciousness, along with bradypnea and tachycardia. Profuse diaphoresis may also occur in the patient.

Expected findings with respiratory failure include tachypnea, tachycardia, and low O2 saturation. The initial laboratory test involved is an arterial blood gas test to measure O2 and CO2 levels in the blood. After confirming that the patient is in respiratory failure, tests will be done to figure out what caused the respiratory failure. Tests are done to find out what is causing the issue includes a chest X-ray (nhlbi, 2019).

Treatment of the disease includes treating the underlying issue that causes respiratory failure. Conventional treatments include oxygen therapy, tracheostomy, and ventilation to aid with breathing. Medications may be used as well to aid with discomfort and help with breathing. Patients may be given fluids to help with blood flow (MedlinePlus, 2019).

For this patient, signs and symptoms include sleepiness, loss of consciousness, bradypnea, and tachycardia. An ABG was done on this patient to confirm respiratory failure. A chest X-ray was done to figure out what caused the respiratory failure, which showed opacification of the left lung and Pneumonia. A chest CT was done to confirm the Pneumonia and resulted in showing complete atelectasis of the left lung. Treatments for this patient include oxygen therapy, such as BiPAP and high flow. The patient was on ventilation while intubated. Medications to help with respiratory failure include Albuterol and Budesonide.

Pathophysiology References (2) (APA):

Respiratory Failure Lung Disease Lung Problems. (2019, October 18). Retrieved from https://medlineplus.gov/respiratoryfailure.html.

Respiratory Failure. (2019). Retrieved from

https://www.nhlbi.nih.gov/health-topics/respiratory-failure.

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.28-5.56	3.47	3.94	May have low RBC due to poor nutrition intake, along with stress on the body due to fighting off Pneumonia. (RN adult medical surgical nursing, 2016)
Hgb	13.5-17.5	7.6	9.6	May have low Hgb due to poor nutrition intake, along with stress on the body due to fighting off Pneumonia. (RN adult medical surgical nursing, 2016)
Hct	37-48	26.2	30.9	May have low Hct due to poor nutrition intake, along with stress on the body due to fighting off Pneumonia. (RN adult medical surgical nursing, 2016)
Platelets	149-393	305	300	
WBC	4.0-11.7	11.9	8.2	Patient had elevated WBC on admission due to the body fighting off the Pneumonia infection.
Neutrophils	45.3-79.0	82.8	95.3	The body produces neutrophils to fight off an infection. Neutrophils are being used by the body to fight off Pneumonia. (RN adult medical surgical nursing, 2016)
Lymphocytes	11.8-45.9	8.7	2.5	Lymphocytes are produced by the bone marrow to fight off infection. Low Lymphocytes in this patient may be due to patient's poor nutrition intake from a lack of appetite. (RN adult medical surgical nursing, 2016)
Monocytes	4.4-12.0	7.3	2.1	Low Monocytes may be related to patient's poor nutrition intake from a lack of appetite. (RN adult medical surgical nursing, 2016)

Eosinophils	0.0-6.3	0.3	0.3	
Bands	0.0-1.0	1.0	0.1	

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	139	147	Elevated Sodium may be due to poor fluid intake. (RN adult medical surgical nursing, 2016)
K+	3.5-5.1	5.1	3.8	
Cl-	98-107	100	107	
CO2	22-29	33	33	Elevated CO2 related to patient's respiratory distress resulting in poor CO2 release. (RN adult medical surgical nursing, 2016)
Glucose	70-99	158	222	Elevated Glucose is related to patient's diabetes. (RN adult medical surgical nursing, 2016)
BUN	6-20	24	29	
Creatinine	06-1.2	1.51	0.94	Elevated Creatinine due to poor kidney function, may be related to patient's poor fluid intake. (RN adult medical surgical nursing, 2016)

