N321 Care Plan #3

Lakeview College of Nursing

Morgan Drennan

Demographics (3 points)

Date of Admission 3/5/2020	Patient Initials LH	Age 75	Gender Male
Race/Ethnicity White/Non-Hispanic	Occupation Retired from military	Marital Status widowed	Allergies Penicillin, tetanus toxoids, fish derived products
Code Status Full	Height 5' 11"	Weight 129 lbs 10.1 oz.	

Medical History (5 Points)

Past Medical History: CHF, COPD, CAD, floaters in visual field, HTN, A-Fib, stroke

Past Surgical History: stent placed 4 times in patients' life, bunionectomy (bilateral), inguinal hernia repair

Family History: cancer found in two sisters, MI in one sister.

Social History (tobacco/alcohol/drugs): quit smoking cigarettes 16 years ago (60 packs a year), no past history of alcohol or drug use.

Assistive Devices: none

Living Situation: lives in Urbana with his family.

Education Level: GED

Admission Assessment

Chief Complaint (2 points): shortness of breath and increased sputum production

History of present Illness (10 points): Patient went to Christie Clinic for routine labs and he was found to be hypoxic, he was then transferred via EMS to OSF for further management of symptoms. Patient reported that he has progressively became more short of breath for the past 3 weeks and he has had an increased sputum production for the past 2 months. The sputum production has just recently became more frequent and a higher volume has

been produced. He has been using Mucinex for the past 2 months and reports that it has not helped. Patient does report that he is compliant with his home inhaler regimen which includes Advair, Combivent, and ProAir. He states that he does not use the rescue inhalers because he "doesn't need them". He is on home oxygen as well.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): pneumonia

Secondary Diagnosis (if applicable): COPD

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

Pneumonia is in most cases caused by bacteria entering the lungs and can be passed from person to person. The bacteria that most frequently causes pneumonia is *Streptococcus pneumoniae*. Many patients that acquire pneumonia have a weakened immune system and develop pneumonia following a different disease such as influenza. Signs and symptoms of pneumonia include chest pain when breathing, cough, confusion, fatigue, shortness of breath, lower than normal body temperature, fever, nausea, and vomiting. Complications with pneumonia include difficulty breathing, lung abscess' and fluid accumulation. Children and older adults are at the highest risk for developing pneumonia because of their weakened immune systems. Patients that have a chronic disease or smoke also have a higher likelihood of developing pneumonia. Diagnostic tests that can be ordered to determine if a patient has pneumonia are a blood test that will confirm infection, a Chest X-ray, pulse oximetry, sputum culture, a CT scan, or a pleural fluid culture. Treatment includes antibiotics, cough medicines and fever/ pain relievers. In the case of my patient he is a man older than 65 with COPD who has smoked in the past. He also has CHF which

puts him at a higher risk for diseases, including pneumonia. My patient acquired pneumonia which led to him having a COPD exacerbation. He was admitted to OSF and was given Azithromycin IV and was on 2 L of oxygen via nasal cannula. The patient also had a chest X-ray done which showed an infiltrate in his lower right lobe. When vitals were assessed his pulse oximetry was slightly low (94%) after O2 therapy at 0957, his respirations were high at 0957 (24 breaths/min) and at 1501 (22 breaths/min).

Pathophysiology References (2) (APA):

Mayo Clinic Staff. (2018, March 13). *Pneumonia*. Retrieved from:

https://www.mayoclinic.org/diseases-conditions/pneumonia/diagnosis-treatment/drc-20354210

***Pneumonia*. Retrieved from:**

https://www.thoracic.org/patients/patient-resources/breathing-in-america/resources/chapter-15-pneumonia.pdf

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	4.40-5.80	Pt admitted today	4.44	
Hgb	13-16.5	Pt admitted today	12.4	Dietary deficiency
Hct	38-50	Pt admitted today	37	Dietary deficiency
Platelets	140-440	Pt admitted today	386	
WBC	4-12	Pt	11.90	

		admitted today		
Neutrophils	**40-68**	**Pt admitted today**	**81.9**	**Infection (pneumonia)**
Lymphocytes	**19-49**	**Pt admitted today**	**18.5**	**Adverse reaction of steroids**
Monocytes	**3-13**	**Pt admitted today**	**8.9**	
Eosinophils	**0-8**	**Pt admitted today**	**0**	
Bands	**<10**	**n/a**	**n/a**	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**133-144**	**Pt admitted today**	**134**	
K+	**3.5-5.1**	**Pt admitted today**	**3.6**	
Cl-	**98-107**	**Pt admitted today**	**95**	**CHF**
CO2	**21-31**	**Pt admitted today**	**31**	
Glucose	**70-99**	**Pt admitted today**	**111**	**Diuretic therapy; corticosteroid therapy**
BUN	**7-25**	**Pt admitted today**	**18**	
Creatinine	**0.50-1.20**	**Pt admitted today**	**0.90**	

