# N441 Care Plan

Lakeview College of Nursing

Madisyn Verostko

## Demographics (3 points)

| Date of Admission<br>3/20/2020 | Patient Initials<br>MJ | Age<br>80 | Gender<br>Female |
|---|---|---|---|
| Race/Ethnicity<br>Caucasian | Occupation<br>Unemployed | Marital Status<br>Married | Allergies<br>PCN, sulfa |
| Code Status<br>DNR | Height<br>5'0" | Weight<br>210 lbs | |

## Medical History (5 Points)

**Past Medical History:**.

- coronary artery disease
- congestive heart failure
- anemia
- deep vein thrombosis
- stage 4 squamous cell carcinoma
- stage 4 laryngeal cancer
- respiratory failure
- impaired gas exchange
- hypothyroidism
- insomnia
- dyslipidemia
- impaired mobility

**Past Surgical History:**

- peg tube placement (2019)
- tracheostomy placement (2013)
- laryngeal and lung cancer excision (2012)
- pleural drain placement (2019)

**Family History:**

- mother- diabetes
- father- diabetes, heart disease, and high blood pressure

**Social History (tobacco/alcohol/drugs):** Pt denies alcohol use. Former smoker of 54 years, quit in 2011 when diagnosed with lung cancer. Pt denies use of any illegal drugs and marijuana.

**Assistive Devices:** Pt uses a walker

**Living Situation:** Pt resides at Brookstone Assisted Living in Charleston, IL with husband

**Education Level:** Associates degree in childcare

## Admission Assessment

**Chief Complaint (2 points):** Pt states "couldn't catch my breath" accompanied by CP

**History of present Illness (10 points):**.

Mrs. Jones presented to the ED on 3/20 via ambulance stating she had chest pain and "couldn't catch my breath". She described her pain as "it feels very tight" and pointed to her left chest. Mrs. Jones stated that her pain did not go away on her ride to the hospital. She said it even got worse when she was put on the cot and forced to ride while lying down. Upon arrival to the ED, Mrs. Jones was able to sit up and stated that this helped relieve some of her pain. Mrs. Jones rated her pain 10/10 on arrival. No other measures have been taken to manage pain at this time.

## Primary Diagnosis

**Primary Diagnosis on Admission (2 points):** Healthcare associated pneumonia

**Secondary Diagnosis (if applicable):** Chronic respiratory failure

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

Healthcare associated pneumonia refers to an upper respiratory infection that was acquired within a healthcare facility of some sort, in my patient's case, it was the nursing home. The most common cause of healthcare associated pneumonia is microsaspiration of bacteria, that colonize in the oropharynx and upper respiratory tract of already-ill patients and progress into an infection known as pneumonia (Sethi, 2019). Pneumonia that develops 4-7 days after hospital admission may be caused by pathogens such as Methicillin-sensitive *S. aureus*, *Streptococcus*

*pneumoniae*, and *Haemophilus influenzae* (Sethi, 2019). With increasing duration of hospitalization, pathogens such as *Pseudomonas aeruginosa*, Methicillin-sensitive *Staphylococcus aureus*, Methicillin-resistant *S. aureus* (MRSA), or enteric gram-negative organisms are more likely to be the source of the infection (Sethi, 2019). Possible but less likely causes of pneumonia include seeding of the lung due to bacteremia, or inhalation of contaminated aerosols such as airborne particles containing *Legionella* species, *Aspergillus* species, or the influenza virus (Sethi, 2019). My patient has several comorbidities that made her more susceptible to developing pneumonia, the greatest being COPD, CHF, and chronic respiratory failure. A sputum culture performed on 3/20 revealed that the causative agent of my patient's pneumonia was *Staphylococcus aureus.*

The most notable risk factors for healthcare associated pneumonia are coexisting comorbidities such as cardiac, pulmonary, hepatic, or renal insufficiency (Sethi, 2019). Other risk factors include recent antibiotic therapy, high gastric pH, and age greater than 70 (Sethi, 2019). Signs and symptoms of healthcare acquired pneumonia include malaise, fever, chills, rigor, cough, dyspnea, and chest pain (Sethi, 2019). My patient presented with dyspnea and chest pain.