Albumin	8.6-10.4	3.5	N/A	
Calcium	8.6-10.4	8.7	8.7	
Mag	1.6-2.4	41	N/A	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0.0-1.2	0.3	N/A	
Alk Phos	40-130	85	N/A	
AST	0-40	29	N/A	
ALT	0-41	24	N/A	
Amylase	23-85	N/A	N/A	
Lipase	13-60	N/A	N/A	
Lactic Acid	0.5-2.0	N/A	N/A	
Troponin	<0.01	0.374	N/A	Elevated Troponin levels may be from kidney failure, heart failure, or injury of the heart. Unknown what caused elevated Troponin. Elevated Troponin could be related to kidney damage from patient's diabetes and hypertension. (RN adult medical surgical nursing, 2016)
CK-MB	0.0-7.70	3.88	N/A	
Total CK	20-200	41	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	1.16	N/A	May be due to the patient's use of Aspirin. (RN adult medical surgical nursing, 2016)
PT	11.9-15	15.0	N/A	
PTT	22.6-35	33.4	N/A	
D-Dimer	500ng/mL	N/A	N/A	
BNP	0.5-20	N/A	N/A	
HDL	>60	N/A	N/A	
LDL	<100	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	<150	N/A	N/A	
Hgb A1c	<5	N/A	N/A	
TSH	0.4-4.0	N/A	N/A	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow	Hazy yellow	N/A	
pH	4.5-8.0	5.0	N/A	
Specific Gravity	1.002-1.030	1.018	N/A	
Glucose	Normal	Normal	N/A	
Protein	Negative	2+	N/A	Protein in urine may be caused by patients low fluid intake, kidney damage from patient's diabetes or hypertension. (RN adult medical

				surgical nursing, 2016)
Ketones	Negative	Negative	N/A	
WBC	Negative	3	N/A	
RBC	Negative	4	N/A	RBC's in the urine may be due to kidney injury or enlarged prostate in this patient, however the true cause of this is not known to the student. (RN adult medical surgical nursing, 2016)
Leukoesterase	Negative	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	7.35-7.45	7.21	7.39	Patient's low blood pH and other ABG's indicates partially compensated respiratory acidosis. Patient is unable to blow off the excess CO2. (RN adult medical surgical nursing, 2016)
PaO2	75-85	91	90.41	Elevated PaO2 may be related to increased oxygen levels in the inhaled air. (RN adult medical surgical nursing, 2016)
PaCO2	35-45	46.7	47.5	Patient's low blood pH and other ABG's indicates partially compensated respiratory acidosis. Patient is unable to blow off the excess CO2. (RN adult medical surgical nursing, 2016)
HCO3	22-26	27.1	27.4	Patient's CO3 is elevated as the body tries to compensate for patient's respiratory acidosis. (RN adult medical surgical nursing,

				2016)
SaO2	95-98	97	97.8	

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

Lab Correlations Reference (APA): *RN adult medical surgical nursing*. (2016) Retrieved November 1st, 2019

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-ray – Was done to check for any problems with the lungs that may have caused the patient's respiratory depression.

Chest CT - Was done to check for any problems with the lungs that may have caused the patient's respiratory depression, also done to confirm patient's Pneumonia seen on X-ray.

Echocardiogram with contrast – Done due to elevated Troponin level.

Diagnostic Test Correlation (5 points):

X-rays are done to check inside of the body for any issues that may be prevalent. This was done on the patient to specify try and diagnose the underlying cause of the respiratory distress. X-ray showed opacification of the left lung.

CT's are done to achieve a better view of the chest. The CT showed the complete atelectasis of the left lung. CT confirmed the X-rays Pneumonia.

Echocardiogram is an ultrasound of the heart. The contrast was done due to see how the blood is pumped through the heart. The echocardiogram was done for the patient's elevated Troponin level. The result was noticing the ejection fraction of 45%.

