N321 Care Plan #2

Lakeview College of Nursing

Rece Doggett

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
02/17/2020	V.S.	67	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Divorced	Aspirin, ciprofloxacin, contrast, Penicillins, Rocephin
Code Status	**Height**	**Weight**	
Full	5ft 5in	135lb	

Medical History (5 Points)

Past Medical History: Arthritis, Asthma, CHF, COPD, Sleep Apnea, GERD

Past Surgical History: Bronchoscopy, Central venous catheter (Power port insertion),

Family History: Father – cancer, Son – Diabetes and heart disease, Brother - CHF

Social History (tobacco/alcohol/drugs): Former smoker quit 1/1/05 approximately ½ a pack a day for 30+ years, no hx of drugs or alcohol

Assistive Devices: C-pap for sleeping

Living Situation: Lives by self

Education Level: Graduated college

Admission Assessment

Chief Complaint (2 points): Short of breath, Dyspnea

History of present Illness (10 points): Client was at home when she was experiencing trouble breathing while relaxing the morning of 02/17/2020. She called 9-1-1 and went into respiratory distress while being transported to E.D. Client stated she felt pressure in chest with no related symptoms during this episode. Client stated, "It felt like forever until I was relieved!" this episode lasted for a few hour. All discomfort was in chest due to being unable to breathe and the discomfort was a 10/10 not spreading to any other areas. After

trying at home medications with no relief she decided to call EMS. EMS brough client to E.D. where she was treated for acute symptoms. After client was treated, she was admitted to OSFSCMC Medical Surgical East for observation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): COPD

Secondary Diagnosis (if applicable): Influenza (This was client's admission Dx, but client was negative for test result. She was also not under any droplet precautions.)

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

Chronic Obstructive Pulmonary Disease is lung disease that can occur due to genetic and environmental factors. COPD is identified as poor irreversible airflow limitation cause by a combination of chronic bronchitis, emphysema, or hyperreactive airway disease. When COPD occurs, the lungs begin to lose the natural elasticity it needs for gas exchange as well as causing over expanding. This results in some air still being trapped in the lungs when you exhale.

The main cause of COPD in developed countries is due to smoking tobacco. With smoking there may be misdiagnosed COPD cases due to the lungs being less functional in general, if this occurs a more thorough evaluation is performed. Other causes of COPD may include exposure to chemical fumes, or excessive inhalation of dust**.**

Symptoms may include shortness of breath (especially during physical activity), wheezing, chest tightness, cyanosis in the fingers, frequent respiratory infections, lack of energy, unintended weight loss, and/or edema of the legs, feet or ankles**. Risk factors** for COPD include exposure to tobacco smoke including secondhand smoking, prolonged exposure to dust or

chemicals, age, and genetics. COPD can cause complications such as respiratory infections, heart problems, lung cancer, high blood pressure in lung arteries, and depression.

There are **no treatments** for COPD, but there are preventions which include avoid smoking or secondhand smoke and reducing exposure to fumes from chemicals. The client's reason for having this disease is most likely from his history of smoking. His COPD caused him to be out of breath and fall to the ground resulting in him being transferred to the facility.

Labs and test results that are expected to be abnormal are O2 levels and CO2 levels. This clients ABGs were very abnormal and became increasing abnormal during clients stay. It is common to have a reading as low as 86 or 87% O2 sat on a pulse oximeter. X-rays are a tool used by doctors to diagnose the disease with. The x-ray will show a cloudy image which is also similar in pneumonia. This patient has been seen by her primary doctor who used her labs and x-rays to diagnose her with COPD.

Pathophysiology References (2) (APA):

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

Cnrn, P. H. J. L. R. N., & PhD Rn, C. K. H. (2013). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing (Brunner and Suddarth's Textbook of Medical-Surgical)* (Thirteenth, North American ed.). Philadelphia, Pennsylvania: LWW.

