

N321 Care Plan #1

Lakeview College of Nursing

Morgan Drennan

**Demographics (3 points)**

<b>Date of Admission</b> 1/19/2020	<b>Patient Initials</b> BS	<b>Age</b> 75	<b>Gender</b> Female
<b>Race/Ethnicity</b> Non-Hispanic white	<b>Occupation</b> Rantoul Products	<b>Marital Status</b> married	<b>Allergies</b> Codeiene, Fenofibrate (rash), Neosporin (rash), oxycodone
<b>Code Status</b> Full	<b>Height</b> 5' 0"	<b>Weight</b> 122lb 11.2 oz (55.7 kg)	

**Medical History (5 Points)**

**Past Medical History:** skin cancer, hyperlipidemia, hypertension, history of heart block, degenerative disc disease, degenerative joint disease of lumbar spine

**Past Surgical History:** Thyroidectomy, hysterectomy, cholecystectomy, cataract removal, cardiac pacemaker placement

**Family History:** none known

**Social History (tobacco/alcohol/drugs):** cigarette smoker (everyday) ¼ pack every day for 50 years, no alcohol or substance abuse

**Assistive Devices:** gait belt while at hospital but none at home

**Living Situation:** personal home with her husband

**Education Level:** GED

**Admission Assessment**

**Chief Complaint (2 points):** Dyspnea

**History of present Illness (10 points):** The patient had an onset of dyspnea on January 10<sup>th</sup> 2020, the feeling of shortness of breath is bilateral and equal. The dyspnea had lasted 10

days before the patient came to the hospital. The patient states that she “felt like I couldn’t catch my breath” and that feeling was occurring all the time. The use of her inhaler relieved it slightly, but not much. The hospital gave her a nebulizer treatment and then diagnosed her with COPD.

### Primary Diagnosis

**Primary Diagnosis on Admission (2 points): COPD**

**Secondary Diagnosis (if applicable): Acute Systolic Congestive Heart Failure**

**Pathophysiology of the Disease, APA format (20 points):** COPD is caused by the loss of elasticity and overexpansion of the alveoli and bronchial tubes, this causes air to be trapped in the lungs because the lungs cannot expel it. This can be caused by emphysema, chronic bronchitis, and smoking. In the case of this patient the COPD is most likely related to her smoking.

**Pathophysiology References (2) (APA):**

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Mayo Clinic Staff. (2017, August 11). *COPD*. Retrieved from:

<https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679>

### 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	4.2-5.4	4.22	4.5	

<b>Hgb</b>	<b>12-16</b>	<b>13.7</b>	<b>14.7</b>	
<b>Hct</b>	<b>37-47</b>	<b>40.6</b>	<b>42.6</b>	
<b>Platelets</b>	<b>150,000-400,000</b>	<b>273,000</b>	<b>250,000</b>	
<b>WBC</b>	<b>5-10x10<sup>9</sup></b>	<b>9.4x10<sup>9</sup></b>	<b>10.50x10<sup>9</sup></b>	<b>Aspirin can increase her WBC's</b>
<b>Neutrophils</b>	<b>55-70</b>	<b>58.9</b>	<b>N/A</b>	
<b>Lymphocytes</b>	<b>20-40</b>	<b>29.9</b>	<b>n/a</b>	
<b>Monocytes</b>	<b>2-8</b>	<b>5.9</b>	<b>n/a</b>	
<b>Eosinophils</b>	<b>1-4</b>	<b>4.0</b>	<b>n/a</b>	
<b>Bands</b>		<b>n/a</b>	<b>n/a</b>	

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

<b>Lab</b>	<b>Normal Range</b>	<b>Admission Value</b>	<b>Today's Value</b>	<b>Reason For Abnormal</b>
<b>Na-</b>	<b>136-145</b>	<b>135</b>	<b>138</b>	<b>Decreased sodium intake in diet</b>
<b>K+</b>	<b>3.5-5.0</b>	<b>3.1</b>	<b>3.7</b>	<b>The K+ became diluted upon patient being put on 0.9% saline</b>
<b>Cl-</b>	<b>98-106</b>	<b>97</b>	<b>100</b>	<b>Congestive Heart Failure or over hydration from 0.9% saline</b>
<b>CO2</b>	<b>23-30</b>	<b>27</b>	<b>29</b>	
<b>Glucose</b>	<b>&gt;200</b>	<b>136</b>	<b>95</b>	
<b>BUN</b>	<b>7-25</b>	<b>25</b>	<b>22</b>	
<b>Creatinine</b>	<b>0.5-1.1</b>	<b>0.94</b>	<b>0.90</b>	
<b>Albumin</b>	<b>3.5-5.7</b>	<b>n/a</b>	<b>n/a</b>	
<b>Calcium</b>	<b>9-10.5</b>	<b>7.9</b>	<b>8.7</b>	<b>Vitamin D deficiency and her thyroid was removed.</b>
<b>Mag</b>	<b>1.3-2.1</b>	<b>n/a</b>	<b>n/a</b>	

