

N321 Care Plan # 3

Lakeview College of Nursing

Rece Doggett

Demographics (3 points)

Date of Admission 04/09/2020	Patient Initials J J	Age 48	Gender F
Race/Ethnicity White	Occupation Sales Woman	Marital Status Married	Allergies Seasonal allergies
Code Status Full	Height 5' 5"	Weight 155 LBS	

Medical History (5 Points)

Past Medical History: HTN, Psoriasis, Hypothyroidism, Gerd

Past Surgical History: No past surgical history

Family History: Mother-cancer, Father-HTN, CHF, and DM

Social History (tobacco/alcohol/drugs): A pack a day

Assistive Devices: None

Living Situation: With husband, son moved out

Education Level: High School

Admission Assessment

Chief Complaint (2 points): Trouble breathing

History of present Illness (10 points): Janis had a cold a week prior to admission. She was treating this with OTC medicines. Recently, she has been noticing SOB and has produced green sputum with her cough. She planned on going to the walk in but woke up in the middle of the night due to dyspnea. She was brought in by her husband who helped her in the car. Client states she has never been this anxious before.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia

Secondary Diagnosis (if applicable):

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

Pneumonia is an infection that can be caused by many different pathogens. Pneumonia is when the air sacs in one or both lungs are inflamed and filled with fluid or pus causing a cough, chills, or difficulty breathing. Some **signs and symptoms** include chest pain when breathing or coughing, confusion or changes in mental awareness (usually in adults >65), cough (may produce phlegm), fatigue, fever, sweating, chills, lower than normal body temperature, N, V, D, and shortness of breath. There are many different **causes** such as bacteria, bacteria-like organisms, fungi, and viruses. Community-acquired pneumonia is the most common type which is caused by the bacteria-like organisms. **Risk factors** including being hospitalized, chronic disease, smoking, weakened or suppressed immune system. The client was most likely exposed to pneumonia by the community but did not actually get sick until she had her cold which would have lowered her immune system. **Complications** include bacteria in the bloodstream (bacteremia), difficulty breathing, fluid accumulation in the lungs, and lung abscess. **Prevention** of the disease includes vaccinations, make sure children are vaccinated, practice good hygiene, don't smoke, and support a strong immune system.

Some of the following information is how pneumonia is related to the client. The client here is a known smoker. When the client obtained her cold, this lowered her immune system to make her more prone to obtaining this disease. An x-ray is a diagnostic test that is used to detect pneumonia. This test was performed on the client which showed signs of infection. Antibiotics may be given as treatment. There are other preventative methods to avoid infection such as vaccines.

Pathophysiology References (2) (APA):

Mayo Clinic Staff. (2018a, March 13). Pneumonia - Symptoms and causes. Retrieved April 16, 2020, from <https://www.mayoclinic.org/diseases-conditions/pneumonia/symptoms-causes/syc-20354204>

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	4.4 – 5.8	5.0		
Hgb	13 – 16.5	11		Possibly d/t low iron b/c of normal RBC
Hct	38 – 50	40		
Platelets	140 – 446			
WBC	4 – 12	17		Indications of Infection
Neutrophils				
Lymphocytes				
Monocytes				
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	158		Probable for dehydration
K+	3.5 – 5.1	2.3		Dehydration
Cl-	98 – 107	108		Not too far out of proportion but r/t K+ and Na-
CO2	21 – 31	28		

N321 Care Plan

Glucose	70 – 99	59		May have not eaten recently
BUN	7 – 25	28		Signs of dehydration
Creatinine	0.5 – 1.2	0.9		
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			
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	X	X	X	X
PT	X	X	X	X
PTT	x	X	X	X

N321 Care Plan

D-Dimer	X	X	X	X
BNP	X	X	X	X
HDL	X	X	X	X
LDL	X	X	X	X
Cholesterol	X	X	X	X
Triglycerides	X	X	X	X
Hgb A1c	X	X	X	X
TSH	X	X	X	X

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	NO UA ON FILE			
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				
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	No CULTURE S ON FILE			
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Troponin – 0.01, CKMB – 0.3, Creatine kinase – 30

Chest X-ray

Diagnostic Test Correlation (5 points): Inflammation/fluid found in L base of lungs

Diagnostic Test Reference (APA):

Hinkle, J. L., & Cheever, K. H. (2013). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (13th Edition, Vol. 2). Philadelphia, PA: Lippincott Williams & Wilkins.

