N431 Care Plan # 3

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
6/28/2020	SB	84	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Unemployed	Married	NKDA
Code Status	**Height**	**Weight**	
Full	5’2”	296 lbs	

Medical History (5 Points)

Past Medical History: TIA, Primary osteoarthritis, pneumonia, obesity, hypercholesterolemia, GERD, Diabetes Mellitus Type 1, Chronic Kidney Disease Stage 4, COPD, carcinoma, breast cancer

Past Surgical History: Upper endoscopy, total hip arthroplasty, joint replacement, breast surgery

Family History: Mother (deceased)- diabetes mellitus, heart disease, cancer; father (deceased)- heart disease

Social History (tobacco/alcohol/drugs): No alcohol, cigarette, tobacco, illicit drugs, or e-cigarette use.

Assistive Devices: Walker, Oxygen

Living Situation: Home

Education Level: High school

Admission Assessment

Chief Complaint (2 points): Dyspnea

History of present Illness (10 points): Patient presents to emergency department complaining of shortness of breath and difficulty breathing for the past three days. The patient describes a constant, tight pressure in their chest. This feeling is exacerbated when lying down or during

exertion. Relief was provided only by sitting up and did not fully relieve the symptoms. Patient has furosemide prescribed at home but does not remember the last time she took the medication.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Symptomatic Anemia

Secondary Diagnosis (if applicable): COPD Exacerbation

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

Anemia is considered a decrease in the level of red blood cells, hemoglobin, and possibly hematocrit. This decreases the ability of the body to carry oxygen throughout the body and provide adequate oxygenation (Sorenson et al., 2019). Many times, anemia is caused by an underlying condition that needs to be discovered and evaluated or treated.

Signs and symptoms of anemia are broad and may differ between patients. If the anemia results from blood loss, oxygen carrying ability will decrease. This decrease can cause hypoxia, hypovolemia, and hypotension (Maakaron, 2019). The patient may present with pallor, petechiae, and nail defects (Sorenson et al., 2019). Patients with symptomatic anemia due to iron deficiency may exhibit signs such as constantly chewing ice, cramps in their calves, and physical fatigue (Maakaron, 2019). Iron-deficiency anemia may also display dysphagia and worsening symptoms of cardiac or respiratory diseases. This client presented with decreased red blood cells, hemoglobin, and hematocrit. Physical symptoms include hyperventilation with poor oxygenation status, pallor, and extended capillary refill.

Expected laboratory findings in this condition include decreased red blood cells, hemoglobin, hematocrit, and increased platelet count in some clients (Maakaron, 2019). Typical vital signs may include tachycardia, increased respiratory rate, and occasionally decreased blood

pressure (Sorenson et al., 2019). This client displayed decreased red blood cells, hemoglobin, and hematocrit but did not present increased platelets. Vital signs for this client included tachycardia and increased respiratory rate upon initial assessment.

Diagnostic tests for iron-deficiency anemia include a complete blood count, peripheral blood smears, iron studies, and monitoring for blood in urine or stool (Maakaron, 2019). This client had a complete blood count and a fecal occult stool test done. Both tests showed results consistent with anemia.

Clients with anemia are most commonly treated with ferrous sulfate, an appropriate type of blood transfusion, and location and treatment of the source of a bleed. Outside of the hospital, a client may also be treated with a special diet to increase dietary intake of iron (Sorenson et al., 2019). This client is being treated with folic acid and a transfusion of packed red blood cells to increase levels of iron, red blood cells, and hemoglobin.

Pathophysiology References (2) (APA):

Maakaron, J. (2019). Anemia: Practice Essentials, Pathophysiology, Etiology. *EMedicine*. https://emedicine.medscape.com/article/198475-overview#a1

Sorenson, M., Quinn, L., & Klein, D. (2019). *Pathophysiology: concepts of human disease*. Pearson.

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	4.2-6.2 million/mm3	2.2	2.27	This is most commonly due to a bleed or anemia. The likely cause for this client is anemia.