<b>Phosphate</b>	<b>3.0-4.5</b>	<b>n/a</b>	<b>n/a</b>	
<b>Bilirubin</b>	<b>0.3-1.0</b>	<b>n/a</b>	<b>n/a</b>	
<b>Alk Phos</b>	<b>30-120</b>	<b>72</b>	<b>n/a</b>	
<b>AST</b>	<b>0-35</b>	<b>n/a</b>	<b>n/a</b>	
<b>ALT</b>	<b>4-36</b>	<b>n/a</b>	<b>n/a</b>	
<b>Amylase</b>	<b>60-120</b>	<b>n/a</b>	<b>n/a</b>	
<b>Lipase</b>	<b>0-160</b>	<b>n/a</b>	<b>n/a</b>	
<b>Lactic Acid</b>	<b>5-20</b>	<b>n/a</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>n/a</b>	<b>n/a</b>	
<b>PT</b>		<b>n/a</b>	<b>n/a</b>	
<b>PTT</b>		<b>n/a</b>	<b>n/a</b>	
<b>D-Dimer</b>		<b>n/a</b>	<b>n/a</b>	
<b>BNP</b>		<b>n/a</b>	<b>n/a</b>	
<b>HDL</b>		<b>n/a</b>	<b>n/a</b>	
<b>LDL</b>		<b>n/a</b>	<b>n/a</b>	
<b>Cholesterol</b>		<b>n/a</b>	<b>n/a</b>	
<b>Triglycerides</b>		<b>n/a</b>	<b>n/a</b>	
<b>Hgb A1c</b>		<b>n/a</b>	<b>n/a</b>	
<b>TSH</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		n/a	n/a	
pH		n/a	n/a	
Specific Gravity		n/a	n/a	
Glucose		n/a	n/a	
Protein		n/a	n/a	
Ketones		n/a	n/a	
WBC		n/a	n/a	
RBC		n/a	n/a	
Leukoesterase		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	
Blood Culture		n/a	n/a	
Sputum Culture		n/a	n/a	
Stool Culture		n/a	n/a	

Lab Correlations Reference (APA):

Pagana & Pagana. (2010). *Mosby's: Manual of Diagnostic and Laboratory Tests* (4<sup>th</sup> ed.) Elsevier.

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):** Chest X-Ray single view, chest X-Ray 2 views, CT

Angio of chest

**Diagnostic Test Correlation (5 points):** view of pacemaker placement and view of how well the pacemaker is working

**Diagnostic Test Reference (APA):**

Mayo Clinic Staff. (2017). *CT Coronary Angiogram*. Retrieved from:

<https://www.mayoclinic.org/tests-procedures/ct-coronary-angiogram/about/pac-20385117>

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

**Home Medications (5 required)**

<b>Brand/Generic</b>	Aspirin	albuterol	Simvastatin (Zocor)	Levothyroxine	Cholecalciferol (vitamin D3)
<b>Dose</b>	81 mg	1 puff	20mg	112 mcg	10mcg
<b>Frequency</b>	PRN	PRN	Nightly	daily	Daily
<b>Route</b>	PO	INH	PO	PO	PO
<b>Classification</b>	Anti-inflammatory, antiplatelet, antipyretic	Bronchodilator	Antihyperlipidemic	Thyroid hormone replacement	vitamins
<b>Mechanism of Action</b>	Blocks prostaglandin production	Relaxes bronchial smooth-muscle and	Forms mevalonic acid that interrupts the pathway that is	Replaces endogenous thyroid hormone that	Binds with intracellular receptors that function as