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	Admission	Today's	Reason for Abnormal Value

	Range	Value	Value	
RBC	4.4 – 5.8			
Hgb	13 – 16.5		11.5	Low Hgb and Hct with normal RBC may be evidence of iron deficiency anemia in the blood.
Hct	38 – 50		35.5	Low Hgb and Hct with normal RBC may be evidence of iron deficiency anemia in the blood.
Platelets	140 – 446			
WBC	4 – 12			
Neutrophils				
Lymphocytes	18-42	8.0		Low lymphocyte count may come from severe stress or malnutrition.
Monocytes	4-12	18.9		High monocyte count usually indicates chronic illness.
Eosinophils				
Bands				

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-	133 – 144			
K+	3.5 – 5.1			
Cl-	98 – 107	93	98	
CO2	21 – 31	36	42	Abnormal CO2 values with clients that control their oxygen flow usually come from the client increasing the flow of oxygen they receive. It is likely that during distress this client increased their flow of O2.
Glucose	70 – 99	135		Client had a meal before blood draw.

BUN	7 – 25	172	24	High BUN and Creatinine usually indicate renal dysfunction.
Creatinine	0.5 – 1.2	1.07	0.76	High BUN and Creatinine usually indicate renal dysfunction.
Albumin	3.5 – 5.7			
Calcium	8.6 – 10.3			
Mag				
Phosphate				
Bilirubin	0.2 – 0.8			
Alk Phos	34 - 104			
AST	13 - 39			
ALT	7 – 52		6	Due to is being several days after admission it is probable that the low result is from diet and medications given at the hospital.
Amylase	29 – 103			
Lipase	11 - 82			
Lactic Acid				

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				
PT	**10.1 – 13.1**			
PTT	**25 - 36**			
D-Dimer				

BNP	0-100	234		Patient has been Dx with CHF this test indicates Heart Failure.
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

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	Clear/yellow	Yellow		
pH	5.0 – 9.0			
Specific Gravity	1.03 – 1.030	1.011		Most likely associated with renal failure
Glucose	Negative	Neg		
Protein	Negative	Neg		
Ketones	Negative	2+		Clients with 2+ ketones it is most likely from dangerously high glucose levels or the body not producing enough insulin.
WBC	Negative	Neg		
RBC	Negative	Neg		
Leukoesterase				

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				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Thompson, E. G. T. (2012, September 17). Urine Test for Ketones. Retrieved February 27, 2020, from https://www.cardiosmart.org/healthwise/aa11/1279/aa111279

Gotter, R. N. A. A. (2018, September 17). Urine Specific Gravity Test. Retrieved February 27, 2020, from https://www.healthline.com/health/urine-specific-gravity

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Serum Ferritin Normal;(5 – 204) Current – 441

Influenza A&B Result – Negative

Chest X-ray 2 views

Diagnostic Test Correlation (5 points):

X-ray – Bilateral emphysematous changes w/ COPD, pleural thickening w/ pleural-based calcifications, pulmonary congestion.

Diagnostic Test Reference (APA):

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

Cnrn, P. H. J. L. R. N., & PhD Rn, C. K. H. (2013). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing (Brunner and Suddarth's Textbook of Medical-Surgical)* (Thirteenth, North American ed.). Philadelphia, Pennsylvania: LWW.

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

Home Medications (5 required)

Brand/ Generic	Potassium Chloride KLORCON	Albuterol	Arformoterol tartrate BROVANA	Carvedilol Coreg	Ferrous Sulfate
Dose	20 MEQ	2-3 Puffs	15 MCG / 2mL	6.25mg	325 (65 Fe) mg
Frequency	Daily	TID	BID	BID w/ Meals	Daily
Route	PO	Aerosol solution	Nebulizer	PO	PO
Classification	Electrolyte cation	Adrenergic agonist	Adrenergic agonist	Antihypertensive	Trace element, mineral
Mechanism of Action	Helps maintain electroneutrality by controlling intra and extracellular ions	Bronchodilator, binds with receptors to help open airways	Relaxes bronchial smooth cells	Reduces cardiac output and tachycardia	Normalizes RBC production
Reason Client Taking	Electrolyte balance	Prevent bronchospas	Relax airway to	Hypertension	Provide adequate RBC

