N431 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 6/30/2020	Patient Initials DW	Age 69 y/o	Gender Female M
Race/Ethnicity White	Occupation Retired	Marital Status- Divorced	Allergies Penicillin
Code Status DNR	Height 5'8"	Weight 43.1 kg	

Medical History (5 Points)

Past Medical History: Anxiety, Chronic back pain, COPD , Depression

Past Surgical History: No previous surgery

Family History: Patient did not feel like talking about family health issues

Social History (tobacco/alcohol/drugs): Smokes one pack a day; smoked cigarettes never used smokeless tobacco

Assistive Devices: Walker/Lift chair at home/Shower chair at home

Living Situation: Lives alone

Education Level: High School

Admission Assessment

Chief Complaint (2 points): Shortness of breath

History of present Illness (10 points): Patient is a sixty-nine-year-old male with a past medical history of COPD was at home on five liters of oxygen via nasal cannula. The patient was brought to the emergency dept. with complaints of weakness and shortness of breath. Patient does live at home alone. Family stated patient was unable to get up out of the chair and struggling to do daily routine. Pulse ox was at 68% upon arrival by EMS in route to hospital it came up to 98%. EMS noticed that his blood glucose was elevated to 215. Pt had no diaphoresis, nausea, vomiting or fever. Patient was warm to touch and alert. Patient was noted to have respiratory failure due to

COPD w/hypercarbia and was placed on bipap. Patient labs revealed leukocytosis. Emergency room vitals were B/P 167/72, Pulse 90, Temp 98.2 (oral), RR 20, 5’8” height, SPO2 100%.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):, Acute on set of chronic respiratory failure w/hypercapnia (HCC)

Secondary Diagnosis (if applicable): N/a

Pathophysiology of the Disease, APA format (20 points): Chronic obstructive pulmonary disease (COPD) is characterized by the airflow limitation that is not fully reversible. A situation like this can be caused by a mixture of small airway inflammation (bronchitis) and parenchymal destruction (emphysema). There can be numerous variations depending on person to person. A patient with COPD can present themselves in many ways. Some patients may be worse than others depending upon the situation. It is important to make a proper assessment. Increased sputum may be seen in patients that have COPD. Common symptoms such as shortness of breath, cough, dyspnea, and weight loss can be prevalent. As a person gets increasingly worse the lung sound will deteriorate which can make them more susceptible to frequent respiratory infections. The lungs decrease in elasticity creating problems with breathing abilities. An environmental exposure can be to blame. In the assessment there needs to be an evaluation of past smoking, fuels, air pollutants, and dust just to name a few. Some patients can complaint of difficulty breathing inability to be physical active. Other expected signs and symptoms can include clubbing, decreased thoracic expansion, ankle edema and distended neck veins. The low oxygen levels related to COPD can make it more difficult for the body to maintain proper function. The patient did show abnormal hemoglobin levels during the time of admission and

current which is consistent with COPD. During examination of the client. The patient is a sixty-nine-year-old Caucasian male that came into the emergency department complaining of shortness of breath. The patient expressed a history of smoking. Patient currently smokes one pack a day. The patient had a pale appearance showing signs of fatigue with no current wheezing or cough. Patient was alert and orientated times three. The patient's blood work showed a decreased blood cell count which could be consistent with COPD. The patient oxygen saturation was at ninety-five on three liters of oxygen currently. Patient stated he had been at home just not feeling well and became short of breath especially when attempting to stand and walk. Patient is exhibiting signs such as fatigue, exhaustion, inability to complete small daily tasks. Patient stated he could not catch his breath and was just to tired to get up and do anything that is why he called for an ambulance and came to the hospital. Vitals currently are pulse 65, blood pressure 112/59, respirations 19 and temperature 98.6 and oxygen at 96. A chest Xray was ordered with results of no significance. The Xray is a normal test that may be ordered due to the possible risk of infections with the COPD. Patient CBC did show a lower than normal level in the RBC's. Oxygen levels are returning to his normal state. Patient was prescribed a bronchodilator which is an anticholinergic. COPD will worsen over time due to the chronic nature of the disease. The patient may need more assistance in the future due to the possible decline of the disease including possible home healthcare, oxygen, and possible steroids to control the inflammation process within the lung cavity. Breathing exercises and an incentive spirometer was encouraged at this time. COPD can be managed by maintaining proper medication compliance and following up with provider appointments.