Diagnosis of pneumonia is made via a chest x-ray, a chest computed tomography (CT), or a combination of the two (Capriotti & Frizzell, 2016). Bronchoscopy and blood cultures can also be used. Sputum cultures are a good way to determine the causative pathogen in order to guide antibiotic therapy (Capriotti & Frizzell, 2016). Treatment via antibiotic therapy is determined by the findings of sputum culture gram stains. If healthcare associated pneumonia is suspected, local sensitivity patterns and patient risk factors for antibiotic-resistant pathogens are taken into consideration (Capriotti & Frizzell, 2016). "In treatment

settings where MRSA rates are > 20%, vancomycin or linezolid should be added." (). My patient is actively being treated with vancomycin.

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

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

Sethi, S., (2019). Hospital-Acquired Pneumonia - Pulmonary Disorders. Retrieved from https://www.merckmanuals.com/professional/pulmonary-disorders/pneumonia/hospital-acquired-pneumonia

## 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 M/uL** | 3.21 | 2.64 | Red blood cell counts are decreased in patients with anemia. This patient has anemia (Van Leeuwen & Bladh, 2017). This is likely the patient's baseline. |
| **Hgb** | **11-15.5 g/dL** | 10.1 | 8.2 | Hemoglobin counts are decreased in patients with anemia. This patient has anemia (Van Leeuwen & Bladh, 2017). This is likely the patient's baseline. |
| **Hct** | **33.2%-45.3%** | 30.0 | 25.5 | Hematocrit counts are decreased in patients with anemia. This patient has anemia (Van Leeuwen & Bladh, 2017). This is likely the patient's baseline. |
| **Platelets** | **100- 400 K/uL** | 278 | 293 | |
| **WBC** | **4.8 – 10.8 K/ uL** | 10.2 | 5.9 | |

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| **Neutrophils** | **45-80 %** | 8.2 | 8.4 | Neutrophils are significantly reduced in the blood serum due to them being recruited to the lungs as the body's initial response to infection (Craig, Mai, Cai, & Jeyaseelan, 2009). Neutrophils are trending up since admission. |
| **Lymphocytes** | **11.8-46 %** | 2.9 | 5.0 | Lymphocytes are decreased in pneumonia and anemia (Van Leeuwen & Bladh, 2017). Lymphocytes are trending up since admission. |
| **Monocytes** | **4.4-12 %** | 2.4 | 5.9 | Decreased monocytes is directly related to an overall low WBC count, related to neutropenia and lymphocytopenia, which this patient also has. This could indicate that the infection has progressed into the bloodstream (Van Leeuwen & Bladh, 2017). Monocytes are trending up, and todays value was within the expected reference range. |
| **Eosinophils** | **0 – 6.3 %** | 5.6 | 6.5 | |
| **Bands** | **0-5 %** | 0.2 | 0.5 | |

**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-** | **135 – 145 mmol/L** | 136 | 137 | |
| **K+** | **3.5- 5.1 mmol/L** | 4.3 | 4.3 | |
| **Cl-** | **96 – 106 mmol/L** | 96 | 98 | |
| **CO2** | **23-29 mEq/ L** | 27 | 28 | |
| **Glucose** | **70-99 mg/dl** | 113 | 99 | Blood glucose is elevated when the body is under stress (Van Leeuwen & Bladh, 2017). An active infection such as pneumonia can cause a high serum glucose reading due to stress on the body. |

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| **BUN** | **6-20** | 44 | 9 | Elevated BUN is common in dehydration and CHF (Van Leeuwen & Bladh, 2017). This patient has CHF. |
| **Creatinine** | **0.5 -0.9 mmol/L** | 1.8 | 0.47 | Creatinine levels are elevated in the blood due to dehydration, renal impairment, and CHF (Van Leeuwen & Bladh, 2017). This explains the increased value upon admission, as this patient has CHF. Today's decreased value is just slightly lower than the reference range. Overall, this is a good trend because the creatinine is much closer to the expected reference range. |
| **Albumin** | **3.5-5.2 g/L** | N/A | 3.3 | **"**Abnormal LFTs are common in community-<br>acquired pneumonia and are of prognostic value. Patients with a low albumin or raised ALT are significantly more likely to die from their disease or to stay in hospital for a prolonged period" (Jinks & Kelly, 2004, para. 4). I found this statement of value as my patient has shown both increased LFTs and a decreased albumin. But her albumin is just slightly low. This is more than likely due to malnutrition r/t intubation and PEG tube diet. |
| **Calcium** | **8.6 – 10.4 mg/dl** | N/A | N/A | |
| **Mag** | **1.6 – 2.4 mmol/L** | 2.1 | 1.6 | |
| **Phosphate** | **2.5-4.5** | N/A | N/A | |
| **Bilirubin** | **0 – 1.2 umol/L** | 0.3 | 0.3 | |
| **Alk Phos** | **44-147 U/L** | N/A | 104 | |
| **AST** | **0-32 U/L** | 40 | 13 | "Abnormal LFTs are common in community-<br>acquired pneumonia and are of prognostic value. Patients with a |