Current Medications (10 points, 1 point per completed med)

10 different medications must be completed

Home Medications (5 required)

Brand/ Generic	Zestril Lisinopril	Tremfya Guselkumab	Multivita min	Synthroid Levothyroxine	Pantoprazole protonix
Dose	20 mg	1 injection	1 pil	50mcg	40mg
Frequency	Daily	Every 8 weeks	Daily	Daily	Daily
Route	PO	SubQ	PO	PO	PO
Classification	Antihypertensive	Antipsoratic	Supplement	Thyroid hormone	Proton pump inhibitor
Mechanism of Action	Lowers BP	Inhibits part of interleukin	Absorbed in GI	Replaces thyroid hormone	Reduces stomach acid
Reason Client Taking	Hypertension	Plaque Psoriasis	Maintain health	Treats hypothyroidism	Heart burn
Contraindications (2)	Diabetes, renal impairment	Hypersensitivity to guselkumab	Allergies to ingredients, alcohol abuse	Acute MI, untreated thyrotoxicosis	Concurrent therapy w/ rilpivirine, hypersensitivity to drug
Side Effects/Adverse Reactions (2)	Fatigue, hallucinations, TIA	Headache, migraine, genital herpes, arthralgia	Constipation, diarrhea, upset stomach	Anxiety, dyspnea	Abdominal px, anaphylaxis
Nursing Considerations (2)	Should not be given after MI, monitor	Assess for TB, allow med to	Should take regularly	Not used for weight loss... plz	Don't give w/in 4 weeks of testing for

N321 Care Plan

	BP	warm to room temp after removing from fridge	@ same time every day, Check allergies	don't do that. Ensure children get proper dosages	h. pylori, give 30 mins before meal
--	-----------	---	---	--	--

Hospital Medications (5 required)

Brand/ Generic	Toradol Ketorolac	Piperacill in Tazocin	Tussionex Chlorphenira mine	Solumedrol Methylprednis olone	Ipratropiu m Atrovent
Dose	30 mg	3.375 g	5 mL	125mg	3mL
Frequency	8H	6H	12 H	6H	4H
Route	IV	IV	PO	IV	Aerosol
Classification	Anti- inflammato ry	Antibiotic	Narcotic	Steroid	Bronchodil ator
Mechanism of Action	Blocks enzymes to synthesize prostagland ins	Prevents reproduct ion of bacteria	Suppress cough	Reduces inflammation, pain, and allergic-type rxn	Opens airways and prevents bronchospa sms
Reason Client Taking	Pain	Infection	cough	Pneumonia	Pneumonia
Contraindica tions (2)	Renal impairment , breastfeedi	Cystic fibrosis, kidney disease	Dyspnea, age - elderly	Bleeding problems, allergies to prednisone	Glaucoma, enlarged prostate

	ng				
Side Effects/ Adverse Reactions (2)	Hyperglycemia, diaphoresis	N,V,D constipation	Lightheadedness, dizziness, sedation	N,V Heartburn, dizziness	Bladder px, bloody/cloudy urine
Nursing Considerations (2)	Should be avoided in clients w/ recent MI Risk for heart failure increases	Should be thawed in fridge, take at proper times.	Check RR before administering , Encourage adequate fluid intake	Check allergies, Slow push to avoid toxicity	Check drug-drug interactions . Should not give if pregnant

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:	AO x 4 Client anxious Dressed appropriate for situation
---	--