Diagnostic Test Reference (APA):

RN adult medical surgical nursing. (2016) Retrieved November 1st, 2019

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

Home Medications (5 required)

Brand/Generic	Albuterol/Pro Air HFA	Budesonide/ Symbicort	Ondansetron/ Zofran	Calcium Carbonate/ Tums	Aspirin/Durlaza
Dose	2.5mg	4.5mcg, 2 puffs	8mg	500mg	81mg
Frequency	QID	BID	TID	QID PRN when experiencing heartburn.	QD
Route	Inhalation	Inhalation	PO	PO	PO
Classification	Bronchodilator	Corticosteroid	Antiemetic	Antacid.	NSAID
Mechanism of Action	Albuterol is a selective beta2-adrenergic receptor agonist with pharmacologi	Budesonide is an inhaled corticosteroid (ICS) that works by reducing and	Serotonin antagonist that blocks serotonin receptors.	This drug treats calcium deficiency through supplement	Both aspirin and salicylate have pharmacologic activity, but only aspirin has antiplatelet effect.

	cal properties and therapeutic indications like terbutaline.	preventing respiratory tract inflammation		ation and neutralizes gastric acid to treat heartburn and indigestion.	
Reason Client Taking	COPD	COPD	Stop nausea/vomiting.	Heartburn.	Generalized pain and aches.
Contraindications (2)	Bronchospasm from previous use of this medication. Cardiovascular disease	Intensive treatment of COPD or asthma Allergy to corticoid steroids	Hepatic impairment. Hypersensitivity to this medication.	Do not use if patient has hypercalcemia or hypercalciuria. Severe renal failure.	Active gastric or duodenal ulcers. Severe renal or hepatic impairment.
Side Effects/Adverse Reactions (2)	Tremors Tachycardia	Nasopharyngitis Back pain	Hypoxia. Fever.	Hypercalcemia. Pruritus.	Increased bleeding tendencies. Dyspepsia.
Nursing Considerations (2)	Monitor heart rate for tachycardia Monitor peak flow/pulmonary function tests	Monitor peak flow/ pulmonary function tests Monitor blood pressure for hypertension	Obtain an ECG prior to starting and while taking. Patients older than 65 may have more side effects.	Observe patient for symptoms of hypercalcemia. Patients with mild hypercalciuria should undergo periodic plasma and urine calcium excretion tests.	Do not use more than 12 tablets in an hour. Monitor for bleeding.
Key Nursing	Do not	If patient is	If patient has	Assess for	Do not give if

Assessment(s) Prior to Administration	administer if pt has sudden worsening of breathing problems or wheezing.	having bronchospasms do not use.	vision loss, or trouble breathing do not administer this medication.	chest pain, shoulder pain, dizziness, and sweating.	patient has signs of intestinal bleeding.
Client Teaching needs (2)	Shake well before use Close after each use.	Never wash your inhaler Shake well before use	Do not drive if this medication makes you dizzy or drowsy. Do not flush this medication if you stop taking it. Contact healthcare provider for best disposal method.	Tell your doctor if you have a kidney disease, or history of kidney stones. Check the label of your calcium carbonate product to see if it should be taken with or without food.	Visit your doctor immediately if you experience bloody stools. Limit alcohol consumption while taking this drug due to increased risk of bleeding with combined use.

Hospital Medications (5 required)

Brand/Generic	Amlodipine/ Norvasc	Piperacillin and Tazobactam/ Zosyn	Diltiazem/ Cardizem	Metoprolol/ Lopressor	Ranitidine/Zantac
Dose	10mg	3.375g	120mg	5mg	150mg
Frequency	QD	Q6H	QD	Q6H	HS
Route	PO	IV drip	PO	IV Push	PO

