

N431 Care Plan #1

Lakeview College of Nursing

Shayla Mitchell

**Demographics (3 points)**

<b>Date of Admission</b> 6 Feb 2020	<b>Patient Initials</b> PP	<b>Age</b> 91	<b>Gender</b> F
<b>Race/Ethnicity</b> White	<b>Occupation</b> Retired	<b>Marital Status</b> Widow	<b>Allergies</b> amiodarone and propoxyphene – reactions are not known
<b>Code Status</b> DNR	<b>Height</b> 162.5 cm	<b>Weight</b> 62.500 kg	

**Medical History (5 Points)**

**Past Medical History:** Atrial Fibrillation, Hypercholesterolemia, Macular Degeneration, Hypertension

**Past Surgical History:** Abdominal Aortic Aneurysm, Cataracts, Cholecystectomy

**Family History:** Diabetes Mellitus (Paternal)

**Social History (tobacco/alcohol/drugs):** Quit tobacco more than 30 years ago. Alcohol – Occasional use now

**Assistive Devices:** Gait belt

**Living Situation:** Home alone

**Education Level:** College

**Admission Assessment**

**Chief Complaint (2 points):** Weakness and Diarrhea

**History of present Illness (10 points):** The 91 y.o. female patient presented to the ED on 2/6/2020 by car with son. The patient has a history of atrial fibrillation, hypercholesterolemia, and hypertension. The patient reports generalized weakness, diarrhea, and inability to drink. The diarrhea started when she was given an antibiotic on January 26, 2020 to treat pneumonia. The patient reports 3-7 episodes per day of diarrhea.

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points):** Community-Acquired Pneumonia

**Secondary Diagnosis (if applicable):** Right-Sided Pleural Effusion

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

Pneumonia is caused by a bacterial, viral, or fungal infection that results in an inflammatory process in the lungs. Pneumonia is an infectious process that is spread by droplets or by contact and is one of the most common causes of death in older adults (Gulanick & Myers, 2017). Risk factors for pneumonia include upper respiratory infections, excessive alcohol intake, depression, cardiac failure, COPD, or postoperative effects of general anesthesia. Pneumonia is a major concern for anyone over the age of 65, anyone who is bedridden, immunocompromised, hospitalized, or is chronically ill. The most common bacteria that causes pneumonia is streptococcus pneumonia. There are three common types of pneumonia. Community acquired, hospital acquired, and ventilator associated pneumonia. Pneumonia that develops outside of the hospital is referred to as CAP or community-acquired. Pneumonia that develops during a hospital stay is considered HAP or hospital acquired. Finally, ventilator pneumonia can be developed by anyone who is using mechanical ventilation for breathing. Treatment is determined by the specific cause, setting, and severity. Antibiotic therapy is usually the go to. If the patient has a responsive immune system then treatment can be maintained in the outpatient setting. Signs of pneumonia include cough with phlegm, fever, chills, and difficulty breathing.

Pleural effusion is accumulation of fluid in the pleural cavity. The pleura are thin membranes that line the lungs and inside of the chest cavity and act to lubricate and facilitate breathing (“Pleural Effusion: Heart & Vascular Institute Overview”, 2018). Signs of pleural

effusion include cough, sharp chest pain, or shortness of breath. Treatment is centered around antibiotic and diuretic therapy.

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

Gulanick, M., & Myers, J. L. (2017). Nursing care plans: diagnoses, interventions, & outcomes. St. Louis, MO: Elsevier.

Pleural Effusion: Heart & Vascular Institute Overview. (2018). Retrieved from <https://my.clevelandclinic.org/health/diseases/17373-pleural-effusion-causes-signs--treatment>

**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	3.58	n/a	Low due to patients infection of pneumonia
Hgb	11.3-15.2	10.0	n/a	Low due to patients infection of pneumonia
Hct	33.2-45.3	30.2%	n/a	Low due to patients infection of pneumonia
Platelets	149-393	351	n/a	The patient did not have labs drawn for today's value
WBC	4-11.7	7.0	n/a	The patient did not have labs drawn for today's value
Neutrophils	2.4-8.4	89.1%	n/a	High due to patients infection of pneumonia
Lymphocytes	11.8-45.9	7.2%	n/a	Low due to patients infection of pneumonia
Monocytes	4.4-12	2.7%	n/a	The patient did not have labs drawn for today's value
Eosinophils	0-6.3	0.1%	n/a	Low due to patients infection of pneumonia
Bands	0.1.0	n/a	n/a	The patient did not have labs drawn for today's value