Hgb	12-18 g/dL	6.9	7.1	This is most commonly due to a bleed or anemia. The likely cause for this client is anemia.
Hct	36-50 mL/dL	20.9	21.7	This is typically due to anemia, which is the likely cause for this client.
Platelets	150,000-350,000/mm3	277	259	
WBC	4,500-11,000/mm3	9.9	7.5	
Neutrophils	52-62%	74.2	72.4	This is most commonly due to infection or inflammation. For this client it is likely due to inflammation.
Lymphocytes	25-33%	14.6	16.6	This is most commonly due to infections or undernutrition. For this client it is likely due to undernutrition.
Monocytes	3-9%	8.0	8.1	
Eosinophils	0-3%	2.1	2.4	
Bands	3-5%	--	--	

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 mEq/L	139	140	
K+	3.5-5 mEq/L	4.5	4.0	
Cl-	98-108 mEq/L	104	103	
CO2	22-32 mEq/L	27	30	
Glucose	70-100 mg/dL	78	87	
BUN	10-25 mg/dL	58	56	This can be due to dehydration or kidney issues. For this client, it is likely due to chronic kidney disease.
Creatinine	0.2-0.9 mg/dL	3.4	3.45	This is most commonly due to kidney impairment. For this client, it is likely due to chronic kidney

				disease.
Albumin	3.5-5 g/dL	3.3	3.0	This is commonly due to inflammation, shock, and malnutrition. For this client, it is likely due to malnutrition.
Calcium	8.5-10.0 mg/dL	10.0	9.2	
Mag	1.5-2.5 mg/dL	2.5	--	
Phosphate	2.5-4.5 mg/dL	--	--	
Bilirubin	0.1-1.3 mg/dL	0.3	0.3	
Alk Phos	40-120 U/L	119	110	
AST	10-30 U/L	28	17	
ALT	10-40 U/L	17	13	
Amylase	23-85 U/L	--	--	
Lipase	0-160 U/L	--	--	
Lactic Acid	0.5-1 mmol/L	0.7	--	
Troponin	0-0.4 ng/mL	0.641	0.379	This is most commonly due to myocardial damage but may also be due to heart failure, COPD, or chronic renal insufficiency. For this client, it is likely to be a combination of COPD and chronic kidney disease.
CK-MB	3-5%	--	--	
Total CK	22-198 U/L	--	--	

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	Non-Medicated: 1.1 Standard: 2-3 High Dose: 3-4	1.1	--	
PT	Males: 9.6-11.8 Females: 9.5-11.3	10.9	--	
PTT	30-40 seconds	31	--	
D-Dimer	</= 250 ng/mL	--	--	
BNP	<100 pg/mL	368	--	This is most often caused by heart failure or the inability to pump blood properly. For this client, it is likely they will receive a new diagnosis of heart failure.
HDL	>60 mg/dL	--	--	
LDL	<130 mg/dL	--	--	
Cholesterol	<200 mg/dL	--	--	
Triglycerides	<150 mg/dL	--	--	
Hgb A1c	Diabetic: 6.5%	--	--	
TSH	0.4-4.0 mU/L	--	--	

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	Light Yellow, Clear	Straw, clear	--	
pH	4.6-8.0	5.0	--	
Specific Gravity	1.001-1.035	1.009	--	
Glucose	Negative	Negative	--	

Protein	Negative	Negative	--	
Ketones	Negative	Negative	--	
WBC	Negative	Negative	--	
RBC	Negative	Negative	--	
Leukoesterase	Negative	Negative	--	

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	7.39	--	
PaO2	75-100	56	--	May be due to hyperventilation, inadequate oxygenation, or COPD. For this patient it is likely a combination of the three.
PaCO2	35-45	47	--	May be due to hyperventilation, inadequate oxygenation, or COPD. For this patient it is likely a combination of the three.
HCO3	22-26	28.1	--	May be due to hyperventilation, inadequate oxygenation, or COPD. For this patient it is likely a combination of the three.
SaO2	>90%	88	--	May be due to hyperventilation, inadequate oxygenation, or COPD. For this patient it is likely a combination of the three.

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	(-) <10,000/ mL (+) >10,000/	--	--	

	mL			
Blood Culture	Negative	Negative	--	
Sputum Culture	Normal Upper Respiratory Tract	--	--	
Stool Culture	Normal Intestinal Flora	--	--	

Lab Correlations Reference (APA):

Pagana, K.D., Pagana, T.J., Pagana, T.N. (2019). *Mosby's diagnostic and laboratory test reference.* Elsevier.

Sorenson, M., Quinn, L., & Klein, D. (2019). *Pathophysiology: concepts of human disease*. Pearson.

White, K. (2016). *Fast facts for critical care*. Kathy White Learning Systems.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Stool Occult Blood: Positive

Blood Type: B+

EKG: Sinus with arrhythmia 1st degree AV block. PRT axes 66, -25, 51. Ventricular rate 86, PR interval 250, QRS duration 96, QT/QTc 348/346.