Classification	Calcium Channel Blocker	Penicillin	Calcium Channel Blocker	Beta Blocker	Histamine-2 blocker
Mechanism of Action	Inhibits influx of calcium into cells. Decreases BP.	Inhibits cell-wall synthesis during bacterial multiplication	Inhibits influx of calcium into cells. Decreases BP.	Beta2-adrenoreceptor blocking agent.	Competitive, reversible inhibitor of the action of histamine at the histamine H_2 receptors found in gastric parietal cells. This results in decreased gastric acid secretion and gastric volume, and reduced hydrogen ion concentration.
Reason Client Taking	Hypertension	Patient taking to treat Pneumonia.	Angina.	Hypertension	Heartburn.
Contraindications (2)	Hypersensitivity to this medication. If patient is in shock.	Bleeding tendencies. Patients with uremia.	Do not give with St. John's wort. Do not give with Rifampin.	Myocardial Infarction. Hypersensitivity to beta blockers.	Porphyria. Liver problems.
Side Effects/Adverse Reactions (2)	Drowsiness Flushing	Arrhythmias can develop. Nausea, vomiting and diarrhea are common side effects	Dizziness. Nausea.	Chest pain, Light-headedness.	Constipation. Vomiting.
Nursing Considerations (2)	Do not give with dantrolene. Watch for peripheral edema.	Monitor patient for any skin reactions that could occur. May increase serum sodium levels due to sodium in	Do not take with alcohol or marijuana. Place under tongue, do not chew, split, or crush tablets.	Check blood pressure. Monitor for signs of CHF.	Monitor for confusion in older clients. Do not give with azole antifungals.

		drug.			
Key Nursing Assessment(s) Prior to Administration	Assess for worsening chest pain prior to administration.	Assess patients heart rhythm before starting and continue monitoring after.	If blood pressure is very low do not give.	Check blood pressure prior to administration.	Monitor for chest pain while taking this medication.
Client Teaching needs (2)	Signs of hypersensitivity. Signs of hypotensive crisis.	Tell patient to report discomfort at the IV site. Advise patients to report any adverse reactions to the provider.	Advise patient to avoid large amounts of grapefruit juice. Tell patient to wear sunscreen when going outside.	Take as prescribed. May cause mental confusion.	Take 30-60 minutes before eating or drinking foods that cause indigestion. Swallow the tablet whole without chewing.

Medications Reference (APA):

2018 *nurses drug handbook*. (2017). Burlington: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:**	Patient was A&O times 4. Patient did not appear to be distressed and commented that he was relaxed. Overall appearance, patient was clean and groomed.

Overall appearance:	
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 13 **Drains present: Y☐ N ☒** **Type:**	Skin is pink and warm to the touch. No cyanosis or pallor noted. Patient has appropriate skin turgor. No rashes, bruises, or wounds upon inspection. Braden score of 13. No drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head: Normocephalic and atraumatic. Ears: No discharge noted. Hearing intact. No tenderness noted. Eyes: Pupils are equal, round, reactive to light and accommodation. Conjunctiva/cornea clear with no abrasions. Nose: Nares patent. Septum midline. Mucosa is moist. Sense of smell intact. Teeth: Teeth are intact. Mouth is moist.
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:**	S1 and S2 sounds heard. Normal sinus rhythm. No rubs, murmurs, or gallops noted. Patient does not have neck vein distension or any noticeable edema upon inspection. Capillary refill less than 3 seconds. Peripheral pulses noted at dorsalis pedis and radial, both graded at a 3+.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	No accessory muscle use when breathing. Lung sounds auscultated in all lobes bilaterally posterior and anteriorly. Lung sounds are diminished, especially in the left lung. Respiration rate is 20. Patient on high-flow 50% O2 30L/min.

