N431 Care Plan #2

Lakeview College of Nursing

Delaney Lockard

Demographics (3 points)

Date of Admission 03/14/2020	**Patient Initials** K.K.	**Age** 72 years old	**Gender** Male
Race/Ethnicity African American	**Occupation** Retired welder	**Marital Status** Widowed	**Allergies** NKDA
Code Status DNR/DNI	**Height** 69 cm	**Weight** 66.4 kg	

Medical History (5 Points)

Past Medical History: Hypertension, atrial fibrillation, hyperlipidemia, chronic obstructive pulmonary disease

Past Surgical History: Appendectomy (1995)

Family History: Maternal - diabetes, paternal - myocardial infarction, brother - diabetes

Social History (tobacco/alcohol/drugs): Never used tobacco products, uses alcohol casually (one-two times per month), never abused drugs/substances

Assistive Devices: N/A

Living Situation: Lives by himself in a townhouse

Education Level: High school diploma

Admission Assessment

Chief Complaint (2 points): "Shortness of breath and cough"

History of present Illness (10 points): K.K. presented to the ED on 03/14/2020 by car with his granddaughter. His granddaughter came to his house for her weekly visit and the patient had told her of his symptoms. He reports that his chief complaint is "shortness of breath and cough." The patient states that his activity level has decreased over the last several days due to the worsening

shortness of breath. He also states that exertion aggravates the shortness of breath and rest periods alleviate the shortness of breath along with the use of his PRN supplemental oxygen of 2L/minute.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): COPD exacerbation

Secondary Diagnosis (if applicable): N/A

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

COPD, or chronic obstructive pulmonary disease, is the third leading cause of death in the United States. This disease process is characterized by poorly reversible airflow limitation. This is caused by chronic bronchitis, emphysema, and hyperactive airway disease. Chronic bronchitis involves overproduction of mucus and this inhibits the patient from optimal oxygenation (Capriotti & Frizzell, 2016). Emphysema occurs from the alveoli over expanding and becoming trapped with air, resulting in high residual volume of carbon dioxide in the lungs. Airflow limitations of this disease involve the bronchioles to become narrow and mucus-filled resulting in fibrosis (Capriotti & Frizzell, 2016). Cigarette smoking is one of the highest risk factors for this disease (Capriotti & Frizzell, 2016).

Signs and symptoms of COPD include chronic bronchitis, emphysema, and asthma. Initially, dyspnea comes upon demanding exertion (Capriotti & Frizzell, 2016). Dyspnea becomes more frequent and the chief complaint can be coughing or wheezing (Capriotti & Frizzell, 2016). Due to the hypoxia of chronic bronchitis, this can lead to comorbidities like

right-sided heart failure. Upon auscultation, wheezing and diminished breath sounds are heard (Hinkle & Cheever, 2018).

Diagnostic testing for this disease process include pulmonary function tests, otherwise known as spirometry. This is used when the classic COPD symptoms are present. Further testing includes a blood draw for complete blood count and arterial blood gases along with diagnostic exams like a chest x-ray and electrocardiogram (Hinkle & Cheever, 2018). For example, ABG values can show an exacerbation and the chest x-ray could reveal chronic bronchitis (Hinkle & Cheever, 2018).

The treatment for COPD starts with bronchodilators, which is essential for this disease process. This can aid in the relief of respiratory symptoms (Capriotti & Frizzell, 2018). In addition to the bronchodilators, medications like oral corticosteroids and leukotriene antagonists can be prescribed for additional therapy if needed (Capriotti & Frizzell, 2018). It is important to also use nonpharmacological interventions when treating COPD. This can include smoking cessation, vaccinations like the pneumococcal vaccine, and supplemental oxygen therapy. With severe respiratory distress, mechanical ventilation support can be required (Capriotti & Frizzell, 2018).

Pathophysiology References (2) (APA):

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

Hinkle, J. L., Cheever, K. H., & Brunner, L. S. (2018). *Brunner & Suddarths textbook of medical-surgical nursing*. Wolters Kluwer.