Albumin	**3.5-5.7**	**Pt admitted today**	**n/a**	
Calcium	**8.6-10.3**	**Pt admitted today**	**9.2**	
Mag	**1.6-2.6**	**Pt admitted today**	**n/a**	
Phosphate	**2.5-4.5**	**Pt admitted today**	**3.5**	
Bilirubin	**0.2-0.8**	**Pt admitted today**	**n/a**	
Alk Phos	**34-104**	**Pt admitted today**	**n/a**	
AST	**13-39**	**Pt admitted today**	**n/a**	
ALT	**7-52**	**Pt admitted today**	**n/a**	
Amylase	**23-85**	**Pt admitted today**	**n/a**	
Lipase	**0-160**	**Pt admitted today**	**n/a**	
Lactic Acid	**0.5-1**	**Pt admitted today**	**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	**0.8-1.1**	**Pt admitted today**	**1.1**	
PT	**11.0-12.5**	**Pt admitted**	**13.4**	**Use of antibiotics**

		today		
PTT	**60-70**	**Pt admitted today**	**n/a**	
D-Dimer	**<0.5**	**Pt admitted today**	**n/a**	
BNP	**0-100**	**Pt admitted today**	**324**	**CHF**
HDL	**>60**	**Pt admitted today**	**n/a**	
LDL	**<100**	**Pt admitted today**	**n/a**	
Cholesterol	**<200**	**Pt admitted today**	**n/a**	
Triglycerides	**<150**	**Pt admitted today**	**n/a**	
Hgb A1c	**4-5.6**	**Pt admitted today**	**n/a**	
TSH	**0.4-4**	**Pt admitted today**	**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 & clear**	**Pt admitted today**	**n/a**	
pH	**5-9**	**Pt admitted today**	**n/a**	
Specific Gravity	**1.003-1.030**	**Pt admitted today**	**n/a**	
Glucose	**Negative**	**Pt**	**n/a**	

		admitted today		
Protein	**Negative**	**Pt admitted today**	**n/a**	
Ketones	**Negative**	**Pt admitted today**	**n/a**	
WBC	**negative**	**Pt admitted today**	**n/a**	
RBC	**Negative; 0-2**	**Pt admitted today**	**n/a**	
Leukoesterase	**negative**	**Pt admitted today**	**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	**No growth**	**Pt admitted today**	**n/a**	
Blood Culture	**No growth**	**Pt admitted today**	**n/a**	
Sputum Culture	**No growth**	**Pt admitted today**	**n/a**	
Stool Culture	**No growth**	**Pt admitted today**	**n/a**	

Lab Correlations Reference (APA):

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

Elsevier

Diagnostic Imaging

All Other Diagnostic Tests (5 points): X-ray of chest

Diagnostic Test Correlation (5 points): The patient had an X-ray of his chest ordered because he has a previous diagnosis of COPD and there were crackles in the lower lobe of his right lung upon auscultation. He was coughing up yellow sputum upon assessment as well. The X-ray showed that there was an infiltrate in the right perihilar region which means that there is a substance denser than air in the lung. I would also recommend that a sputum culture be done.