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| | | | | low albumin or raised ALT are significantly more likely to die from their disease or to stay in hospital for a prolonged period" (Jinks & Kelly, 2004, para. 4). I found this statement of value as my patient has shown both increased LFTs and a decreased albumin. Since admission, AST has returned to normal value but ALT has since risen to an above normal value. |
| **ALT** | **0-33 U/L** | 13 | 41 | "Abnormal LFTs are common in community-acquired pneumonia and are of prognostic value. Patients with a low albumin or raised ALT are significantly more likely to die from their disease or to stay in hospital for a prolonged period" (Jinks & Kelly, 2004, para. 4). I found this statement of value as my patient has shown both increased LFTs and a decreased albumin. Since admission, AST has returned to normal value but ALT has since risen to an above normal value. |
| **Amylase** | **23-85** | N/A | N/A | |
| **Lipase** | **23-85** | N/A | N/A | |
| **Lactic Acid** | **< 2 mmol/L** | 0.9 | 1.1 | |
| **Troponin** | **<0.01** | <1 | <1 | |
| **CK-MB** | **3-5%** | N/A | N/A | |
| **Total CK** | **22-198 U/L** | N/A | 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 Admissio | Today's Value | Reason for Abnormal |
|---|---|---|---|---|

| | | n | | |
|---|---|---|---|---|
| **INR** | **0.86 – 1.14** | N/A | N/A | |
| **PT** | **11.9 – 15 sec.** | N/A | N/A | |
| **PTT** | **23- 37 sec.** | N/A | N/A | |
| **D-Dimer** | **< 0.4 or <250** | N/A | N/A | |
| **BNP** | **< 100** | N/A | N/A | |
| **HDL** | **>60** | N/A | N/A | |
| **LDL** | **< 100** | N/A | N/A | |
| **Cholesterol** | .**< 200** | N/A | N/A | |
| **Triglycerides** | **< 150** | N/A | N/A | |
| **Hgb A1c** | **4-5.6%** | N/A | N/A | |
| **TSH** | **0.45-4.5** mU/L | N/A | N/A | |

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

| Lab Test | Normal Range | Value on Admission | Today's Value | Reason for Abnormal |
|---|---|---|---|---|
| **Color & Clarity** | **Yellow / Clear** | Clear yellow | N/A | |
| **pH** | **4.5- 8** | 8.0 | N/A | |
| **Specific Gravity** | **1.005-1.025** | 1.015 | N/A | |
| **Glucose** | **< 130 mg/d** | Negative | N/A | |
| **Protein** | **< 150 mg/d** | Negative | N/A | |
| **Ketones** | **None** | Negative | N/A | |
| **WBC** | **<2-5 /hpf** | 4 | N/A | |
| **RBC** | **< 2 /hpf** | 2 | N/A | |
| **Leukoesterase** | **Negative** | Negative | N/A | |

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

| Test | Normal Range | Value on Admission | Today's Value | Explanation of Findings |
|---|---|---|---|---|
| **pH** | **7.35-7.45** | 7.42 | 7.51 | Blood pH can be increased due to dehydration (Van Leeuwen & Bladh, 2017). This is likely for this patient along with malnutrition due to intubation and feeding via PEG tube. |
| **PaO2** | **80-100** | 31 | 31 | Partial pressure of oxygen (PaO2) is decreased in respiratory conditions such as COPD and respiratory failure, both of which my patient has (Van Leeuwen & Bladh, 2017). This value is extremely too low and suggests that this patient is not receiving enough oxygen. |
| **PaCO2** | **35-45** | 48 | 41 | Increased partial pressure of carbon dioxide (PaCO2) occurs when the patient is retaining CO2 due to hyperventilation (Van Leeuwen & Bladh, 2017). This has COPD which makes her prone for CO2 retention. Her PaCO2 has since returned to the reference range after being placed on a vent to help her blow off the excess CO2. |
| **HCO3** | **22-26** | 25 | 23 | |
| **SaO2** | **94-100%** | 96% | 97% | |