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 (03/14/2020)	Today's Value	Reason for Abnormal Value
RBC	3.80-5.41 mcl	N/A	N/A	
Hgb	11.3-16 g/L	13.6	N/A	
Hct	37-47%	N/A	N/A	
Platelets	149-393 k/mcl	N/A	N/A	
WBC	4.0-11.4 k/mcl	9.4	N/A	
Neutrophils	45.3-79%	N/A	N/A	
Lymphocytes	11.8-45.9%	N/A	N/A	
Monocytes	4.4-12%	N/A	N/A	
Eosinophils	0.0-6.3%	N/A	N/A	
Bands	0.0-5.0%	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 (03/20/2020)	Today's Value	Reason For Abnormal
Na-	135-145 mmol/L	124 mmol/L	N/A	This patient's sodium levels are decreased due to inadequate

				intake. This is likely due to his lack of activity (Van Leeuwen & Bladh, 2015).
K+	3.5-5.0 mmol/L	2.8 mmol/L	N/A	The potassium levels are decreased due to his past medical history of hypertension and his current prescription for Lisinopril 40 mg (Van Leeuwen & Bladh, 2015).
Cl-	98-106 mmol/L	N/A	N/A	
CO2	21-31 mmol/L	N/A	N/A	
Glucose	74-109 mg/dL	94	N/A	
BUN	7-25 mg/dL	24	N/A	
Creatinine	0.05-0.90 mg/dL	2.8 mg/dL	N/A	This patient's creatinine level is elevated because of his current prescription for amiodarone (Pacerone) 200 mg (Van Leeuwen & Bladh, 2015).
Albumin	3.5-5 g/dL	N/A	N/A	
Calcium	9.0-10.5 mEq/dL	N/A	N/A	
Mag	1.3-2.1 mEq/dL	N/A	N/A	
Phosphate	2.5-4.5 mg/dL	N/A	N/A	
Bilirubin	0.3-1 mg/dL	N/A	N/A	
Alk Phos	35-105 units/L	N/A	N/A	
AST	0.0-32 units/L	N/A	N/A	
ALT	4-33 units/L	N/A	N/A	
Amylase	30-220 units/L	N/A	N/A	

Lipase	0.0/160 units/L	N/A	N/A	
Lactic Acid	0.5-1 mmol/L	N/A	N/A	
Troponin	>0.03	N/A	N/A	
CK-MB	>90	N/A	N/A	
Total CK	30-170 mmol/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 Admission	Today's Value	Reason for Abnormal
INR	0.8-1.1	N/A	N/A	
PT	11-12.5	N/A	N/A	
PTT	30-40 sec	N/A	N/A	
D-Dimer	<0.4 mcg/mL	N/A	N/A	
BNP	0.5-30 pg/mL	N/A	N/A	
HDL	>55 mg/dL	N/A	N/A	
LDL	<130 mg/dL	N/A	N/A	
Cholesterol	50-60 mg/dL	N/A	N/A	
Triglycerides	35-135 mg/dL	N/A	N/A	
Hgb A1c	>55 mg/dL	N/A	N/A	
TSH	0.4-4.2 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 and clear	N/A	N/A	
pH	5.0-8.0	N/A	N/A	
Specific Gravity	1.005-1.035	N/A	N/A	
Glucose	Normal	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	>5	N/A	N/A	
RBC	0-3	N/A	N/A	
Leukoesterase	Negative	N/A	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	7.25	N/A	The pH levels are elevated due to the patient's recent diagnosis of a COPD exacerbation (Van Leeuwen & Bladh, 2015).
PaO2	80-100 mmHg	91	N/A	
PaCO2	35-45 mmHg	84	N/A	This patient's PaCO2 levels are elevated due to his recent diagnosis of a COPD exacerbation (Van Leeuwen & Bladh, 2015).
HCO3	21-28 mEq/L	24	N/A	
SaO2	95-100%	N/A	N/A	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2015). *Davis's Comprehensive handbook of Laboratory & Diagnostic tests* (6th ed.). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): On 03/14/2020, this patient had undergone a chest x-ray to visualize the respiratory and cardiovascular systems and this was indicative of chronic bronchitis. The same day, an electrocardiogram shows the patient in atrial fibrillation at a rate of 88 beats per minute.