Pathophysiology References (2) (APA):

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

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

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	**3.80**	**3.84**	**3.31**	Red blood cells can be low due to anemia, dehydration or age related problems—resulting in hypoxia due to COPD and his blood levels could be low due to blood in stool (his stool was positive for blood) (Capriotti & Frizzell, 2016). Prednisone & Acetazolamide can cause low RBC levels (Jones & Bartlett, 2018).
Hgb	**13.0-16.5**	**10.9**	**10.7**	Hemoglobin can be low because of chronic disease, immune disorders, or cancer-NSAID use, aging (osteoporosis) –smoking (Capriotti & Frizzell, 2016).
Hct	**36.0-47.0**	**33.8**	**31.2**	Hematocrit levels can be low due to the lack of mobility chronic disease (Capriotti & Frizzell, 2016).
Platelets	**140-440**	**312**	**163**	**N/A**
WBC	**4-12.00**	**11.30**	**9.30**	**N/A**
Neutrophils	**47.0-73.0**	**N/A**	**95.2**	Prednisone & Acetazolamide can increase blood cell levels (Jones & Bartlett, 2018).
Lymphocytes	**18.0-42.0**	**N/A**	**19.5**	**N/A**

Monocytes	**4.0-12.0**	**N/A**	**3.6**	**N/A**
Eosinophils	**0.0-5.0**	**N/A**	**0.00**	**N/A**
Bands	**N/A**	**N/A**	**N/A**	**N/A**

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**133-144**	**141**	**147**	**N/A**
K+	**3.5-5.1**	**4.4**	**3.8**	**N/A**
Cl-	**98-107**	**98**	**104**	**N/A**
CO2	**21-31**	**43**	**39(H)**	COPD impaired gas exchange –poor perfusion/smoker (Capriotti & Frizzell, 2016).
Glucose	**70-99**	**215(H)**	**166 (H)**	Med-Acetazolamide & Prednisone can cause high glucose readings (Jones & Bartlett, 2018).
BUN	**7-25**	**N/A**	**21**	**N/A**
Creatinine	**0.50-1.20**	**.75**	**0.58**	**N/A**
Albumin	**3.5-5.7**	**N/A**	**N/A**	**N/A**
Calcium	**8.6-10.3**	**9.9**	**9.5**	**N/A**
Mag	**1.5-2.5**	**N/A**	**N/A**	**N/A**
Phosphate	**2.5-4.5**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.0**	**N/A**	**N/A**	**N/A**
Alk Phos	**34-104**	**N/A**	**N/A**	**N/A**
AST	**13-39**	**N/A**	**N/A**	**N/A**

ALT	**7-52**	**23**	**N/A**	**N/A**
Amylase	**23-470**	**N/A**	**N/A**	**N/A**
Lipase	**20-86**	**N/A**	**N/A**	**N/A**
Lactic Acid	**300-239**	**N/A**	**N/A**	**N/A**
Troponin	**0.000-0.040**	**N/A**	**N/A**	**N/A**
CK-MB	**0.36**	**N/A**	**N/A**	**N/A**
Total CK	**N/A**	**N/A**	**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	**0.9-1.1**	**N/A**	**N/A**	**N/A**
PT	**10.1-13.1**	**N/A**	**N/A**	**N/A**
PTT	**25-36**	**N/A**	**N/A**	**N/A**
D-Dimer	**<0.5**	**N/A**	**N/A**	**N/A**
BNP	**N/A**	**N/A**	**N/A**	**N/A**
HDL	**N/A**	**N/A**	**N/A**	**N/A**
LDL	**N/A**	**N/A**	**N/A**	**N/A**
Cholesterol	**N/A**	**N/A**	**N/A**	**N/A**
Triglycerides	**N/A**	**N/A**	**N/A**	**N/A**
Hgb A1c	**N/A**	**N/A**	**N/A**	**N/A**
TSH	**0.270-4.200**	**N/A**	**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	5.0-9.0	N/A	N/A	N/A
pH	5.0-8.5	N/A	N/A	N/A
Specific Gravity	1.001-1.035	N/A	N/A	N/A
Glucose	Neg	N/A	N/A	N/A
Protein	Neg	N/A	N/A	N/A
Ketones	Neg	N/A	N/A	N/A
WBC	Neg 0-5	N/A	N/A	N/A
RBC	Neg 0-5	N/A	N/A	N/A
Leukoesterase	Neg	N/A	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	N/A	N/A	N/A	N/A
PaO2	N/A	N/A	N/A	N/A
PaCO2	N/A	N/A	N/A	N/A
HCO3	N/A	N/A	N/A	N/A
SaO2	90-100	96	98	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	N/A	N/A	N/A	N/A

Blood Culture	**N/A**	**N/A**	**N/A**	**N/A**
Sputum Culture	**N/A**	**N/A**	**N/A**	**N/A**
Stool Culture	**N/A**	**N/A**	**+**	Test result was positive for occult blood patient may have a GI bleed due to age or chronic disease or medications (Capriotti & Frizzell, 2016).