Diagnostic Test Reference (APA):

(2019, January 23). *Pneumonia*. Retrieved from:

https://www.radiologyinfo.org/en/info.cfm?pg=pneumonia

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

Home medications

Brand/Generic	**Furosemide (Lasix)**	**Atorvastatin (Lipitor)**	**Lisinopril (Prinivil)**	**Albuterol nebulizer (Proventil)**	**Metoprolol (Lopressor)**
Dose	**40 mg**	**80 mg**	**5 mg**	**2.5 mg**	**10 mg**
Frequency	**Daily**	**Daily**	**Daily**	**Every 4 hrs PRN**	**Every evening**
Route	**PO**	**PO**	**PO**	**INH**	**PO**
Classification	**Antihypertensive; diuretic**	**antihyperlipidemic**	**Antihypertensive; vasodilator**	**bronchodilator**	**Antianginal; antihypertensive**
Mechanism of Action	**Inhibits sodium and water reabsorption into the Loop of Henle; increases**	**Reduces cholesterol and lipoprotein levels; inhibits cholesterol synthesis in the**	**Decreases the release of aldosterone which reduces water and**	**Decreases intracellular calcium levels and increase cAMP levels;**	**Inhibits stimulation of beta 1-receptor sites which decreases**

	fluid excretion.	**liver and increases LDL's**	**sodium reabsorption, reducing BP**	**which relaxes bronchial smooth muscles and inhibits the release of histamine**	**cardiac excitability, cardiac output, and myocardial oxygen demand.**
Reason Client Taking	**CHF and HTN**	**Control lipid levels in Coronary Artery Disease**	**HTN**	**Prevention of bronchospasm**	**HTN**
Contraindications (2)	**Anuria unresponsive to furosemide; hypersensitivity to furosemide**	**Active hepatic disease; breastfeeding**	**Hypersensitivity to lisinopril; hereditary or idiopathic angioedema**	**Hypersensitivity to albuterol; heart arrythmias**	**Acute heart failure; pulse less than 45 beats per minute**
Side Effects/Adverse Reactions (2)	**Elevated cholesterol; tachycardia**	**Vasodilation; palpitations**	**Fluid overload; angina**	**Pulmonary edema; bronchospasm**	**Dyspnea; heart failure**
Nursing Considerations (2)	**Administer drug slowly IVP over 1-2 minutes to prevent ototoxicity; monitor blood pressure.**	**Educate the patient to that the drug at the same time each day; monitor liver function before and during Atorvastatin therapy.**	**Monitor BP; notify provider if the patient has a persistent, nonproductive cough.**	**Monitor serum potassium level; use cautiously in patients with cardiac disorders**	**If dosage exceeds 400mg daily monitor for bronchospasm; assess EKG of patient.**

Hospital Medications (5 required)

Brand/Generic	**guaifenesin (Robitussin)**	**Ceftriaxone (Rocephin)**	**Metoclopramide (Reglan)**	**Spironolactone (Aldactone)**	**Budesonide-formoterol**
Dose	**200 mg**	**1 g**	**10 mg**	**12.5 mg**	**2 puffs**
Frequency	**Every 4 hrs PRN**	**daily**	**Every 6 hrs PRN**	**daily**	**BID**
Route	**PO**	**IV**	**IV**	**PO**	**INH**
Classification	**expectorant**	**antibiotic**	**Upper GI stimulant**	**Diuretic; aldosterone antagonist; antihypertensiv**	**Anti-asthmatic; Anti-inflammatory**

				e	
Mechanism of Action	**Increases fluid and mucous removal from upper respiratory tract; reduces secretion adhesiveness and surface tension**	**Interferes with bacterial cell wall synthesis by inhibiting cross-linking of peptidoglyca n causing the cells to rupture and die.**	**Causes gastric contraction to promote gastric emptying and peristalsis; also prevents nausea and vomiting.**	**Prevents sodium and water reabsorption; increases sodium and water excretion which reduces blood volume and blood pressure**	**Inhibits inflammatory cells and mediators which decreases inflammation of the airway**
Reason Client Taking	**Relieve cough; pneumonia**	**pneumonia**	**nausea**	**CHF and HTN**	**Manage chronic asthma**
Contraindication s (2)	**Hypersensitivit y to guaifenesin; HTN**	**Calcium containing IV solutions; penicillin**	**Seizure disorders; Mechanical obstruction**	**Hyperkalemia; anuria**	**Acute Asthma episodes; recent nasal surgery or trauma**
Side Effects/Adverse Reactions (2)	**Dizziness; headache**	**Edema; dyspnea**	**Fluid retention; bronchospasm**	**Cough; dyspnea**	**Hypertension; bronchospasm**
Nursing Considerations (2)	**Watch for evidence of more serious condition; educate the patient to take with a full glass of water.**	**Monitor BUN and creatinine levels; asses bowel pattern daily.**	**Monitor patient for fluid overload; store in light resistant container**	**Assess for edema; educate the patient to take medication with food.**	**Monitor patient for hypersensitivity ; educate patient to not chew or break capsules**