Diagnostic Test Correlation (5 points): A chest x-ray was ordered to allow the physician to diagnose abnormalities to the lungs or heart (Van Leeuwen & Bladh, 2015). In this case, there is noted to be chronic bronchitis. An electrocardiogram was ordered to assess the patient's heart rhythm due to her lab values showing electrolyte imbalances (Van Leeuwen & Bladh, 2015). This patient's EKG results show his heart in atrial fibrillation at a rate of 88 bpm.

Diagnostic Test Reference (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2015). *Davis's Comprehensive handbook of Laboratory & Diagnostic tests* (6th ed.). 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	lisinopril (Prinivil)	amiodarone hydrochloride (Pacerone)	aspirin (Bayer)	atorvastatin calcium (Lipitor)	metoprolol tartrate (Lopressor)
Dose	40 mg	200 mg	81 mg	40 mg	50 mg
Frequency	Daily	Daily	Daily	Daily HS	BID
Route	PO	PO	PO	PO	PO
Classification	Ace inhibitor/vasodilator	Class III antiarrhythmic	Antiplatelet	Antihyperlipidemic	Beta blocker
Mechanism of Action	This can reduce blood pressure by stopping the angiotensin I to angiotensin II conversion. This then leads to a decrease of aldosterone and this reduces sodium and water reabsorption. The outcome is lower blood pressure.	This medication acts on the membranes of the cardiac cell. It prolongs the repolarization and refractory period, this raising ventricular fibrillation.	This inhibits the synthesis of prostaglandin by cyclooxy-genase; also inhibits platelet irrigation	This medication reduces plasma cholesterol and lipoprotein levels by stopping the HMG-CoA reductase and cholesterol synthesis in the liver - this increases the number of LDL receptors and enhances uptake/ breakdown process	This pharmacological drug aids in decreasing high blood pressure by lowering the release of resin from the renal system.
Reason Client Taking	Tx hypertension	Tx atrial fibrillation	Tx blood thinner	Tx hyperlipidemia	Tx hypertension

Contraindications (2)	Hypersensitivity, hereditary or idiopathic angioedema or history of angioedema	Bradycardia that causes syncope, SA node dysfunction	Asthma, hemophilia	Active hepatic disease, breastfeeding	Heart rate less than 60 bpm, acute heart failure
Side Effects/Adverse Reactions (2)	Ataxia, hyperglycemia	Abnormal gait, muscle weakness	Confusion, ecchymosis	Abnormal dreams, dyspnea	Bradycardia, insomnia
Nursing Considerations (2)	Use cautiously in patients with fluid volume deficit or heart failure, monitor blood pressure often - especially during first two weeks of therapy	Be aware this drug may worsen pulmonary disorders - get a chest x-ray at beginning of therapy, be aware to regularly undergo ophthalmic exams	Don't crush time-release or controlled release tablets, ask patient about tinnitus	Should not be used in patients taking cyclosporine, gemfibrozil or telaprevir - high risk for rhabdomyolysis, use cautiously in patients with alcoholism	Taper over 2 weeks, may worsen heart failure
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor patient's serum creatinine and potassium, monitor patient's blood pressure	Monitor vital signs, EKG, thyroid hormone levels, liver enzymes	Monitor bleeding, monitor for tinnitus	Measure lipid levels every 2 to 4 weeks, liver function tests	Assess EKG, monitor vital signs
Client Teaching needs (2)	Explain how this helps to control not cure hypertension, take at the same time every day	Explain how they will need to undergo frequent lab testings and monitoring, report cough, dark urine, dyspnea, fainting	Don't take ibuprofen during low-dose aspirin therapy, take with food/after meals to avoid GI upset	Educate patient on low-cholesterol diet, take drug at same time	Do not stop abruptly, take with food at the same day every day

Hospital Medications (5 required)