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

| Test | Normal | Value on | Today's | Explanation of Findings |
|---|---|---|---|---|

| | Range | Admission | Value | |
|---|---|---|---|---|
| **Urine Culture** | **Negative - < 10,000** | **N/A** | **N/A** | |
| **Blood Culture** | **Negative** | **N/A** | **N/A** | |
| **Sputum Culture** | **Negative** | Staphylococcus aureus (resulted on 3/22/2020) | **N/A** | Staphylococcus aureus is the causative agent of active pneumonia infection. |
| **Stool Culture** | **Negative** | **N/A** | **N/A** | |

**Lab Correlations Reference (APA):**

Craig, A., Mai, J., Cai, S., & Jeyaseelan, S. (2009, February 1). Neutrophil Recruitment to the Lungs during Bacterial Pneumonia. Retrieved from https://iai.asm.org/content/77/2/568

Jinks, M. F., & Kelly, C. A. (2004, November). The pattern and significance of abnormal liver function tests in community-acquired pneumonia. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/15581747

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company.

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):**

- CXR: Completed in the ER on 3/20/2020
  - Radiologist report: The right lung has increased peripheral and basilar opacities related to the disease process of pneumonia. Interstitial thickening suggestive of pulmonary edema also noted.
- CXR: Completed on 3/24/2020 - Completed post-intubation.
  - Radiologist report: Endotracheal tube in place 2cm above carina.
- CT chest with contrast: Completed while patient was in ED on 3/20/2020
  - Radiologist report: Unremarkable. No evidence of pulmonary emboli.
- EKG 3/20/2020 - NSR at a rate of 87

- EKG 3/24/2020 NSR at a rate of 80

**Diagnostic Test Correlation (5 points):**

Chest X-ray findings are consistent with the diagnosis of pneumonia. Findings indicative of pneumonia are airspace opacity, lobar consolidation, or interstitial opacities. The clients first CXR upon arrival to the ER showed basilar opacities and interstitial thickening (lobar consolidation). Pulmonary edema was also evident on this X-Ray. A chest CT with contrast was also performed in the ER to rule out acute PE, which came back unremarkable. EKG was performed due to patient's complaint of chest pain, showed NSR.

**Diagnostic Test Reference (APA):**

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company.

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

**Home Medications (5 required)**

| **Brand/Generic** | Protonix pantoprazole | Lipitor atorvastatin | Ambien zolpidem | Lasix furosemide | Tylenol acetaminophen |
|---|---|---|---|---|---|
| **Dose** | 40 mg | 20 mg | 0.5 mg | 20 mg | 650 mg |
| **Frequency** | Once daily | Once daily | HS | HS | Q6hr PRN |
| **Route** | PO crushed via peg tube | PO crushed via peg tube | PO crushed via peg tube | PO crushed via peg tube | PO crushed via peg tube |
| **Classification** | Proton pump inhibitor | HMG CoA reductase inhibitor | Sedative or hypnotic | Loop diuretic | Antipyretic/ non-opioid analgesic |
| **Mechanism of** | Interferes w/ | Inhibits 3- | Interacts with | nhibits | Inhibits the |

| | | | | | |
|---|---|---|---|---|---|
| **Action** | gastric secretion by inhibiting proton pump | hydroxy-3-methylglutaryl-coenzyme A reductase, inhibiting cholesterol synthesis | GABA-benzodiazepine receptor complexes | NA and Cl reabsorption at proximal and distal tubules and Loop of Helen. | synthesis of prostaglandins that may serve as mediators of pain and fever, primarily in the CNS |
| **Reason Client Taking** | PEG tube | dyslipidemia | Insomnia | CHF | Pain |
| **Contraindications (2)** | Concurrent use w/ rilpivirine-containing products<br><br>Hypersensitivity | Pregnancy<br><br>myopathy | Alcohol use<br><br>Severe hepatic impairment | Anuria<br><br>Hepatic coma | Hepatic impairment<br><br>Severe malnutrition |
| **Side Effects/Adverse Reactions (2)** | Abdominal pain<br><br>anxiety | Tendon rupture<br><br>arthralgia | Hallucinations<br><br>Complex sleep-related behaviors | Electrolyte imbalance<br><br>ototxicity | Nausea<br><br>headache |
| **Nursing Considerations (2)** | Don't give w/in 4 weeks of testing for H. pylori<br><br>Flush IV w/ D5W after admin | Monitor for n/v/d side effects<br><br>Administer at same time everyday | Beware of complex sleep behaviors (walking, driving, etc)<br><br>Monitor for suicidality | Be attentive to foley bag (large urine output)<br><br>Monitor for FVD | Monitor temp/ pain<br><br>Document when last dose was given |
| **Key Nursing Assessment(s)/Lab (s) Prior to Administration** | Swallow whole, do not chew<br><br>take delayed-release 30 min before a meal mixed in apple juice or applesauce | Monitor Cr<br><br>Monitor LFTs | No routine tests recommended | Monitor potassium<br><br>Monitor BUN, Cr, electorlytes | Liver enzymes<br><br>Cr at baseline |
| **Client Teaching** | Proton pump | Take along | Notify pt of | Consume | Take |