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	136	n/a	The patient did not have labs drawn for today's value
K+	3.5-5.1	4.5	n/a	The patient did not have labs drawn for today's value
Cl-	98-107	103	n/a	The patient did not have labs drawn for today's value
CO2	21-31	26	n/a	The patient did not have labs drawn for today's value
Glucose	74-109	138	n/a	Patient had not been able to eat/drink due to weakness. The patient does not have a hx of diabetes.
BUN	7-25	15	n/a	The patient did not have labs drawn for today's value
Creatinine	0.5-0.9	0.80	n/a	The patient did not have labs drawn for today's value
Albumin	3.5-5.2	3.9	n/a	The patient did not have labs drawn for today's value
Calcium	8.6-10.3	9.5	n/a	The patient did not have labs drawn for today's value
Mag	1.5-2.5	1.7	n/a	The patient did not have labs drawn for today's value
Phosphate	35-105	n/a	n/a	The patient did not have labs drawn for today's value
Bilirubin	0.3-1.0	0.3	n/a	The patient did not have labs drawn for today's value
Alk Phos	20-140	56	n/a	The patient did not have labs drawn for today's value
AST	0-32	19	n/a	The patient did not have labs drawn for today's value
ALT	0-33	14	n/a	The patient did not have labs drawn for today's value
Amylase	23-85	n/a	n/a	The patient did not have labs drawn for today's value

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<b>Lipase</b>	0-160	n/a	n/a	The patient did not have labs drawn for today's value
<b>Lactic Acid</b>	0.5-1.0	n/a	n/a	The patient did not have labs drawn for today's value
<b>Troponin</b>	0-.0.4	0.010	n/a	The patient did not have labs drawn for today's value
<b>CK-MB</b>	3-5%	n/a	n/a	The patient did not have labs drawn for today's value
<b>Total CK</b>	<b>22-198</b>	n/a	n/a	The patient did not have labs drawn for today's value

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
<b>INR</b>	0.86-1.14	<b>3.04</b>	n/a	Patient is on coumadin therapy
<b>PT</b>	11.9-15.0	<b>31.3</b>	n/a	Patient is on coumadin therapy
<b>PTT</b>	22.6-35.3	<b>66.3</b>	n/a	Patient is on coumadin therapy
<b>D-Dimer</b>	<0.50	n/a	n/a	The patient did not have labs drawn for today's value
<b>BNP</b>	<100	n/a	n/a	The patient did not have labs drawn for today's value
<b>HDL</b>	23-92	n/a	n/a	The patient did not have labs drawn for today's value
<b>LDL</b>	<100	n/a	n/a	The patient did not have labs drawn for today's value
<b>Cholesterol</b>	<130	n/a	n/a	The patient did not have labs drawn for today's value
<b>Triglycerides</b>	0-149	n/a	n/a	The patient did not have labs drawn for today's value
<b>Hgb A1c</b>	< = 6.4	n/a	n/a	The patient did not have labs drawn for today's value
<b>TSH</b>	0.45-5.33	n/a	n/a	The patient did not have labs drawn for today's value

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

Lab Test	Normal	Value on	Today's	Reason for Abnormal
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	Range	Admission	Value	
<b>Color &amp; Clarity</b>	Yellow/ Clear	Yellow/ Clear	n/a	The patient did not have labs drawn for today's value
<b>pH</b>	4.5-8.0	6.0	n/a	The patient did not have labs drawn for today's value
<b>Specific Gravity</b>	1.010-1.030	1.008	n/a	The patient did not have labs drawn for today's value
<b>Glucose</b>	0 – 0.8	Negative	n/a	The patient did not have labs drawn for today's value
<b>Protein</b>	0-20mg/dL	Negative	n/a	The patient did not have labs drawn for today's value
<b>Ketones</b>	Negative	Negative	n/a	The patient did not have labs drawn for today's value
<b>WBC</b>	Negative	4/HPF	n/a	The patient did not have labs drawn for today's value
<b>RBC</b>	Negative	1/HPF	n/a	The patient did not have labs drawn for today's value
<b>Leukoesterase</b>	Negative	1 +	n/a	The patient did not have labs drawn for today's value

**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
<b>pH</b>	7.35-7.45	n/a	n/a	Labs not performed
<b>PaO2</b>	80-100	n/a	n/a	Labs not performed
<b>PaCO2</b>	35-45	n/a	n/a	Labs not performed
<b>HCO3</b>	22-28	n/a	n/a	Labs not performed
<b>SaO2</b>	95-100	n/a	n/a	Labs not performed