Diagnostic Test Correlation (5 points):

Stool occult blood: This test was performed to determine if the source of this patient's low hemoglobin stems from a bleed in the gastrointestinal system.

Blood Type: This test was performed to determine the patient's blood type prior to administering blood.

EKG: This test is typically part of a standard protocol for patients presenting with these symptoms combined with a cardiac history.

Diagnostic Test Reference (APA):

RN adult medical surgical nursing. (11.0, pp. 271–272). (2019). Ati Nursing Education.

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

Home Medications (5 required)

Brand/Generic	Allopurinol (Aloprim)	Amlodipine (Norvasc)	Glipizide (Glucotrol)	Pantoprazole (Protonix)	Simvastatin (Zocor)
Dose	100 mg	10 mg	5 mg	40 mg	20 mg
Frequency	Daily	Nightly	Daily	Daily	Nightly
Route	Oral	Oral	Oral	Oral	Oral
Classification	Antigout Agent	Antihypertensive	Antidiabetic	Proton Pump Inhibitor	Antilipemic Agent
Mechanism of Action	Inhibits enzyme that converts things to uric acid.	Inhibits calcium ions from entering select areas of vascular smooth muscle	Stimulates insulin release from beta cells of the pancreas	Suppresses gastric acid secretion	Reduce inflammation of coronary plaque, inhibit platelet aggregation, and anticoagulation effects
Reason Client Taking	Chronic Kidney Disease Stage 4	Hypertension	Diabetes Mellitus Type 2	GERD	Hyperlipidemia
Contraindications (2)	1. Asymptomatic	1. Hypersensitivity	1. Type 1 DM 2. Allergy to	1. Iron deficiency	1. Persistently elevated ALT/

	hyperuricemia 2. HLA-B*5801 gene carrier	2. Hypotension	sulfonylureas	2. Lupus	AST 2. Liver disease
Side Effects/Adverse Reactions (2)	1. Gout 2. Diarrhea	1. Peripheral Edema 2. Dizziness	1. Hypoglycemia 2. Syncope	1. Headache 2. Edema	1. Atrial fibrillation 2. Edema
Nursing Considerations (2)	1. May interact with Penicillin's 2. May interact with loop diuretics	1. May increase renal impairment 2. Monitor for new onset or worsening edema	1. Monitor for signs of hypoglycemia 2. Question order in the presence of a sulfa allergy	1. May decrease iron absorption 2. Monitor for increased edema	1. Use with caution in patients with renal impairment 2. May increase HbA1c
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor uric acid levels, kidney function	Monitor blood pressure, heart rate	Monitor blood sugar ACHS	Monitor for increased edema, zinc and hemoglobin levels	Monitor platelets, coagulation factors, and cholesterol and triglyceride levels
Client Teaching needs (2)	1. Monitor for signs of decreased kidney function 2. Be cautious when operating heavy machinery	1. Report signs of liver problems 2. Report increased peripheral edema	1. Take 30 minutes before meals 2. Follow individualized diet	1. May need zinc supplements 2. High risk for bone loss and fractures	1. Follow low cholesterol diet 2. Perform daily exercise

Hospital Medications (5 required)

Brand/Generic	Calcitriol (Rocaltrol)	Diphenhydramine (Benadryl)	Docusate Sodium (Colace)	Folic Acid (Folvite)	Furosemide (Lasix)
Dose	0.5 mcg	25 mg	100 mg	40 mg	40 mg
Frequency	Daily	PRN	Daily	Daily	Q8 hours