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:**	Patient is on a regular diet at home and in the hospital. Height is 70 inches, weight is 94.4kg. Abdomen is round, soft, and non-tender. Patient is passing flatus. No pain or masses noted on palpation. No distension, incisions, drains, wounds, or scars noted other than scar from previous Cholecystectomy. Patient does not have an ostomy, nasogastric, or feeding tube. Last bowel movement was on 10/25. Patient has normoactive bowel sounds in all 4 quadrants upon auscultation.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	Urine is hazy yellow, with no notable odor. Patient has a Foley catheter inserted, the output on this shift was 200mL. Catheter size in a 14 French. CAUTI prevention measures are catheter care every 4 hours. Patient is not on dialysis. No skin breakdown of the genitals, genitals are intact.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk ☐**	Patient has poor range of motion. Patient has no gait as he had his right leg amputated and has no prosthesis, instead uses a wheelchair to get around. Patient has grab bars and shower chair. Patient has poor strength, but it is equal in both arms and legs. Patient can barely lift cup up to his lips. Fall score is 50.

NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Pupils are equal, round, reactive to light and accommodating. Patient struggles to move his extremities. Strength is equal, but minimal. A&O times 4. Mental status is intact, patient holds conversations and makes jokes. Speech intact, sentences make sense. Patient is conscious.
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's coping methods are through talking to his wife. Patient is Baptist, his relationship means a lot to him as it provides comfort. Patient lives at home with his wife. Patient reports feeling safe at home.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	92	142/87	20	36.7	94%
1100	90	145/87	19	36.7	93%

Vital Sign Trends/Correlation:

The patient is slightly hypertensive. Patient is on medication to bring down his blood pressure.

Oxygen is on the lower side but still within normal O2 levels of 93-100%.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric pain scale	General pain	0/10	Patient reports no pain.	N/A

1100	Numeric pain scale	General pain	0/10	Patient reports no pain.	N/A

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	
Other Lines (PICC, Port, central line, etc.)	
Type: Central line **Size:** N/A **Location:** Left femoral artery. **Date of insertion:** 10/14/19 **Patency:** Line is patent. **Signs of erythema, drainage, etc.:** No signs of erythema or drainage. **Dressing assessment:** Dressing is clean. **Date on dressing:** 10/25 **CUROS caps in place: Y ☐ N ☒** **CLABSI prevention measures:** Dressing changes and wiping with alcohol before usage.	Zosyn 3.375g Q6H

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
8oz	200mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was given a bath. Given a cup of Sprite. Catheter care completed. Accu-check completed.

Procedures/testing done: N/A

Complaints/Issues: N/A

Vital signs (stable/unstable): Vitals are stable, mild hypertension.

Tolerating diet, activity, etc.: Patient has no appetite. No activity being done.

Physician notifications: N/A

Future plans for patient: Patient to be transferred to 2nd floor step-down unit.

Discharge Planning (2 points)

Discharge location: To home with his wife.

Home health needs (if applicable): May need a caretaker at home.

Equipment needs (if applicable): Already has a wheelchair, grab bars, and shower chair at home. No new equipment needed.

Follow up plan: Patient should follow up to provider if any new issues arise upon discharge.

Education needs: Patient should receive education on Pneumonia prevention and information to help control his diabetes.

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. Risk for impaired gas related to respiratory failure exchange as evidenced by patient's hospitalization for poor oxygenation and respiratory acidosis.	Patient has atelectasis of the left lung that has contributed to respiratory failure and respiratory acidosis.	**1.** Educate patient on deep breathing tactics such as turning and coughing. **2.** Patient will use incentive spirometer to help prevent further atelectasis.	Patient is education on deep breathing tactics such as turning and coughing, declines to do so. Patient educated on the use of an incentive spirometer, patient declines to use it.
2. Non-compliance related to not taking his meds at home as evidenced by patient stating he has not been taking his home meds or CPAP.	Patient has not been taking his medications at home, or using his CPAP machine, these all are attributes that may contribute to his current medical problems.	**1.** Educate patient on importance of compliance. **2.** Seek ways to ensure access to medications and appointments after discharge.	Patient will make a better attempt to keep complaint with his medications and appointments. Accommodations for medications and appointments to be done prior to discharge, to help patient remain compliant.
3. Risk for	Patient has been	**1.** Look for	Patient shows no physical