**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
<b>Urine Culture</b>	Negative	<b>Positive</b>	n/a	Enterococcus Faecalis
<b>Blood Culture</b>	Negative	Negative	n/a	The patient did not have labs drawn for today's value
<b>Sputum Culture</b>	Negative	Negative	n/a	The patient did not have labs drawn

				for today's value
<b>Stool Culture</b>	Negative	Negative	n/a	The patient did not have labs drawn for today's value

**Lab Correlations Reference (APA): (Medical Chart, February 10, 2020)**

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):** Chest CT with contrast

Brain CT without contrast

**Diagnostic Test Correlation (5 points):** Chest CT was within normal limits and no acute intracranial abnormality on brain CT

**Diagnostic Test Reference (APA):** (Medical Chart, February 10, 2020).

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

**Home Medications (5 required)**

<b>Brand/Generic</b>	Warfarin/ Coumadin	Lipitor/ Atorvastatin	Augmentin/ Amoxicillin	Digoxin/ Digox	Cardizem/ diltiazem
<b>Dose</b>	2mg	20mg	875mg	0.125mg	180mg
<b>Frequency</b>	Daily	HS	Q12hour	Daily	Daily
<b>Route</b>	PO	PO	PO	PO	PO
<b>Classification</b>	Anticoagulant	Lipid-Lowering Agent	Antibiotic	Cardiac glycosides	Calcium channel blocker
<b>Mechanism of Action</b>	Interferes with clotting factor synthesis by inhibition of the C1enzyme	Inhibits rate- limiting step in cholesterol	Treats different infections from becoming resistant to amoxicillin	Helps make the heart beat stronger and with a more regular	Relaxes the muscles of the heart and blood vessels

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				rhythm	
<b>Reason Client Taking</b>	Atrial fibrillation puts client at risk for clotting	hypercholesterol emia	Pneumonia to fight bacterial infection	Atrial fibrillation	Hypertension
<b>Contraindications (2)</b>	Hemorrhagic tendencies Lower doses may be warranted in the elderly	Liver dysfunction Pregnancy	Penicillin allergy Severe kidney disease	Ventricular Fibrillation Kidney disease	Sick sinus syndrome  Second-or-third degree AV block
<b>Side Effects/Adverse Reactions (2)</b>	Abdominal pain Pruritis	Diarrhea Arthralgia	Severe stomach pain Diarrhea that is watery or bloody	Nausea Fast or slow heart rate	Slow heartbeats  Light-headed feeling; like you might pass out
<b>Nursing Considerations (2)</b>	For IV administration administer over 1-2 minutes Assess for signs of bleeding	Withhold or discontinue if signs of myopathy Report increased HbA1C levels with statin intake	Advise patient to take at the start of a meal to reduce stomach upset  Patients symptoms may improve before infection is completely cleared	Assess HR at apical pulse for one full minute  Assess kidney function while taking this medication as it can be hard on the liver	Assess HR at apical pulse for one full minute  Caution patient to change positions slowly to minimize orthostatic hypotension
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	PT/INR	Serum cholesterol and triglycerides	Verify presence of pneumonia via sputum culture/elevated WBCs count	Blood pressure and heart rate	Assess HR and BP
<b>Client Teaching needs (2)</b>	Avoid drinking excessive amounts of alcohol Teach bleeding precautions since client is at greater risk for bleeding	Take at the same time daily Take with or without food	Take at the start of meals to reduce stomach upset  Swallow the pill whole	Take at the same time daily Take if you feel fine or have no symptoms	Do not suddenly stop taking this medication as it can make the condition worse  Keep using the medication even if you feel well