Brand/Generic	sodium chloride solution (Normal saline 0.9%)	potassium chloride (Cena-K)	levofloxacin (Levaquin)	acetaminophen (Tylenol)	docusate sodium (Colace)
Dose	75 mL/hr	40 mEq	750 mg	650 mg	100 mg
Frequency	Continuously	Once	Daily	PRN Q6H	PRN BID
Route	IV	IV	IV	PO	PO
Classification	Minerals/electrolytes	Electrolyte replacement	Antibiotic	Nonopioid analgesic	Stool softener
Mechanism of Action	Sodium is an essential cation of fluid function and helps control water distribution, and balances electrolytes and osmotic pressure. This intravenous solution is valuable in balancing fluids and electrolytes.	This electrolyte replacement acts as a major cation in the intracellular fluid and is essential for physiologic processes.	This antibiotic interferes with bacterial cell replication by inhibiting the bacterial enzyme of DNA gyrase - this is essential for repair/ replication of bacterial DNA.	Inhibits cyclooxygenase, then blocking prostaglandin production and tampering with pain impulse generation in the peripheral NS.	This drug acts as a surfactant that softens the stool by decreasing the surface tension. More fluid then penetrates the stool, forming it to become softer.
Reason Client Taking	Tx "generalized weakness" and potential dehydration	Tx electrolyte imbalances	Tx chronic bronchitis	Tx generalized pain	Tx constipation prevention
Contraindications (2)	congestive heart failure patients, severe renal impairment	Acute dehydration, hyperkalemia	Hypersensitivity, myasthenia gravis	Hypersensitivity, severe hepatic impairment	Hypersensitivity, fecal impaction
Side Effects/Adve	Hypertension, fluid retention	Chills, arrhythmias	Anxiety, blurred vision	Agitation, hypotension	Dizziness, diarrhea

rse Reactions (2)					
Nursing Considerations (2)	Store at room temperature, monitor for edema	Review past medical history prior to administration, infuse at a slow and controlled rate	Use cautiously in patients with renal impairment, stop at first sign of hypersensitivity	Use cautiously in patients with hepatic impairment, use cautiously in patients with alcoholism	Electrolyte imbalance may happen with long-term use, may need to assess for laxative abuse syndrome
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess IV site and patency, auscultate lung and heart sounds	Monitor vital signs, serum potassium levels, serum creatinine levels, urinary output following therapy	Monitor QT interval if needed, monitor for tendon rupture, monitor bowel movements	Prior to long-term therapy, obtain liver function tests, monitor renal function	Monitor CBC, monitor bowel movements, monitor stool characteristics
Client Teaching needs (2)	Report issues with IV site immediately, report signs of allergic reactions	Educate patients on potassium-rich foods, take with or after food to avoid GI upset	Increase fluid intake, take 1 to 2 hours after eating	Tablets can be swallowed whole or may be crushed, do not exceed daily limit	Contact physician if nausea/vomiting occur, discontinue if bleeding occurs

Medications Reference (APA):

Jones, & Bartlett. (2017). Nurse's Drug Handbook (16th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is A&Ox4. He is lying in the high Fowler's position in her hospital bed. He seems fatigued but remains chipper. The patient is in a little pain, but no distress noted. Overall appearance x3.