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| **needs (2)** | inhibitor | with diet modifications (low carb, no alcohol)<br><br>Stop smoking | suicidality side effect, urge to reach out for help if needed<br><br>Warn pt of complex sleep-related behavior, create restful safe environment when going to sleep | adequate fluids<br><br>Get routine blood work to check K+ levels | recommended dose on label<br><br>OD can cause liver damage or death |

**Hospital Medications (5 required)**

| **Brand/Generic** | Precedex dexmedetomidine | Zofran ondansetron | Merrem meropenem | Firvanq vancomycin | Lovenox enoxaparin |
|---|---|---|---|---|---|
| **Dose** | 1mcg/kg/hr | 4 mg | 1000 mg | 1000 mg | 40mg |
| **Frequency** | PRN | Q8hr PRN | Q12hr PRN | Q12hr | Once daily |
| **Route** | IV drip | IV push | Crushed via PEG tube | IV | SQ |
| **Classification** | Sedative | Selective 5HT5 receptor antagonist | antibiotic | antibiotic | LMWH - anticoagulant |
| **Mechanism of Action** | Produces centrally mediated sympatholytic sedative and analgesic effects | antiemetic | Inhibits cell wall synthesis, bactericidal | Inhibits cell wall and RNA synthesis | Binds thrombin III, inhibits IIa and Xa |
| **Reason Client Taking** | Intubated | nausea | pneumonia | pneumonia | DVT prophylaxis |
| **Contraindications** | Avoid abrupt | Use with | Anaphylactic | Renal | Hypersensitivity |

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| **(2)** | withdrawal<br><br>Caution in elderly patients | apomorphine<br><br>hypersensitivity | rxn to beta-lactams<br><br>Caution with seizure disorder | impairment<br><br>Concurrent nephrotoxic agent use | active bleeding |
| **Side Effects/Adverse Reactions (2)** | Hypotension<br><br>bradycardia | Headache<br><br>diarrhea | Seizures<br><br>Stevens-Johnson syndrome | Red man syndrome<br><br>hypotension | Thrombocytopenia (HIT)<br><br>bleeding |
| **Nursing Considerations (2)** | Monitor vs continuously<br><br>Perform neuro checks routinely | Drug interactions<br><br>Monitor ECG if electrolyte abnormalities noted | Monitor for hypersensitivity rxn<br><br>Monitor for s/sx of Stevens-Johnsons syndrome | Monitor for hypotension<br><br>Administer slowly | Bleeding precautions<br><br>beers criteria (older adults) |
| **Key Nursing Assessment(s)/Lab(s) Prior to Administration** | Monitor LFTs<br><br>Monitor HR and rhythm for irregularities | monitor cholesterol<br><br>monitor LFTs | Monitor Cr<br><br>Monitor CBC | BUN, Cr<br><br>Monitor for fever | s/sx of bleeding<br><br>s/sx of thromboembolism |
| **Client Teaching needs (2)** | This medication will put you to sleep<br><br>Notify personnel if you have difficulty breathing | Seek immediate help if experiencing persistent, severe, unusual, or worsening sx<br><br>immediately report rash | Educate pt about possible side effects<br><br>Educate pt on purpose of this drug | Monitor for C. difficile (diarrhea)<br><br>Change positions slowly d/t orthostatic hypotension | LMWH - anticoagulant |

**Medications Reference (APA):**

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). *Davis's Drug Guide for Nurses* (15 ed.). Philadelphia, PA: F.A. Davis Company.