Medications Reference (APA):

(2019). *Nurse's Drug Handbook*. (18th ed.). Jones and Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:**	**AOx4** **Patient does not to appear to be in any distress and does not report and distress.** **Patient's appearance is appropriate.**

Overall appearance:	
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Skin color is appropriate for ethnicity with generalized bruising. The skin is intact and moist. The skin is warm. Turgor is loose as expected with the patients age. There are no rashes or wounds present.** **Braden score is 22**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head, ears, eyes, and nose is symmetrical. The thyroid is midline. The sclera is white, and the conjunctiva is pink and moist. There is no drainage present. External ear is intact. Dentition is intact, mucous membranes are pink and moist. Teeth are yellowing and the patient has some teeth missing. Airway is patent.**
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 present with no gallops or murmurs present. Cardiac monitor was not being used so cardiac rhythm was not assessed. Peripheral pulses are 3+, capillary refill < 3. There is no edema present.**
RESPIRATORY (2 points): **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	**Patient is using accessory muscles to breath and is abdominally breathing. Patients respirations are clear on the left side, but there are crackles on the right side. Respirations are slightly labored and his respirations are high. His respirations are even. There is clubbing present.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:**	**Diet at home is vegetarian and his current diet at the hospital is cardiac. Patient's height is 5' 11" and his weight is 129 lbs 10.1 oz. Bowel sounds are present is all four quadrants and are active. There is no pain or masses upon palpation. The last BM was 03/05/2020. Upon inspection there is no distention, incisions, scars, drains, or wounds.**

Inspection: **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Color of urine is pale yellow and clear. The patient has no pain with urination. There is not any intake or output charted, but patient reported having a bowel movement. Genitals were not assessed, but patient does not report any genital issues.**
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☐**	**Active ROM** **Strength is equal in both hands and feet.** **Strength is a 5 on a 0-5 scale** **Patient does not use any supportive devices** **Fall score: 35** **Patient is a low fall risk**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Nails are cloudy** **Extremities are warm to the touch** **Skin color is appropriate for ethnicity** **Strength is equal in both the hands and feet** **Cognition is normal** **Memory is intact** **Speech is clear** **LOC: patient is alert and answering all questions**
PSYCHOSOCIAL/CULTURAL (2	**Patient's family was coming to visit upon**

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):**	**assessment. He has a good support system through his family and loves talking about them. The patient's development level is as expected for age. The patient is not religious.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0957	77 bpm	116/70 mmHg	24 breaths per minute	98.7°F temporal	94% with 2L via nasal cannula
1501	94 bpm	130/69 mmHg	22 breaths per minute	97.6°F temporal	95% with 2L via nasal cannula

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1251	0-10	n/a	0	n/a	n/a
1501	0-10	n/a	0	n/a	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:**	20 gauge Median cubital vein in right arm 3/5/2020 IV is patent There are no signs of drainage, erythema or ecchymosis.

	The dressing is clean and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
None charted or observed **3 glasses of Sprite was ordered for the patient prior to leaving the floor**	**None charted, but 1 loose stool occurrence observed**

Nursing Care

Summary of Care (2 points)

Overview of care: vitals were taken, fluids (Sprite) was ordered, patient was assessed head to toe, patient was educated on keeping his O2 tubing next to him, not under him

Procedures/testing done: Chest X-ray done

Complaints/Issues: SOB

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: tolerating diet; not tolerable of activity because it causes SOB

Physician notifications: Chest X-ray was completed and sent to the provider

Future plans for patient: follow up with his primary within 7 days of discharge from hospital

Discharge Planning (2 points)

Discharge location: home with his family

Home health needs (if applicable): n/a

Equipment needs (if applicable): continue home oxygen as ordered

Follow up plan: follow up with provider within 7 days after discharge and follow up with pulmonology and cardiology as needed.

Education needs: continue educating patient on keeping his O2 tubing patent and not laying on top of it.