Route	Oral	IV	Oral	Oral	IV
Classification	Vitamin D analog	Histamine Antagonist	Stool Softener	Water-soluble vitamin	Loop diuretic, Antihypertensive
Mechanism of Action	Binds to and activates Vitamin D receptor in kidneys.	Competes for H1 receptors. Provides anticholinergic effects.	Reduces surface tension of stool.	Assists in forming coenzymes in metabolic systems.	Inhibits reabsorption of sodium and chloride.
Reason Client Taking	Chronic Kidney Disease	Anticholinergic effects, relieve cough	Constipation	Anemia	Hypertension, fluid overload
Contraindications (2)	1. Hypercalcemia 2. Hypersensitivity	1. Hypersensitivity 2. Decreased LOC	1. Not to be used for extended periods of time. 2. Do not use with mineral oil.	1. Hypersensitivity 2. Use with caution in patients with respiratory disease	1. Anuria 2. Hypotension
Side Effects/Adverse Reactions (2)	1. Hypercalcemia 2. Nausea	1.Hypotension 2. Sedation	1. Stomach cramps 2. Bitter taste	1. Flushing 2. Bronchospasm	1. Hypokalemia 2. Orthostatic hypotension
Nursing Considerations (2)	1. Half life is extended in renal impairment. 2. Use caution in patients with renal impairment.	1. Use with caution in addition to opioids. 2. Use with caution in fatigued patients.	1. Should not be used with abdominal pain. 2. Should not be used with nausea or vomiting.	1. Not appropriate for monotherapy. 2. Monitor for neurologic affects.	1. May interact with allopurinol 2. May decrease potassium levels
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor calcium level, kidney function	Monitor LOC	Monitor bowel sounds, presence of flatulence, ability to	Monitor respiratory status, improvement of anemia.	Monitor fluid levels, urine output, potassium/sodium/chloride levels

			have a BM.		
Client Teaching needs (2)	1. May be taken with or without food. 2. Maintain adequate calcium intake.	1. May be used to relieve cough. 2. Report severe dizziness.	1. Do not use longer than 7 days. 2. Do not use if nausea or abdominal pain is present.	1.Report signs of allergic reaction. 2. Monitor for adverse reactions.	1. May cause potassium loss. 2. Supplement dietary potassium.

Medications Reference (APA):

Drugs.com. (2018). *Drugs.com | Prescription Drug Information, Interactions & Side Effects*. Drugs.Com. https://www.drugs.com/

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook* (18th ed.).

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Awake and alert Oriented to self, place, time, and situation No signs of distress Ill-appearing
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Pale Dry Cool Less than 3 seconds No rashes noted Bruises present on arms and stomach Scabbing on arms 18
HEENT (1 point):	

Head/Neck: **Ears:** **Eyes:** **Nose:** **Teeth:**	Head normocephalic, no tracheal deviation noted No excess cerumen, no hearing aid Vision aid, glasses not present Nose centered, no evidence of septal deviation Dentures present
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, S2 sounds clear throughout No S3, S4 sounds or murmur noted Normal Sinus Rhythm Even bilaterally, weak Greater than 3 seconds Bilateral lower extremities
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 Cough present, non-productive, infrequent. All fields diminished; no adventitious breath sounds noted.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	 Regular NPO pending a speech evaluation 5’2” 296 lbs Bowel sounds present all four quadrants 6/24/2020 No pain with palpation. No masses or organomegaly noted. No distension noted. No incisions noted. No scars noted. No drains present. No wounds noted.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒**	 Yellow Clear Adequate

Dialysis: Y ☐ N ☒ **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:**	 No redness, hernias, palpable lymph nodes. Indwelling 16 French
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☐**	 No pain, pallor, paralysis, paresthesia present. Pulses present bilaterally throughout. ROM intact, equal bilaterally upper extremities. ROM diminished in bilateral lower extremities. Walker. Weak 16 Needs support to stand and walk
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 Lower extremities have limited mobility Oriented to self, place, time, and situation Cognitive Clear, non-slurred. Purposeful. Appropriate. Vision aid, no other sensory deficits. No change in level of consciousness.
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):**	Client enjoys visiting as a distraction and prays for coping. Older adult Christian. This client is very dependent upon her religion. She requested a visit from the chaplain daily while admitted. Client lives at home with her husband. Couple may benefit from home health care.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1403	96	122/41	16	97.7 F	94% on 2L nasal cannula

1425	97	128/55	20	97.8 F	95% on 2L nasal cannula

Vital Sign Trends: Client's vital signs remained stable during this nursing student's care. The vitals provided above were performed during a blood transfusion. Blood transfusion vital signs were compared to regular baseline vitals.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numbers	Left leg	6	Constant, sharp	Request for morphine order. Repositioning and relaxing environment provided.
1005	Numbers	Leg leg	6	Constant, sharp	Morphine 2.5 mg

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 **Location of IV:** Right shoulder **Date on IV:** 6/30/2020 **Patency of IV:** Patent, flushes with ease **Signs of erythema, drainage, etc.:** No evidence of erythema, drainage, or infiltration. **IV dressing assessment:** Clean, dry, intact.	0.9% NaCl continuous infusion running at 10mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

80 mL	1100

Nursing Care

Summary of Care (2 points)

Overview of care: Vital signs, pain assessment, oral swabbing, medication administration, blood transfusion.