## Assessment

**Physical Exam (18 points)**

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|---|---|
| **GENERAL (1 point):**<br>**Alertness:**<br>**Orientation:**<br>**Distress:**<br>**Overall appearance:** | Pt is sedated and appears to be in no acute distress. Pt appears well nourished. Pt is Cooperative, appropriate mood and affect, coherent when awake. Pt appears clean. Speech is impaired d/t ETT. |
| **INTEGUMENTARY (2 points):**<br>**Skin color: gray**<br>**Character: dry**<br>**Temperature: warm**<br>**Turgor: N/A**<br>**Rashes: no noted rashes**<br>**Bruises: no noted bruises**<br>**Wounds: no noted wounds**<br>**Braden Score: 13**<br>**Drains present: Y☒ N ☐**<br>**Type: Pleural, left side** | Skin is warm, dry and grey, no rashes, bruises or wounds present. Braden score of 13. Pleural drain in place, left side. |
| **HEENT (1 point):**<br>**Head/Neck:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth:** | Head and neck appear normocephalic. Vision and hearing are intact, PERRLA noted and EOMI. Normal conjunctiva, eyelids bilateral- no abnormalities noted, sclera bilaterally clear. No septum deviation, nasal polyps, or drainage noted. Tympanic membrane is clear, pearly gray. No noted abnormalities to the external ear. Oral mucosa is pink, moist, and intact. Uvula is midline - no abnormalities noted. Dentures are at bedside, were removed prior to intubation. |
| **CARDIOVASCULAR (2 points):**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable):**<br>**Peripheral Pulses:**<br>**Capillary refill:**<br>**Neck Vein Distention: Y ☐ N ☒**<br>**Edema Y ☒ N ☐**<br>**Location of Edema:**<br>**Bilateral legs and ankles – 1+** | Heart rhythm is regular. Heart sounds auscultated-normal S1, S2. Peripheral Edema noted in legs bilaterally -1+; ankles: bilaterally-1+. Capillary refill is WNL (<3 seconds). Peripheral pulses normal bilaterally. |
| **RESPIRATORY (2 points):** | Respiratory effort is regular, no accessory muscle |

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| **Accessory muscle use: Y☐ N ☒**<br>**Breath Sounds: Location, character**<br><br>**ET Tube:**<br>**Size of tube: 7 fr**<br>**Placement (cm to lip): 19**<br>**Respiration rate: 22**<br>**FiO2: 60**<br>**Total volume (TV): 350**<br>**PEEP: 8**<br>**VAP prevention measures: frequent suctioning and oral care.** | use. No chest deformities noted. Diminished sounds in right middle and lower lobes upon auscultation, left is clear. ETT in place, 7 fr, 19 at the lip. Current settings include: RR:22, FiO2: 60, TV: 350, PEEP: 8. Frequent suctioning and oral care completed. |
| **GASTROINTESTINAL (2 points):**<br>**Diet at home: PEG tube** - Jevity 50 mL/ hour<br>**Current Diet PEG tube** - Jevity 50 mL/ hour<br>**Height: 5'0"**<br>**Weight: 210 lbs**<br>**Auscultation Bowel sounds: present in all 4 quadrants**<br>**Last BM: 3/22**<br>**Palpation: Pain, Mass etc.:**<br>**Inspection:**<br>**Distention: non-distended**<br>**Incisions: no incisions**<br>**Scars: no scars**<br>**Drains: no drains**<br>**Wounds: no wounds present**<br>**Ostomy: Y ☐ N ☒**<br>**Nasogastric: Y ☐ N ☒**<br>**Size:**<br>**Feeding tubes/PEG tube Y ☒ N ☐**<br>**Type: PEG tube** | Soft, non-tender, non-distended, normal bowel sounds in all four quadrants, no masses/abdominal tenderness/abdominal hernias, no incisions, drains, or wounds. PEG tube present. Patient's last BM was 3/22. Patient is receiving Jevity 50 mL/ hour while in the hospital which is also norm for her at home. |
| **GENITOURINARY (2 Points):**<br>**Color: yellow**<br>**Character: clear**<br>**Quantity of urine: 350 mL in foley bag**<br>**Pain with urination: Y ☐ N ☒**<br>**Dialysis: Y ☐ N ☒**<br>**Inspection of genitals:**<br>**Catheter: Y ☒ N ☐**<br>**Type: foley**<br>**Size: 14 fr** | 14fr foley catheter in place, peri care completed Q shift. Urine is yellow and clear. 350mL urine present in foley bag. All external genitalia is present and unremarkable. |