	<b>which blocks swelling and pain</b>	<b>inhibit histamine release</b>	<b>necessary for cholesterol synthesis</b>	<b>may control DNA transcription and protein synthesis</b>	<b>transcription factors to modulate gene expression</b>
<b>Reason Client Taking</b>	<b>Mild pain</b>	<b>Dyspnea</b>	<b>Hyperlipidemia</b>	<b>Her thyroid has been removed</b>	<b>Vitamin D deficiency</b>
<b>Contraindications (2)</b>	<b>Asthma, bleeding problems</b>	<b>Allergic to albuterol, allergic to albuterol's component</b>	<b>Active hepatic disease, allergic to simvastatin</b>	<b>Acute MI, allergic to levothyroxine</b>	<b>Interacts with levothyroxine, interacts with simvastatin</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>Bronchospasm, leukopenia</b>	<b>Hypertension, pulmonary edema</b>	<b>Cataracts, upper respiratory infection</b>	<b>Heart failure, dyspnea</b>	<b>Dyspnea, chest pain</b>
<b>Nursing Considerations (2)</b>	<b>Advise patient to take with food, advise patient to not take ibuprofen</b>	<b>Observe patients with cardiac issues because albuterol can worsen conditions, monitor K<sup>+</sup> levels for hypokalemia</b>	<b>Obtain liver enzymes before administering, Use cautiously in elderly and people with hepatic or renal impairment</b>	<b>The capsules must be swallowed whole, monitor PT of patient who is receiving anticoagulants</b>	
<b>Brand/Generic</b>	<b>Enoxaparin (lovenox)</b>	<b>Levothyroxine (Synthroid)</b>	<b>Ondansetron (Zofran)</b>	<b>Bisacodyl (Dulcolax)</b>	<b>furosemide (Lasix)</b>
<b>Dose</b>	<b>40 mg</b>	<b>112 mcg</b>	<b>4 mg</b>	<b>5 mg</b>	<b>20 mg</b>
<b>Frequency</b>	<b>Daily</b>	<b>Daily before breakfast</b>	<b>Every 6 hrs PRN</b>	<b>2x daily PRN</b>	<b>daily</b>
<b>Route</b>	<b>SC</b>	<b>PO</b>	<b>IV</b>	<b>PO</b>	<b>PO</b>
<b>Classification</b>	<b>antithrombotic</b>	<b>Thyroid hormone replacement</b>	<b>Antiemetic</b>	<b>Stimulant laxatives</b>	<b>Antihypertensive, diuretic</b>
<b>Mechanism of Action</b>	<b>Inactivates clotting factors</b>	<b>Replaces endogenous hormone that may control DNA transcription and protein</b>	<b>Reduces nausea and vomiting by preventing serotonin release</b>	<b>Stimulates peristalsis</b>	<b>Inhibits Na and water reabsorption which increases urine formation</b>

		synthesis			
<b>Reason Client Taking</b>	<b>Prevent blood clots</b>	<b>Her thyroid was removed</b>	<b>nausea</b>	<b>constipation</b>	<b>Hypertension</b>
<b>Contraindications (2)</b>	<b>Active major bleeding, hypersensitivity to benzyl alcohol</b>	<b>Allergic to levothyroxine, uncorrected adrenal insufficiency</b>	<b>Concomitant use of apomorphine, allergic to ondansetron</b>	<b>Intestinal obstruction, appendicitis</b>	<b>Allergic to furosemide, anuria unresponsive to furosemide</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>CHF, pulmonary embolism</b>	<b>Angina, weight gain or loss</b>	<b>Hypotension, dyspnea</b>	<b>Diarrhea, nausea</b>	<b>Elevated cholesterol, tachycardia</b>
<b>Nursing Considerations (2)</b>	<b>Do not give drug by IM injection, use extreme caution for those with increased risk of hemorrhage</b>	<b>Use cautiously with patients with an underlying heart disease because it can increase contractility, have patient take with food is taking PO</b>	<b>Monitor patient closely for signs of hypersensitivity, know if hypokalemia or hypomagnesemia is present so it can be corrected before administration</b>	<b>Hypersensitivity to Bisacodyl, Check for an obstruction or severe impaction.</b>	<b>Obtain patients weight before administering, give the drug in the morning so the patients sleep won't be interrupted by the need to urinate</b>

**Medications Reference (APA):**

(2019). *Nurse's Drug Handbook*. (18<sup>th</sup> ed.). Jones & Bartlett.