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Flagyl/Metronidazole	Zithromax/ Azithromycin	Lopressor/ Metoprolol	Vitamin K/Phytonadione	Nystatin/Mycostatin
<b>Dose</b>	500mg=100mL	500mg	25mg	5mg	5mL
<b>Frequency</b>	Q8hr	Daily	BID	Daily	Daily
<b>Route</b>	IV PB	IV PB	PO	PO	PO
<b>Classification</b>	Antibiotic	Antibiotic	Beta Blocker		Antifungal
<b>Mechanism of Action</b>	Stops the growth of certain bacteria and parasites	Stops the growth of bacteria	Blocks response to beta-adrenergic stimulation	Prevent bleeding in people with blood clotting problems or too little vitamin K in the body	Used to treat yeast infections in the mouth or stomach
<b>Reason Client Taking</b>	Pneumonia	Pneumonia	Hypertension	Prevent bleeding	Suspected thrush on tongue
<b>Contraindications (2)</b>	Seizures Encephalopathy	History of jaundice Hypersensitivity	Angina Sinus bradycardia	Hypersensitivity Immediate IV infusion	Hypersensitivity
<b>Side Effects/Adverse Reactions (2)</b>	Headache Stomach upset	Diarrhea/loose stools Stomach upset	Dizziness Headache	Unusual bruising	Fast HR Swelling in face or tongue
<b>Nursing Considerations (2)</b>	Advise client to not drink alcohol while taking this medication  Do not administer may immunizations/vaccinations while using this medication unless your doctor tells you to	Monitor patient for signs of anaphylaxis  May increase risk for warfarin toxicity	Give undiluted by direct injection  Swallow whole	Do not administer vitamin K rapidly via IV infusion  Monitor patients diet of vitamin K	Monitor patients tongue and note any changes or improvement  Monitor for signs of allergic reaction such as hives or difficulty breathing
<b>Key Nursing Assessment(s)/Lab(s) Prior to Administration</b>	None.	EKG for prolonged PT interval	Heart Rate	Monitor INR status	Assess site and note any changes
<b>Client Teaching needs (2)</b>	Take this medication with a full glass of water or milk to prevent stomach upset Continue to take this medication until the full prescribed	Take the full dose of medication; do not suddenly stop taking	Swallow the tablet whole	Tell your doctor about the amount of vitamin K-rich foods you consume in your diet  Do not increase	Swish and swallow this medication  Use for full prescribed length of time

	amount is finished			or decrease normal intake of green leafy vegetables	
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**Medications Reference (APA):** Goodman, D. M. (2020, January 2). Nurses. Retrieved from <https://www.medscape.com/nurses>

**Assessment**

**Physical Exam (18 points)**

<b>GENERAL (1 point):</b> <b>Alertness:</b> <b>Orientation:</b> <b>Distress:</b> <b>Overall appearance:</b>	Patient is A/O x4 Oriented to person, place, time, and condition No signs of distress Generalized weakness Appropriate for age
<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>	Pink, warm, and dry Color is appropriate for ethnicity 36.8°C temporal site Turgor is loose No rashes, brushes, or wounds Braden score: 19 No drains present
<b>HEENT (1 point):</b> <b>Head/Neck:</b> <b>Ears:</b>	Normocephalic No JVD Ears are symmetric. No hearing deficits.

<p><b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>PERLA present          Nose is centered          Tongue has white, patchy, locations that are red and inflamed appears to be thrush. Treating with Nystatin.</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>Normal S1, S2 heart sounds auscultated at apical pulse          Normal 3+ radial and pedal pulses          Capillary refill &lt;3 seconds</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>Upper Right Lobe – Coarse          Clear all remaining lunch fields          Respirations are regular and unlabored</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>  <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>Heart healthy diet          Heart healthy diet          Height: 162.5 cm          Weight: 62.500 kg          Bowels auscultated and active/present all four quadrants          Last BM: 2-10-2020          Abdomen is soft and non-tender          No distention, incisions, scars, drains, or wounds</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></p>	<p>Did not witness urine color or character          Voiding with no difficulties          Bladder distention is absent          Genitals not inspected</p>

<p><b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b>  <b>Size:</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 checked="" type="checkbox"/> N <input 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 type="checkbox"/>  <b>Needs assistance with equipment</b> <input type="checkbox"/>  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>ROM equal all four extremities                  Up ad lib                  Gait belt use                  Strength is equal both upper and lower extremities                  Minimal assistance with ADL                  - Bathing, dressing, toileting, and transfer require one assist                  - Contenance and feeding is independent                  Fall Score: 50</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>No altered mental status                  No speech or sensory deficits                  No loss of consciousness</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 available family support):</b></p>	<p>Patient lives home alone                  Spends time with her son                  Not asked if religion is important to patient</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	60 bpm	152/66 mmHg	18/min	36.8° C	91% on 3L NC
1050	58 bpm	163/72 mmHg	21/min	36.7°C	93% on 3L NC

**Vital Sign Trends:** Vitals are stable

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

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numeric Pain Scale	n/a	0/10	n/a	n/a
1050	Numeric Pain Scale	n/a	0/10	n/a	n/a

**IV Assessment (2 Points)**

IV Assessment	Fluid Type/Rate or Saline Lock
<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>	20 gauge Right Antecubital 2-6-2020 IV is patent No signs of erythema or drainage Transparent dressing

**Intake and Output (2 points)**

Intake (in mL)	Output (in mL)
1297 mL	844 mL

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care:** Oral and IV medication was administered to patient, full head to toe assessment on completed on patient, vital signs every 2 hours, and removal of left AC IV.