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| **CAUTI prevention measures: peri care q shift, foley bag emptied and kept below level of bladder** | |
| **MUSCULOSKELETAL (2 points):**<br>**Neurovascular status: adequate**<br>**ROM: MOEW**<br>**Supportive devices: Bedridden**<br>**Strength: Equal bilaterally**<br>**ADL Assistance: Y☐ N ☐**<br>**Fall Risk: Y ☒ N☐**<br>**Fall Score: 55**<br>**Activity/Mobility Status:**<br>**Independent (up ad lib)** ☐<br>**Needs assistance with equipment** ☒<br>**Needs support to stand and walk** ☐ | Passive range of motion in all extremities, no tenderness or swelling. Patient is bedridden while intubated and receiving mechanical ventilation. Fall score of 55. Full assist required at this time. Strength equal bilaterally. |
| **NEUROLOGICAL (2 points):**<br>**MAEW: Y ☒ N☐**<br>**PERLA: Y ☒ N☐**<br>**Strength Equal: Y ☒ N ☐ if no -**<br>**Legs ☐ Arms ☐ Both ☐**<br>**Orientation: sedated**<br>**Mental Status: normal with developmental level**<br>**Speech: intact but sedated**<br>**Sensory: no deficits**<br>**LOC: sedated** | Sedated, but when awake CN II-XII grossly intact and exhibited. Patient's mental status is normal for her developmental level. No sensory deficits. |
| **PSYCHOSOCIAL/CULTURAL (2 points):**<br>**Coping method(s): remaining active and involved in activities**<br>**Developmental level: appropriate for age**<br>**Religion & what it means to pt.: Christian**<br>**Personal/Family Data (Think about home environment, family structure, and available family support): pt resides at Brookstone assisted living with husband. Husband at bedside. Pt has 4 children who live 1+ hours away.** | Patient's husband is at bedside and reports they have been strong Christians all their lives. He states the patient enjoys participating in activities at their assisted living facility and finds joy in remaining active. They have 4 children whom live across the country with the closest residing 1 hour from Sarah Bush Lincoln. |

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

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| 0800 | 78 | 106/62 | 20 | 36.8 | 99 |

| | | | | | |
|---|---|---|---|---|---|
| 1245 | 99 | 101/59 | 24 | 36.6 | 99 |

**Vital Sign Trends/Correlation:**

Vital signs remain stable throughout my shift. RR was elevated at 1245 d/t pain, pain relief interventions implemented.

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

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| 0800 | Numeric (0-10) | N/A | 0 | N/A | N/A |
| 1245 | Numeric (0-10) | N/A | 4 | N/A | Repositioned and 650 mg of Tylenol given PO via PEG tube |

**IV Assessment (2 Points)**

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|---|
| **Size of IV: 22g**<br>**Location of IV: right upper arm**<br>**Date on IV: 3/20/20**<br>**Patency of IV: patent, flushes easily**<br>**Signs of erythema, drainage, etc.: there are no signs of erythema, drainage, infiltration, or phlebitis at IV site.**<br>**IV dressing assessment: tegaderm is intact, dry, and clean** | Vancomycin 1000 mg q12 hr |
| **Other Lines (PICC, Port, central line, etc.)** | |
| **Type: Port accessed**<br>**Size: N/A**<br>**Location: left chest**<br>**Date of insertion: 3/20**<br>**Patency:fluses good, patent**<br>**Signs of erythema, drainage, etc.: no signs of erythema, drainage, or any other signs of infection**<br>**Dressing assessment: tegaderm is intact,** | N/A – port accessed |

| | |
|---|---|
| **clean, and dry**<br>**Date on dressing: 3/20**<br>**CUROS caps in place: Y ☒ N ☐**<br>**CLABSI prevention measures:** CLABSI prevention measures are being taken as ordered | |

**Intake and Output (2 points)**

| Intake (in mL) | Output (in mL) |
|---|---|
| 500 mL | 980 mL |

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care:** On this clinical day I would have performed oral care, repositioned the patient as needed, suctioned as needed, administered medication, provided peri/catheter care as needed, and provided necessary pain relief measures.

**Procedures/testing done:** No procedures performed on this day.

**Complaints/Issues:** pt c/o pain at 1245, pain interventions implemented

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

**Tolerating diet, activity, etc.:** Pt is tolerating diet via PEG tube well.

**Physician notifications:** No need for physician notifications on this day.

**Future plans for patient:** Pt is to d/c back to Brookstone Nursing Home in Charleston, IL.

**Discharge Planning (2 points)**

**Discharge location:** Pt is to d/c back to Brookstone Nursing Home in Charleston, IL.

**Home health needs (if applicable):** Home health should see this patient weekly.

**Equipment needs (if applicable):** Pt may need oxygen for in home use

**Follow up plan:** Patient is currently receiving palliative care

**Education needs:** Educate patient and husband about needs for hospice care. Mrs. Jones wishes were not to be hooked up to a machine forever. I would educate them about her condition and probable prognosis, lay out all their options, and give them time to make a decision.