INTEGUMENTARY (2 points): **Skin color:** Normal for ethnic **Character:** Pink, dry, warm to touch **Temperature:** 36.8 **Turgor:** Good **Rashes:** None present **Bruises:** None present **Wounds:** None present **Braden Score:** 19 **Drains present: Y☐ N■** **Type:**	Patient is African American and presents with a dark complexion. Skin is pink, dry, and warm to touch. The skin turgor and its elasticity is normal with no tenting present or abnormal textures. No rashes, bruises, or wounds present. Braden score: 19
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head is normocephalic. The neck is supple. Ears show no abnormal drainage; the tympanic membrane is visible and pearly grey. Hair is a darker gray color and is combed back. PEERLA is noted. Nose shows the turbinates equal bilaterally. Oral mucosa is pink and moist with no abnormalities. Patient does currently wear glasses. His teeth are clean and intact.
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:**	Patient is not currently on telemetry. Heart sounds auscultated and S1 and S2 sounds noted. No murmur present. Dorsalis pedis pulses graded at 3+ and present bilaterally. Capillary refill was < 3 seconds on the left hand. Patient does not currently have edema. No signs of neck vein distention.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N■** **Breath Sounds: Location, character**	The patient's lungs were auscultated anteriorly and posteriorly. Lungs noted to have bilateral wheezes and diminished lung sounds. The patient has no present accessory muscle use when breathing. He seems to be short of breath sometimes. He is on supplemental oxygen via nasal cannula at 2L.
GASTROINTESTINAL (2 points): **Diet at home:** Heart-healthy **Current Diet:** Heart-healthy **Height:** 69 cm **Weight:** 66.4 kg **Auscultation Bowel sounds:** **Last BM:** 03/30/2020 **Palpation: Pain, Mass etc.:**	Patient's current diet is heart-healthy at home and in the hospital. He denies the use of alcohol. Upon auscultation, bowel sounds are active in all four quadrants. Last BM was today, on 03/30/2020. He states he does not have pain upon palpation. Abdomen is round and distended. There is scar tissue present on his abdomen due to past surgical history including an

Inspection: **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ■** **Nasogastric: Y ☐ N ■** **Size:** **Feeding tubes/PEG tube Y ☐ N ■** **Type:**	appendectomy in 1995. No masses present. No ostomy, nasogastric or PEG tubes present. The patient also denies rapid or current weight loss.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N■** **Dialysis: Y ☐ N■** **Inspection of genitals:** **Catheter: Y ☐ N ■** **Type:** **Size:**	Urine is yellow and hazy; there was 1,750 mL voided during my shift. Patient says he feels no pain, hesitancy or urgency upon urination. There is no dialysis or catheter present. Genitals were not assessed. Patient is on I's and O's.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N■** **Fall Risk: Y ☐ N■** **Fall Score:** 50 **Activity/Mobility Status:** **Independent (up ad lib) ■** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	This patient has full range of motion and does not require additional support upon ambulation. He shows no signs of neurovascular deficit. He also exhibits an active range of motion bilaterally. The fall risk score is 50; this concludes he is not a fall risk. He is up ad lib with no assistive devices and he does not need ADL assistance.
NEUROLOGICAL (2 points): **MAEW: Y ■ N☐** **PERLA: Y ■ N☐** **Strength Equal: Y ■ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient can move all extremities well. Strength is equal in all extremities as well. PERLA is noted and present upon assessment. He appears a little fatigued but cheerful; his granddaughter is visiting with him. A&O x4 and LOC x3. He speaks English well.

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):**	Patient states that he "enjoys reading, visiting with family, and building model airplanes." His developmental level is noted to be normal. Patient states that he is of the Christian religion. Patient appears to have family support by the presence of his granddaughter. He is a retired welder.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	88 bpm	152/68 mmHg	24 bpm	36.5 C	98% 2L via nasal cannula (NC)
1100	68 bpm	138/62 mmHg	24 bpm	36.8 C	97% 2L via nasal cannula (NC)

Vital Sign Trends: Vital sign observations include that at the 0700 check the patient's blood pressure was 152/68 mmHg. Following this, his daily medications were administered; this included lisinopril 40 mg. At the second vital sign check at 1100, his blood pressure had decreased to 138/62 mmHg.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric Pain Scale	Generalized pain	6/10	Soreness, achy	Tylenol (acetaminophen) 650 mg administered
1100	Numeric Pain Scale	Generalized pain	2/10	Dull	No further intervention at this time

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g **Location of IV:** L. antecubital **Date on IV:** 03/29/2020 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No signs of erythema, drainage or complications present. **IV dressing assessment:** IV dressing is clean, dry, and intact.	Normal Saline 0.9% at 75 mL/hr
Size of IV: 18 g **Location of IV:** R. hand **Date on IV:** 03/30/2020 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No signs of erythema, drainage or complications present. **IV dressing assessment:** IV dressing is clean, dry, and intact.	Saline lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
660 mL	1,750 mL

Nursing Care

Summary of Care (2 points)

Overview of care: During my shift, I administered medications orally and intravenously to the patient. After rating his pain 6/10, I administered Tylenol 650 mg orally. Upon re-assessment at 1100, his pain rating decreased to 2/10 and needed no further intervention. This patient was ordered to have his intake and output monitored and I documented the amounts during my shift.