**Procedures/testing done:** Chest and Brain CT, Echocardiogram is pending

**Complaints/Issues:** The patient did not have any complains or issues during my time of care

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

**Tolerating diet, activity, etc.:** Patient is tolerating a normal heart healthy diet. Patient is able to ambulate to the bathroom with one assist.

**Physician notifications:** Notify physician if patient’s heart rate is below 60bpm when administering medication

**Future plans for patient:** Patient will be discharged home

**Discharge Planning (2 points)**

**Discharge location:** Home

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

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

**Follow up plan:** Discharge home with caregiver. No follow-up plans as of now.

**Education needs:** Homecare giver should be present when education is taking place

**Nursing Diagnosis (15 points)**

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

<p><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<p><b>Rational</b></p> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<p><b>Intervention (2 per dx)</b></p>	<p><b>Evaluation</b></p> <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>
<p><b>1.</b> Infection r/t bacterial organisms AEB positive sputum culture report of community acquired pneumonia</p>	<p>The patient has community acquired pneumonia and her infection is going to the center of her care.</p>	<p><b>1.</b>Monitor breath sounds <b>2.</b>Monitor WBC count and blood cultures</p>	<p>The patient was very pleasant and willingly to let me assess her breath sounds during physical exam. The right upper lobe has coarse sounds.</p>
<p><b>2.</b> Ineffective airway</p>	<p>The patient reports that she</p>	<p><b>1.</b> Observe the characteristics of</p>	<p>The patient was very cooperative. I did not get</p>

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clearance r/t decreased energy and increased fatigue AEB patient reports generalized weakness	has generalized weakness and she shows signs of decreased energy and increased fatigue	sputum  2. Assess hydration status	to assess the patients sputum during my shift and she did receive lots of fluids during my shift (water and black coffee)
3. Ineffective breathing pattern r/t right-sided pleural effusion AEB dyspnea	The patient has a secondary diagnosis of right-sided pleural effusion which causes some difficulty breathing	1. Elevate head of bed  2 Monitor and record vital signs	The patient was fine with elevating the head of the bed to allow better gas exchange.
4. Risk for acute pain r/t pain resulting from community acquired pneumonia AEB change in physiological parameter	The patient has pneumonia and due to advanced age she is at risk for pain	1. Administer analgesics as prescribed and as needed  2. Use additional measures, including positioning and relaxation techniques	The patient does not have any reported pain at this time so will continue to monitor.

**Other References (APA):** Gulanick, M., & Myers, J. L. (2017). Nursing care plans: diagnoses, interventions, & outcomes. St. Louis, MO: Elsevier.

**Concept Map (20 Points):**

### Subjective Data

Patient reports feelings of weakness and diarrhea that is occurring 3-7 episodes per day  
Patient reports no pain and rated pain 0/10 on numeric scale

### Nursing Diagnosis/Outcomes

Infection r/t bacterial organisms AEB positive sputum culture report of community acquired pneumonia  
The patient will continue antibiotic therapy to eliminate infection. The patient will take the entire prescribed dose.  
Ineffective airway clearance r/t decreased energy and increased fatigue AEB patient reports generalized weakness  
By discharge, the patient will show increased energy levels and no difficulty breathing.  
Ineffective breathing pattern r/t right-sided pleural effusion AEB dyspnea  
By discharge, patient will report no signs of distress upon breathing  
Risk for acute pain r/t pain resulting from community acquired pneumonia AEB change in physiological parameter  
By discharge, the patient will continue to report no presence of pain

### Objective Data

0950 Vitals  
BP - 152/66 mmHg  
RR - 18/min  
HR - 60 bpm  
Temp - 36.8 °C  
O2 - 91% 3L NC  
1050 Vitals  
BP - 163/72 mmHg  
RR - 21/min  
HR - 58 bpm  
Temp - 36.7°C  
O2 - 93% 3L NC

### Patient Information

91 yo female  
Patient Initials: PP  
DNR  
DOA: 6 Feb 20  
Ht: 162.5 cm  
Wt: 62.500 kg  
Allergies: amiodarone and propoxyphene

### Nursing Interventions

Monitor breath sounds  
Monitor WBC count and blood cultures  
Observe the characteristics of sputum  
Assess hydration status  
Elevate head of bed  
Monitor and record vital signs  
Administer analgesics as prescribed and as needed  
Use additional measures, including positioning and relaxation techniques

## N431 Care Plan

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