**Nursing Diagnosis (15 points)**
***Must be NANDA approved nursing diagnosis and listed in order of priority***

| **Nursing Diagnosis**<br>• Include full nursing diagnosis with "related to" and "as evidenced by" components | **Rational**<br>• Explain why the nursing diagnosis was chosen | **Intervention (2 per dx)** | **Evaluation**<br>• How did the patient/family respond to the nurse's actions?<br>• Client response, status of goals and outcomes, modifications to plan. |
|---|---|---|---|
| 1. Ineffective airway clearance r/t pneumonia AEB respiratory secretions | Pt is producing thick secretions d/t pneumonia infection, can block airway | 1. Suction pt PRN<br><br>2.Provide good oral care | Goals met- pt responded well to interventions (pt is sedated) |
| 2. Impaired gas exchange r/t pneumonia and COPD AEB low PaO2 and elevated PaCO2 | Pt is prone to CO2 retention d/t COPD (hyperventilating), pt is not receiving adequate oxygenation according to PaCO2 | 1. Monitor pulse Ox and ABGs<br><br>2.Adjust vent settings as needed | Goals met- pt responded well to interventions (pt is sedated). Nurse continues to monitor ABGs and SpO2 |
| 3. Risk for infection r/t urinary catheter in place | Catheter in place poses risk for CAUTI | 1. Perform catheter/peri care<br><br>2. Empty urine bag | Goals met- pt responded well to interventions (pt is sedated). Peri/catheter care provided (hypothetically) and 630 mL emptied from foley bag |

| | | | |
|---|---|---|---|
| | | regularly, keep bag below level of bladder | |
| 4. Risk for imbalanced nutrition: Less than body requirements r/ t PEG tube feedings | Pt receives feedings via PEG tube, poses risk for deficiencies | 1. Provide supplementation as needed<br><br>2. monitor hydration status and albumin levels | Goals met- pt responded well to interventions (pt is sedated) |
| 5. Risk for impaired skin integrity r/t bedrest | Pt is intubated and on ordered bed rest, poses risk for bed sores | 1. turn patient PRN<br><br>2.Perform daily skin assessments | Goals met- pt responded well to interventions (pt is sedated) |

**Other References (APA):**

Swearingen, P. L. (2016). *All-In-One Nursing Care Planning Resource* (4 ed.). St. Louis, Missouri: ELSEVIER.

**Concept Map (20 Points):**

N441 CARE PLAN

**Subjective Data**

Upon arrival to ED pt stated "couldn't catch m breath"
She described her pain as "it feels very tight" and pointed to her left chest
Mrs. Jones stated that her pain did not go away on her ride to the hospital, it got worse when she was put on the cot and forced to ride while lying down
Stated pain relief upon sitting up
Mrs. Jones rated her pain 10/10 on arrival.
Mrs. Jones verbalized pain 4/10 at 1245 during my clinical shift

**Nursing Diagnosis/Outcomes**

- **Ineffective airway clearance r/t pneumonia AEB respiratory secretions → maintain patent airway**
- **Impaired gas exchange r/t pneumonia and COPD AEB low PaO2 and elevated PaCO2 → ensure adequate ventilation**
- **Risk for infection r/t urinary catheter in place → prevent CAUTI**
- **Risk for imbalanced nutrition: Less than body requirements r/t PEG tube feedings → ensure adequate nutrition**
- **Risk for impaired skin integrity r/t bedrest → prevent immobility complications**

**Objective Data**

- CXR and CT confirmed pneumonia
- PMH of COPD, CHF, anemia, cancer
- EKG –NSR
- Sputum culture – Staphylococcus aureus
- VSS

**Patient Information**

Mrs Jones
80 y/o
Resides at Brookstone assisted living with husband
Christian
5'0"
210 lbs
Caucasian
Female

**Nursing Interventions**

- **Suction pt PRN**
- **Provide good oral care**
- **Pt is prone to CO2 retention d/t COPD (hyperventilating), pt is not receiving adequate oxygenation according to PaCO2**
- **Perform catheter/peri care**
- **Empty urine bag regularly, keep bag below level of bladder**
- **Provide supplementation as needed**
- **monitor hydration status and albumin levels**
- **turn patient PRN**