Procedures/testing done: No additional testing run on this day.

Complaints/Issues: Patient complained of leg pain. Patient expresses irritation about NPO diet. No other complaints or issues were reported.

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Irritated about the order to have nothing by mouth as she "eats at home just fine". Patient requests to not ambulate due to fatigue.

Physician notifications: Physician was notified for a request of morphine medication through intravenous administration.

Future plans for patient: Complete blood transfusion and reassess laboratory values for resolution of imbalances. Reevaluate presence of symptoms. Determine readiness for discharge.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): May benefit from home health care to monitor medication regimen and presence of symptoms.

Equipment needs (if applicable): Continue use of walker and oxygen. Add the use of a medication container to increase compliance.

Follow up plan: Follow up with primary care provider for repeat lab values, symptom management.

Education needs: Importance of adhering to medication schedule.

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

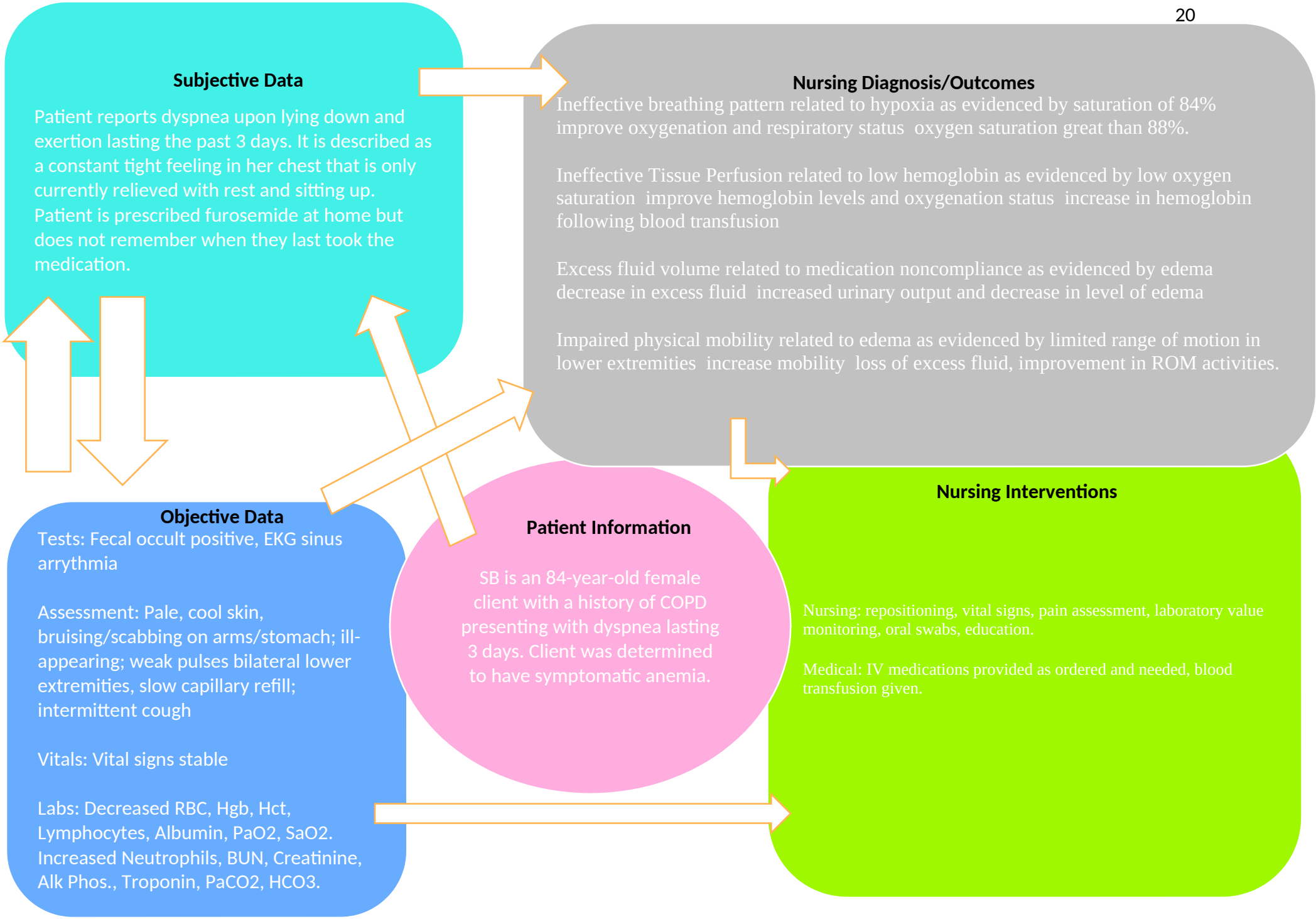
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Ineffective breathing pattern related to hypoxia as evidenced by saturation of 84%.	This client originally presented with respirations above 30/minute with oxygen saturations below 85%.	**1.**Apply low level continuous oxygen through nasal cannula. **2.**Assist with repositioning in ways that will allow for optimal lung expansion.	This client appreciated the assistance with repositioning as they were uncomfortable and did not realize they were not taking deep breaths the way they were laying. Client was concerned about the use of oxygen and their COPD. Education was provided about low level oxygen to maintain appropriate saturations with COPD. Goals for this client include maintaining an oxygen saturation above 88%. Goal is met at the end of this nursing student's care.
2. Ineffective Tissue Perfusion related to low hemoglobin as evidenced by	This client has an oxygen saturation of near 88%, a hemoglobin level of 7.1, and extended	**1.**Improve respiratory status through oxygenation and decreasing excess fluid volume.	This client was willing to agree with all treatment offered in order to improve her health status. Patient goals include visible, audible, and