imbalanced nutrition related to lack of appetite as evidenced by patient stating he is not hungry.	refusing to eat due to not having an appetite.	physical signs of poor nutrition intake. **2.** Assess patient's ability to feed themselves.	signs of poor nutritional intake other than no appetite for several days, and no bowel movements for 4 days. Patient can feed himself but may require help as it is tiring.
4. Risk for falls related to amputation of right leg and weak muscles as evidence by poor muscle strength and patient not having his right leg.	Patient has very poor muscle control and muscle strength. Patient has had his right leg amputated as well.	**1.** Educate patient on maintaining an uncluttered environment to prevent wheelchair from getting flipped or stuck. **2.** Encourage patient to ask for assistance prior to making any attempt of getting out of bed to his wheelchair.	Patient understood the importance of maintaining an uncluttered environment. Patient is happy to ask for assistance prior to getting up on his own.
5. Deficient knowledge related to Pneumonia as evidenced by patient asking about it.	Patient seemed unsure about what caused his illness. Providing knowledge may help him to seek emergency treatment immediately if it occurs again.	**1.** Patient was told what Pneumonia was and the signs and symptoms. **2.** Patient is to be provided educational materials upon	The patient was taught about Pneumonia and the importance of seeking help immediately if he has symptoms again. Educational material is to be provided at discharge.

		discharge.	

Other References (APA):

Concept Map (20 Points):

Subjective Data

Subjective data for this patient includes 0/10 pain at the time of today's shift. Patient reported feeling sleepy. No other subjective data for this patient.

Nursing Diagnosis/Outcomes

Risk for impaired gas related to respiratory failure exchange as evidenced by patient's hospitalization for poor oxygenation and respiratory acidosis.
Non-compliance related to not taking his meds at home as evidenced by patient stating he has not been taking his home meds or CPAP.
Risk for imbalanced nutrition related to lack of appetite as evidenced by patient stating he is not hungry.
Risk for falls related to amputation of right leg and weak muscles as evidence by poor muscle strength and patient not having his right leg.
Deficient knowledge related to Pneumonia as evidenced by patient asking about it.
Outcomes:
Patient is education on deep breathing tactics such as turning and coughing, declines to do so.
Patient educated on the use of an incentive spirometer, patient declines to use it.
Patient will make a better attempt to keep complaint with his medications and appointments.
Accommodations for medications and appointments to be done prior to discharge, to help patient remain compliant.
Patient shows no physical signs of poor nutritional intake other than no appetite for several days, and no bowel movements for 4 days.
Patient can feed himself but may require help as it is tiring.
Patient understood the importance of maintaining an uncluttered environment.
Patient is happy to ask for assistance prior to getting up on his own.
The patient was taught about Pneumonia and the importance of seeking help immediately if he has symptoms again.
Educational material is to be provided at discharge.

Objective Data

Objective data on this patient includes sleepiness and loss of consciousness on 10/14/19. A chest X-ray showed opacification of the left lung and Pneumonia. A chest CT showed atelectasis of the left lung along with Pneumonia. Labs show Respiratory Acidosis, indicating respiratory failure. Patient was hypertensive at the time of this shift.

Patient Information

72-year-old male with excessive sleepiness and potential loss of consciousness was brought to the ER by his wife on 10/14/19. Patient was intubated and sent to CCU for respiratory failure with Pneumonia.

Nursing Interventions

Educate patient on deep breathing tactics such as turning and coughing.
Patient will use incentive spirometer to help prevent further atelectasis.
Educate patient on importance of compliance.
Seek ways to ensure access to medications and appointments after discharge.
Look for physical signs of poor nutrition intake.
Assess patient's ability to feed themselves.
Educate patient on maintaining an uncluttered environment to prevent wheelchair from getting flipped or stuck.
Encourage patient to ask for assistance prior to making any attempt of getting out of bed to his wheelchair.
Patient was told what Pneumonia was and the signs and symptoms.
Patient is to be provided educational materials upon discharge.