Procedures/testing done: No procedures or testing done during my shift.

Complaints/Issues: No current complaints or issues present from the patient or his family.

Vital signs (stable/unstable): After obtaining this patient's vital signs at 0700, his blood pressure was documented as 152/68 mmHg. Following this, his daily medications were administered, which included lisinopril 40 mg. After intervention and a second vital sign assessment at 1100, his blood pressure had decreased to 138/62 mmHg. No further trends were noted.

Tolerating diet, activity, etc.: He is tolerating his heart-healthy diet in the hospital well. He can ambulate independently and needs no assistance regarding ADLs.

Physician notifications: There are no current notes from the physician regarding this patient at this time.

Future plans for patient: Future plans for this patient is to educate on oxygen therapy and discharge him.

Discharge Planning (2 points)

Discharge location: The location of her discharge will be his home, where he lives by himself.

Home health needs (if applicable): The home health needs that are to be put in place for this patient include continuous supplemental oxygen therapy 2L via nasal cannula at home as well as the visits of nurses and bath aides.

Equipment needs (if applicable): The equipment needed for this patient includes the supplies required for continuous supplemental oxygen therapy at home.

Follow up plan: Patient is to follow-up with his PCP in one week from discharge at Sarah Bush Lincoln Health Center in Mattoon, Illinois.

Education needs: It is very important for this patient to leave the hospital educated on his home health needs of oxygen therapy. He should also be educated on the importance of avoiding electrolyte imbalances through his dietary and fluid intake.