		ms, open airways	open airway		production
Contraindications (2)	Acute dehydration, Crush syndrome	Hypersensitivity to albuterol, Hypersensitivity to albuterol components	Acute bronchospasms, acute deterioration of COPD conditions	Asthma or related bronchospastic conditions, severe bradycardia	Hemochromatosis, hemolytic anemias
Side Effects/ Adverse Reactions (2)	Confusion, Arrhythmias	Anxiety, Angina	Agitation, Leukocytosis	Asthenia, hyper/hypoglycemia	Fever, dyspnea
Nursing Considerations (2)	Review labs before giving, administer with or immediately after meal	Administer during seconds half of inspiration, Use cautiously in patients with cardiac Hx.	Should not be given to pts with deterioratin g COPD, use cautiously with patients that have cardiac Hx.	Use cautiously in clients with peripheral vascular disease, monitor glucose levels	Give supplement with full glass of water or juice, do not crush or open capsules, should be given 1 to 2 hours after meal

Hospital Medications (5 required)

Brand/ Generic	Furosemide Lasix	Guaifenesin Mucinex	Latanoprost Xalatan	Merapenem Merrem	Methylprednisolone sodium succinate Solu-medrol
Dose	40mg	600mg	1 drop 0.005%	1g/ 100mL 0.9% saline	40mg

Frequency	Daily	BID	Nightly	Every 8H	Every 8H
Route	PO	PO	Eye drop	IV	IV
Classification	Antihypertensive	Expectorant	Ophthalmic	Antibiotic	Anti-inflammatory
Mechanism of Action	Reduce cardiac output	Increases fluid and mucus removal	Reduces IOP in ocular HTN	Penetrates cell wall of most gram-negative bacteria	Binds to glucocorticoid receptors to reduce inflammation
Reason Client Taking	Hypertension	Relieve cough and thick secretions	Ocular hypertension	Infection	Immune and inflammatory disorder (asthma and dyspnea)
Contraindications (2)	Anuria unresponsive to furosemide, hypersensitivity to drug	Hypersensitivity to drug, Hypersensitivity to components	Lacerations or abrasions in eye, Iritis	Hypersensitivity to drug, hypersensitivity to components	Fungal infections, hypersensitivity to methylprednisolone
Side Effects/Adverse Reactions (2)	Drowsiness, orthostatic hypotension	Nausea, urticaria	Blurred vision, burning after administration	Elevated BUN and serum creatinine, epistaxis	Ataxia, edema, adrenal insufficiency
Nursing Considerations (2)	Use cautiously with clients with hx of electrolyte imbalance, clients allergic to sulfas are likely allergic to this drug as well.	Give to client with full glass of water, give liquid forms to children as prescribed.	Use proper administration technique and teach client how, give medication as prescribed	Monitor for diarrhea, take seizure precautions when giving to client.	Should not be used with traumatic brain injuries due to high chance of death, use cautiously with clients that have congestive heart failure.

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2019 Nurse's Drug Handbook* (18th ed.). USA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A & O x 4 name date place modern event Patient dressed in gown appropriate for setting.
INTEGUMENTARY (2 points): **Skin color: Pink** **Character: Dry** **Temperature: Warm** **Turgor: Poor** **Rashes: None** **Bruises: None** **Wounds: None** **Braden Score: 21 – No/Low risk** **Drains present: Y☐ N ☒** **Type:**	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Normal Cephalic, erect No drainage from eyes, nose or ears Teeth in good condition

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** 2+ throughout **Capillary refill: Approx.** 5 to 6 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	S1, S2 heart sounds no S3, S4 noted
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Bilateral crackles in both of lungs likely to copd, client was on c-pap during auscultation
GASTROINTESTINAL (2 points): **Diet at home:** Normal **Current Diet:** normal **Height**: 5' 5" **Weight:** 135lb**.** **Auscultation Bowel sounds:** Normoactive **Last BM:** Evening of 2/17/2020 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Scars noted on client's abdomen in ULQ extending to URQ. No distention, current incisions, drains or wounds present.
GENITOURINARY (2 Points): **Color:** Yellow **Character:** Clear **Quantity of urine:** Unknown **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	
MUSCULOSKELETAL (2 points): **Neurovascular status: Normal**	Client MAEW, stands independently, independent in ADL,