**Assessment**

**Physical Exam (18 points)**

<b>GENERAL (1 point):</b> Alertness: Orientation: Distress: Overall appearance:	<b>AOx3</b> No pain or distress present Well groomed Good dentition
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<p><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:</b>  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>Skin is a pale pink and is intact. There are no open wounds except for where 2 IVs were just recently removed from the right median cubital vein and the left cephalic vein. The patient has bruises from previous IV placement. There are no rashes visible. Skin turgor is as expected for the patients age. Braden score: 23</p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>Head, neck, ears, eyes, and nose are all symmetrical. Dentition is good. Patient does not have any dentures. She has had cataract surgery in the past.</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:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>S1-S4 are present and strong  Peripheral pulses are strong and present  Capillary refill is &lt;3 seconds  The patient does have a pacemaker. There is no edema present</p>
<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>Breath sounds are clear and bilateral in the sitting position</p>
<p><b>GASTROINTESTINAL (2 points):</b>  <b>Diet at home:</b>  <b>Current Diet</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</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></p>	<p>Patient states that she “eats whatever I want in moderation at home”  She is on a low sodium diet at the hospital because of her heart.  Height is 5’0”  Weight is 122 lb 11.2 oz  Bowel sounds are present in Q1-Q4  Last bowel movement was 1/23/2020 (the morning before the assessment) Patient states “it was small”  There was no pain upon palpation.  There was not any distention, incisions, scars, drains, or wounds present on the abdomen</p>

<p><b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	
<p><b>GENITOURINARY (2 Points):</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>Size:</b></p>	<p><b>The urine is pale, yellow</b>  <b>The urine has a low viscosity which is expected</b>  <b>Genitals are pink and moist like the rest of the skin</b></p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>Neurovascular status:</b>  <b>ROM:</b>  <b>Supportive devices:</b>  <b>Strength:</b>  <b>ADL Assistance:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Fall Risk:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input checked="" type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p><b>AOx3</b>  <b>Patient’s ROM is intact and she can move very well and independently</b>  <b>A gait belt is used in the hospital but there are no assistive devices needed at home</b>  <b>Strength is equal on both sides in the legs and arms</b>  <b>Fall Score: 5</b></p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b>  <b>Mental Status:</b>  <b>Speech:</b>  <b>Sensory:</b>  <b>LOC:</b></p>	<p><b>AOx3</b>  <b>Patient’s speech is clear and can be understood</b>  <b>The patient’s mental status is positive, she is appears to be happy</b>  <b>The patient has hearing aids that she does not use, but she does has a slight difficulty hearing</b>  <b>There has been no LOC present in the patient</b></p>
<p><b>PSYCHOSOCIAL/CULTURAL (2 points):</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and</b></p>	<p><b>The patient appreciates the professional help that she has received while she was a patient at the hospital. She was happy to be at the hospital.</b>  <b>The patients’ development level is appropriate for her age.</b>  <b>The patient is a devote Methodist and it gives</b></p>

<p><b>available family support):</b></p>	<p><b>her something to believe in</b>  <b>The patient has a husband that was present during her stay at the hospital, she also has a daughter and son-in-law close to her home, she has another daughter and son-in-law in Colorado, grandchildren and three great-grandchildren.</b></p>
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**Vital Signs, 2 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
15:15	68 bpm	103/62	18	97.4 oral	95%
Patient	discharged	At	15:56		

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

Time	Scale	Location	Severity	Characteristics	Interventions
15:15	0-10	n/a	0	n/a	n/a
patient	discharged	at	15:56		

**IV Assessment (2 Points)**

IV Assessment	Fluid Type/Rate or Saline Lock
<p><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></p>	<p>Two 20 gauge IV's                      Right median cubital vein, left cephalic vein                      01/19/2020                      IV's are patent                      Ecchymosis present at IV sites                      Dressing is intact and IV's are in place</p>

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
240 (observed)	195mL (observed)

## **Nursing Care**

### **Summary of Care (2 points)**

**Overview of care: The patient was admitted on 01/19/2020. Patient had shortness of breath and was then diagnosed with COPD. She was given a breathing treatment. She was monitored and discharge on 01/23/2020.**