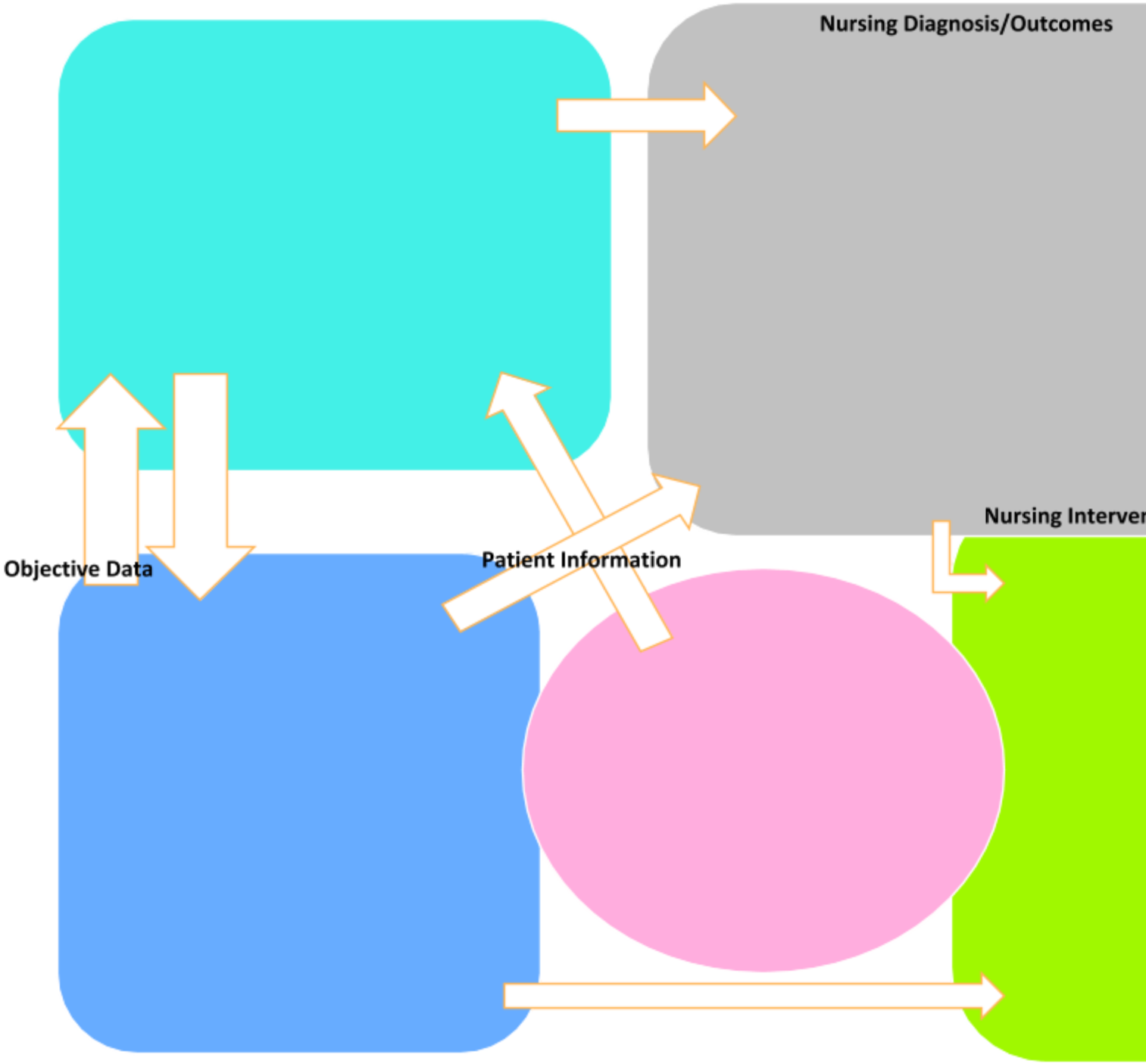
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Ineffective breathing pattern related to ineffective inspiration and expiration occurring with chronic airflow limitations as evidence by COPD exacerbation.	Following treatment and intervention, the patient's breathing pattern improves as evidence by a report of reduction/absence of shortness of breath.	**1.** Assess respiratory status Q2-4H and as indicated by the patient's condition. Report significant findings. **2.** Administer bronchodilator therapy as prescribed.	During my shift, the patient's respiratory status was assessed at 0700 and 1100. He was prescribed DuoNeb Q4H PRN and has been receiving that via inhalation to relieve his symptoms of shortness of breath.
2. Impaired gas exchange related to altered oxygen supply occurring with small airway	This diagnosis was chosen due to the patient's report of "shortness of breath" and his need for	1. Assess signs and symptoms of hypoxia and report significant findings. 2. Monitor pulse oximetry readings	During my physical assessment of this patient, there were no noted signs of hypoxia. At 0700 and 1100, his pulse oximetry reading was documented to be at 98% and 97%.

inflammation as evidence by the administration of supplemental oxygen.	supplemental oxygen therapy.	and titrate oxygen to keep O2 at normal levels.	
3. Activity intolerance related to imbalance of oxygen supply and demand due to inefficient work of breathing as evidence by his report of decline in his level of activity.	Upon discharge, the patient can report a decrease in his report of dyspnea during activity and rates perceived exertion at 3 or less on scale of 0-10.	1. Monitor the patient's respiratory response to activity, including O2 saturations. 2. Allow at least 90 minutes in between activities for undisturbed rest.	During my shift, I took a walk with the patient around the unit floor and noted no signs of shortness of breath. Afterwards, he was in his hospital room for a rest period.
4. Imbalanced nutrition: less than body requirements related to decreased intake occurring with fatigue as evidence by his decreased levels of sodium and potassium.	This diagnosis was chosen due to the lab results showing hyponatremia and hypokalemia and is prescribed IV fluids and medications as well as an increase in fluid intake.	1. Assess food and fluid intake. **2.** Discuss with the patient and significant others the importance of good nutrition in the treatment of COPD.	This patient has been responding well to his increase in fluid intake. During my shift, he was educated on foods that are high in potassium and the importance of hydration.

Other References (APA):

Swearingen, P. L. (2016). *All-in-one care planning resource: medical-surgical, pediatric, maternity; psychiatric nursing care plans.* Elsevier/Mosby.



Concept Map (20 Poin