ROM: Full **Supportive devices: walking cane,** **Strength: Normal to client** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 2** **Activity/Mobility Status:** **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☒ **Needs support to stand and walk**☐	Client fall score of 2 resulting in no risk. Client did have bedside commode present. Uses cane to walk
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** Understands commands **Mental Status:** Follows commands **Speech:** Clear **Sensory:** Normal **LOC:** None noted	A & O x4 client understands and follows commands Client very verbal once removed from C-pap
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):**	Christian, Client not experiencing acute distress. She did verbalize desire to leave the hospital and requested a physical from PT to be confirmed.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1101	**65**	**102/53**	**16**	**98.0**	**100% on 4L O2**
1600	**88**	**133/69**	**16**		**98% on 4L O2**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

0730	**0-10**	**Generalized**	**0**	**None**	**Prevention of px**
0330	**0-10**	**Generalized**	**0**	**None**	**None**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Power Port used instead of IV **Location of IV: Upper right section of chest** **Date on IV: PP placed on 08/29/2019** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
720	**400**

According to chart ^.

Nursing Care

Summary of Care (2 points)

Overview of care: Current plan of care is working well as client is gaining strength and now able to perform ADLs independently.

Procedures/testing done: EKG, ABGs, Daily CBCs and BMPs, X-ray, Serum Ferratin, influenza test

Complaints/Issues: Client verbalized the desire to go home**.**

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Within daily limits, Normal for client.

Physician notifications: None noted

Future plans for patient: Physical exam from physical therapy to determine if patient is well enough to return home.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): None

Equipment needs (if applicable): Client owns all needed equipment**.**

Follow up plan: Regularly scheduled doctor's appointments for medications.

Education needs: Prevention of flu, hand washing, how to clean c-pap

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. Dyspnea	Related to COPD as evidence by increase respirations and short of breath. While standing client stated "I'm out of breath."	**1.**Controlled breathing – having her breath deeply and exhaling slowly **2**. Assess O2 saturations every 2 hours to be sure client is within 88-92%	Goal met with client by keeping O2 within recommended limits for COPD. Number of respirations reduced to normal range.

2. Fatigue	R/t imbalance between oxygen supply and demand as evidence by patient short of breath after activity	**1.** Maintain prescribed activity levels and explain importance to client 2. Request evaluation from PT and RT during or after activity	Desired outcome of client reducing dyspnea or fatigue after activity is in progress. Client complying with plan of care.
3. At risk for weight loss	Due to decreased intake associated with fatigue and anorexia (common in COPD clients) as evidenced by studies on COPD	**1.** Assess food and fluid intake (I/O) **2.** Request consultation with a dietitian as needed	Client does not currently experience much issue with dietary intake, but as COPD progresses this client is at risk for these issues. She is currently eating well as her fatigue only comes with physical activity.

Other References (APA):

Swearingen, P. L., & Wright, J. (2018). *All-in-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health* (5th ed.). USA: Mosby.

Concept Map (20 Points):

Subjective Data

Client stated she had trouble breathing.
Discomfort was stated at 10/10.
Client said her at home meds would not work for her dyspnea.
Client did not complain of N/V/D.

Nursing Diagnosis/Outcomes

Dyspnea - Goal met with client by keeping O2 within recommended limits for COPD. Number of respirations reduced to normal range.

Fatigue - Desired outcome of client reducing dyspnea or fatigue after activity is in progress. Client complying with plan of care.

At risk for weight loss - Client does not currently experience much issue with dietary intake, but as COPD progresses this client is at risk for these issues. She is currently eating well as her fatigue only comes with physical activity.

Objective Data

Client vitals were stable.
Labs include CBC, BMP, Serum Ferratin.
Other diagnostic tests include X-ray of chest.
Client has been Dx with COPD, asthma, and CHF

Patient Information

Client is a 67 Y.O. Caucasian female. She is divorced and retired. Client identifies as Christian. Admitted for influenza.

Nursing Interventions

Dyspnea –
1.Controlled breathing – having her breath deeply and exhaling slowly
2. Assess O2 saturations every 2 hours to be sure client is within 88-92%
Fatigue –
1. Maintain prescribed activity levels and explain importance to client
2. Request evaluation from PT and RT during or after activity
Risk for weight loss –
Assess food and fluid intake (I/O)
Request consultation with a dietitian as needed