<p>Overall appearance:</p>	
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 20 Drains present: Y<input type="checkbox"/> N<input type="checkbox"/> Type:</p>	<p>Skin is hot dry No edema Nailbeds pale Peripheral pulses 2+ throughout No skin breakdown</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Appears pale Lips dry and cracked HEENT present Flat neck veins no abnormalities noted</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): regular Peripheral Pulses: 2+ Capillary refill: Quick Neck Vein Distention: Y<input checked="" type="checkbox"/> N<input checked="" type="checkbox"/> Edema Y<input type="checkbox"/> N<input checked="" type="checkbox"/> Location of Edema:</p>	<p>S1 and S2 sounds with no murmur Sinus Tach @ 110 BMP rhythm is regular</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y<input checked="" type="checkbox"/> N<input type="checkbox"/> Breath Sounds: Location, character</p>	<p>Client using accessory muscles at 28 RR Coughing yellow/green sputum Crackles in left base of the lungs</p>
<p>GASTROINTESTINAL (2 points): Diet at home: normal Current Diet: Normal Height: 5' 5" Weight: 155lb Auscultation Bowel sounds: Normoactive Last BM: Yes Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains:</p>	<p>No scaring drainage or wounds upon inspections</p>

<p>Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	
<p>GENITOURINARY (2 Points): Color: Yellow Character: Clear Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Full Supportive devices: none Strength: description ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 10 Activity/Mobility Status: normal Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Client is weak compared to normal, but can perform ADLs as needed</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Clear Sensory: Normal LOC: No</p>	<p>Client understands and follows commands</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home</p>	<p>Client has a husband who stayed with her and a son who is married out of the house.</p>

environment, family structure, and available family support):	
--	--

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1000	110	150/98	28	101.1	90% 2L
1230	108	126/84	24		95% @ 3L

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	1 - 10	Back and chest	7	Sharp	Dilaudid
1230	1 – 10	Back and Chest	5	Sharp	After toradol

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18G Location of IV: L Forearm Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	0.9 NS

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

Nursing Care

Summary of Care (2 points)

Overview of care: Client received IV antibiotics and O2 to maintain pulmonary health.

Procedures/testing done: X-ray of chest and labs

Complaints/Issues: Trouble breathing

Vital signs (stable/unstable): Stable with interventions

Tolerating diet, activity, etc.: Tolerating as normal

Physician notifications:

Future plans for patient: Continue doctor visits as normal

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): None

Equipment needs (if applicable): May take home nebulizer if needed

Follow up plan: As needed for previous health conditions

Education needs: Client should be taught early signs and risk factors for pneumonia

because many people experience it yearly.

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none">• Include full nursing diagnosis with “related to” and “as evidenced by” components	<ul style="list-style-type: none">• Explain why the nursing diagnosis was chosen		<ul style="list-style-type: none">• How did the patient/family respond to the nurse’s actions?• Client response, status of goals and

N321 Care Plan

			outcomes, modifications to plan.
1. Decreased gas exchange	Related to low O2 sat as evidenced by rapid RR	1.Elevate HOB 2.Suction secretions if needed	Interventions successful clients O2 increased to 95%.
2. Dehydration	Related to increased insensible loss as evidenced by tachypnea, fever, or diaphoresis	1. Encourage fluid intake 2.Promote oral hygiene	Client is working on this intervention by consuming more fluids
3. Potential for insufficient airway clearance	Related to production of phlegm as evidence cough	1. Auscultate breath sounds 2.ensure deep breath and cough exercise	Patient improving in this evaluation. Cough has suppressed with medication.

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
Client stated she had a cold
Experiencing dyspnea
Feels weak

Nursing Diagnosis/Outcomes

Dehydration - Interventions successful clients O2 increased to 95%.
Impaired gas exchange - Client is working on this intervention by consuming more fluids
Potential for insufficient airway - Patient improving in this evaluation.
Cough has suppressed with medication.