**Procedures/testing done: Chest X-Ray with two views**

**Complaints/Issues: complaints of shortness of breath upon admission, but upon assessment there were no issues or complaints**

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

**Tolerating diet, activity, etc.: Patient was tolerable of diet and activity, she moved really well within the room prior to discharge**

**Physician notifications: there were no known physician notifications**

**Future plans for patient: Plans for the patient include continuing to use her inhaler when she needs to and following up her primary provider in reference to her shortness of breath.**

### **Discharge Planning (2 points)**

**Discharge location: personal home without additional care**

**Home health needs (if applicable): N/A**

**Equipment needs (if applicable): N/A**

**Follow up plan: The patient should follow up with her primary provider in reference to her dyspnea**

**Education needs:** The patient does not seem to have any educational needs. She understands the medications that she is taking and why she is taking them. She understands what her limits are as well.

**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?</li> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<b>1. Decreased gas exchange related to altered oxygen supply as evidence by patient reporting shortness of breath</b>	<b>This was chosen because the patient’s chief complaint upon admittance was dyspnea.</b>	<b>1. Teach the patient about the effects smoking is having on her lungs</b>  <b>2. monitor pulse oximetry</b>	<b>The patient does not have any desire to quit smoking because she has been smoking for 50 years. The information was taught but the goal of the patient quitting smoking was not met. The patients pulse oximetry was 95%, this what is expected of patients with COPD</b>
<b>2. Risk for excessive clotting as evidence by interrupted venous flow due to decreased mobility.</b>	<b>This was chosen because the patient did not move out of bed as much while admitted to the hospital</b>	<b>1. Instruct the patient to not cross the ankles because it can cause venous stasis</b>  <b>2. administer intermittent pneumatic compression devices to increase blood flow.</b>	<b>The patient responded well to these interventions, she did not cross her feet after education and she liked the compression devices and stated that “it feels like a massage”.</b>
<b>3. Dyspnea due to</b>	<b>This was chosen because the</b>	<b>1. Access respiratory status every 2-4</b>	<b>The patient did not have dyspnea prior to</b>

<p><b>ineffective inspiration and expiration occurring with chronic airflow as evidence by the patients chief complaint</b></p>	<p><b>patient was recently diagnosed with COPD.</b></p>	<p><b>hours, so that changes can be reported promptly</b></p> <p><b>2ausculatate breath sounds every 2-4 hours to listen for changes like wheezing</b></p>	<p><b>discharge and there were no signs of wheezing upon auscultation of the lungs. The patient reacted well to being asked about breathing and was eager to be listened to so she could be discharged.</b></p>
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**Other References (APA): Swearingen, P & Wright, J. (2019). *All in One: Nursing Care Planning Resource*. Elsevier.**

**Concept Map (20 Points):**

### Subjective Data

Patient states that pain is a "0" on a 0-10 scale. She states that she is "very thankful for the professional care that has been received in the hospital".

### Nursing Diagnosis/Outcomes

Decreased gas exchange related to altered oxygen supply as evidence by patient reporting shortness of breath.  
Patient does not want to stop smoking, however her pulse oximetry is in normal range for someone with COPD.

Risk for excessive clotting as evidence by interrupted venous flow due to decreased mobility.  
The patient does not cross her feet interrupting blood flow and appreciated the compression devices because they "feel like a massage".

Dyspnea related to ineffective inspiration and expiration occurring with chronic airflow as evidence by the patients' chief complaint.  
The patient is not experiencing dyspnea prior to discharge and upon auscultation of the lungs there were not any wheezes present. The patient was eager to be assessed so that she could be discharged.

### Objective Data

Pulse: 68 bpm  
BP: 103/62 mmHg  
Resp: 18 breaths/min  
Temp: 97.4 oral  
O2: 95%  
Gait is balanced and steady  
Weight: 122 lbs 11.2 oz.  
Height: 5'0"

### Patient Information

75 y/o white female with the initials BS. Date of admission: 1/19/2020. Martial status: married. Allergies: codeine, fenofibrate, Neosporin, oxycodone Code Status: Full

### Nursing Interventions

Teach the client about how smoking is affecting her body  
Monitoring pulse oximetry  
Instruct the patient not to cross her ankles  
Administer compression devices to increase blood flow  
Access respiratory status every 2-4 hours  
Auscultate lung sounds every 2-4 hours