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. Impaired gas exchange related to COPD as evidenced by dyspnea	**The patient has previously been diagnosed with pneumonia which caused an exacerbation of his COPD and he has been short of breath for weeks**	**1.raise the head of the bed up to at least 45°** **2.encourage the patient to ambulate**	**The patient responded to the raising of the head of the bed very well and seemed to catch his breath quicker.** **The patient wanted to ambulate but was nervous about SOB, so he ambulated to the bathroom and back as needed. He then rested after ambulation.**
2. Ineffective airway clearance related to thick secretions secondary	**The patient has previously been diagnosed with pneumonia and has been producing thick yellow sputum**	**1. encourage the patient to increase fluid intake.** **2. give expectorants as prescribed.**	**The patient wanted to drink Sprite so 3 glasses of Sprite were ordered and the patient was very willing to keep drinking his water at the bedside. There were**

to pneumonia as evidenced by the patient coughing up thick yellow sputum.	**for the past 2 weeks. The patient reports that he coughs up large amounts of the sputum as well.**		**not any expectorants due at the time on the floor, but the patient had been taking Mucinex with no relief for the past few months. Robitussin is to be administered every 4 hours PRN.**
3. Activity intolerance related to imbalance between oxygen supply and demand as evidence by dyspnea upon activity.	**The patient became short of breath after going to and from the bathroom and had to rest on his bed to catch his breath.**	**1.assess clients pulse oximetry.** **2assess the patency of the clients O2 tubing.**	**The patients pulse oximetry level was 95% after activity while he was on 2L of O2 via nasal cannula. The patient came out of the bathroom and got in bed and then laid on top of his oxygen tubing. The patient was then educated by this student nurse that he cannot lay on top of his tubing because then it will become ineffective.**

Other References (APA):

Vera, M. (2017, September 24). *Activity Intolerance*. Retrieved from:

https://nurseslabs.com/activity-intolerance/

Wayne, Gil. (2017, September 24). *Impaired Gas Exchange*. Retrieved from:

https://nurseslabs.com/impaired-gas-exchange/

Wayne, Gil. (2019, March 20). *Ineffective Airway Clearance*. Retrieved from:

https://nurseslabs.com/ineffective-airway-clearance/

Concept Map (20 Points):

Subjective Data

Allergies: **Penicillin, tetanus toxoids, fish derived products**.
Patient is experiencing 0 pain on a 0-10 scale. The patient came to OSF after being sent from Christie Clinic for hypoxia. Patient reports shortness of breath and increased sputum production in the last 3 weeks. He reports that he is following his at home inhaler and O2 regimen.

Nursing Diagnosis/Outcomes

ired gas exchange related to COPD as evidenced by dyspnea.
Outcomes: The patient responded to the raising of the head of the bed very well and seemed to catch his breath quicker. The patient wanted to ambulate but was nervous about SOB, so he ambulated to the bathroom and back as needed. He then rested after ambulation.

Ineffective airway clearance related to thick secretions secondary to pneumonia as evidenced by the patient coughing up thick yellow sputum.
Outcomes: The patient wanted to drink Sprite, so 3 glasses were ordered and the patient was very willing to keep drinking his water at the bedside. There were not any expectorants due at the time on the floor, but the patient had been taking Mucinex with no relief for the past few months. Robitussin is to be administered every 4 hours PRN
Activity intolerance related to imbalance between oxygen supply and demand as evidenced by dyspnea upon activity.
Outcomes: The patient's pulse oximetry level was 95% after activity while he was on 2l of O2 via nasal cannula. The patient came out of the bathroom and got in bed, then laid on top of his oxygen tubing. The patient was then educated by this student nurse that he cannot lay on his tubing because then it will become ineffective.

Objective Data

Upon auscultation of the lungs crackles in the lower lobe of the right lung were noted. Patients BP was high at 130/69 at 1501. Patient's BNP was 324 on a 0-100 scale. The X-ray of the chest was showing an infiltrate in the perihilar region of the right lung. His O2 stats were on the low end at 94% and 95%, which is expected for a patient with COPD. The patient is also produces thick, yellow sputum. The patient's height is 5' 11" and his weight is 129 lbs 10.1 oz.

Patient Information

The patient is a 75 year old, Caucasian male, with the intials LH. He is a widow and currently lives with his son and his family in Urbana. He retired from the military and is a full code. His date of admission is 3/5/2020.

Nursing Interventions

Raise the head of the bed up to at least 45°; encourage the atient to ambulate
ncourage the patient to increase fluid intake; give xpectorants as prescribed
Assess clients pulse oximetry; assess the patency of the clients O2 tubing.