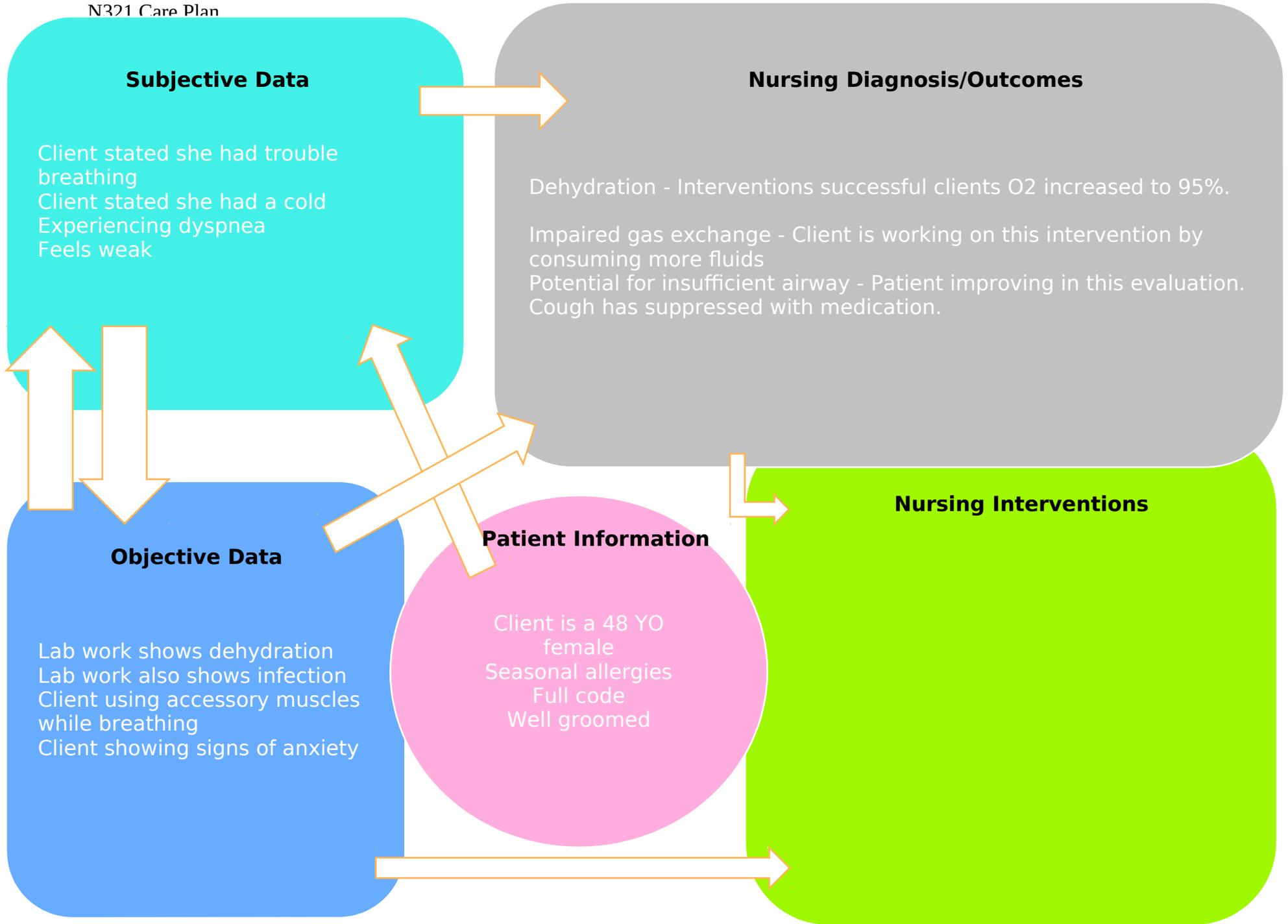
Objective Data

Lab work shows dehydration
Lab work also shows infection
Client using accessory muscles while breathing
Client showing signs of anxiety

Patient Information

Client is a 48 YO female
Seasonal allergies
Full code
Well groomed

Nursing Interventions



N321 Care Plan