low oxygen saturation.	capillary refill.	**2.**Administer blood transfusion to increase hemoglobin and oxygen carrying abilities.	physiological improvement in condition. At the end of this nursing student's care, this goal was still in progress.
3. Excess fluid volume related to medication noncompliance as evidenced by edema.	This client presents with bilateral lower extremity 4+ pitting edema. The client does not recall the last time they took their furosemide at home.	**1.**Administer furosemide to decrease fluid volume. **2.**Monitor strict intake and output to ensure proper elimination.	This client expected to feel immediate relief from fluid elimination and was disappointed it did not occur. Education was provided about the need for medication to have time in order to work properly. Goals for this client are to remove as much excess fluid as possible. This goal is still in progress.
4. Impaired physical mobility related to edema as evidenced by limited range of motion in lower extremities.	This client is unable to perform active ROM and has limited passive ROM due to 4+ edema.	**1.**Assist with passive ROM activities. **2.** Prevent skin breakdown from extended time in bed.	Client was reluctant to participate in ROM activities prior to blood transfusion during episodes of fatigue. Client was given opportunity to perform ROM following transfusion. Goals for this client are increased mobility and ROM.

Other References (APA):

Swearingen, P.L. & Wright, J.D. (2019). *All-in-one nursing care plan resource: medical-surgical, pediatric, maternity, and psychiatric mental health* (5th ed.). Elsevier.

Concept Map (20 Points):


Subjective Data
Patient reports dyspnea upon lying down and exertion lasting the past 3 days. It is described as a constant tight feeling in her chest that is only currently relieved with rest and sitting up. Patient is prescribed furosemide at home but does not remember when they last took the medication.
Nursing Diagnosis/Outcomes
Ineffective breathing pattern related to hypoxia as evidenced by saturation of 84% improve oxygenation and respiratory status oxygen saturation great than 88%.
Ineffective Tissue Perfusion related to low hemoglobin as evidenced by low oxygen saturation improve hemoglobin levels and oxygenation status increase in hemoglobin following blood transfusion
Excess fluid volume related to medication noncompliance as evidenced by edema decrease in excess fluid increased urinary output and decrease in level of edema
Impaired physical mobility related to edema as evidenced by limited range of motion in lower extremities increase mobility loss of excess fluid, improvement in ROM activities.
Objective Data
Tests: Fecal occult positive, EKG sinus arrythmia
Assessment: Pale, cool skin, bruising/scabbing on arms/stomach; ill-appearing; weak pulses bilateral lower extremities, slow capillary refill; intermittent cough
Vitals: Vital signs stable
Labs: Decreased RBC, Hgb, Hct, Lymphocytes, Albumin, PaO2, SaO2. Increased Neutrophils, BUN, Creatinine, Alk Phos., Troponin, PaCO2, HCO3.
Patient Information
SB is an 84-year-old female client with a history of COPD presenting with dyspnea lasting 3 days. Client was determined to have symptomatic anemia.
Nursing Interventions
Nursing: repositioning, vital signs, pain assessment, laboratory value monitoring, oral swabs, education.
Medical: IV medications provided as ordered and needed, blood transfusion given.