Lab Correlations Reference (APA): CBC labs are consistent with COPD. Low hemoglobin can cause low oxygen levels in the blood allow for impaired gas exchange due to COPD. These tests show what is going on in relation to blood gases and the red blood cells. Red blood cells testing can show us how well the cells are carrying oxygen which can help determine the reason for low levels in such cases as COPD.

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

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest Xray , 12 Lead EKG

Diagnostic Test Correlation (5 points): Chest X ray -is a chest film or picture which is a projection radio graph used to help diagnose certain types of conditions. These conditions could be affecting the chest or lung area. These pictures provide us with information to help spot different types of abnormalities or deformities. The chest X-ray can help your doctor recognize

normal to abnormal areas such as masses or broken bones. Chest Xray can help identify pneumonia or even TB. Lung cancers and other serious conditions can also be found. Patient had an Xray which did not show any current significant changes to the current diagnosis of COPD. Pulse Ox- Patient to have pulse ox level done q 4 hours to measure O2 levels. Monitor O2 levels to make sure patient is maintaining proper levels currently. Patient is currently maintaining oxygen saturation within normal limits currently. Patient currently on 3 liters. EKG was done in the emergency room department which showed no signs of abnormalities.

Diagnostic Test Correlation, APA Format & References (5 points):

The patient had been previously diagnosed with COPD a chest Xray can help identify possible infections that could exacerbate the COPD. Patient is currently on 3 liters of oxygen via nasal cannula without any signs or symptoms of distress with a current O2 stat of ninety-six.

Diagnostic Test Reference (APA):

Swearington, P. (2018). *All-In-One Nursing Care Planning Resource.* [S.I.]: Mosby. St. Louis, Missouri: Mosby, Inc.

Sorenson, M., Quinn, L., Klein, D. (2019). *Pathophysiology: concepts of human disease*. Hoboken, NJ: Pearson, Education, Inc

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

Home Medications (5 required)

Brand/ Generic	**Albuterol**	**Prednisone**	**Guaifenesin**	**Acetaminophen**	**Nicoderm Patch**
Dose	**2.5mg**	**5mg**	**600 mg**	**650 mg**	**21 mg**

Frequency	**PRN**	**Once a day**	**2x daily**	**Every 6 hours**	**Every 24 hours**
Route	**Inhalation**	**PO**	**PO**	**PO**	**transdermal patch**
Classification	**Bronchodilator Shortness of breath**	**corticosteroids**	**expectorant**	**Pain**	**To supply nicotine**
Mechanism of Action	**Works by opening up the airways/bronchodilation**	**Decreases inflammation**	**Liquefy secretions**	**Helps reduce pain and inflammation**	**To help stop smoking**
Reason Client Taking	**Shortness of breath**	**Chronic lung inflammation**	**reduce thickness of fluids**	**Pain and joint soreness due to age**	**Help stop smoking**
Contraindications (2)	**Use caution if the pt has hypothyroidism, or seizure disorder, or heart disease**	**Hypersensitivity, renal disease, osteoporosis**	**Risk for dizziness, rash, hypersensitivity**	**Hemorrhage or liver failure**	**Closed angle glaucoma, injury or trauma**
Side Effects/ Adverse Reactions (2)	**Nausea, Nervousness-**	**Euphoria, insomnia, headache, delayed wound healing**	**Vomiting, diarrhea, urticaria**	**hypersensitivity, liver failure**	**Irritation redness, burning, compromised vision**
Nursing Considerations (2)	**Use caution if the pt has hypothyroidism, or seizure disorder, or heart disease**	**Alternate day therapy, monitor pts moon face, buffalo hump, monitor glucose level**	**May contain alcohol, should not use with smoking, take with water**	**S/s of bleeding, patient safety**	**Place patch properly, patient education on patch admin**
Key Nursing Assessment(s)/Lab(s) Prior to Administrati	**Lung assessment, and pulse ox**	**Watch for depression, monitor for GI distress,**	**Monitor B/P, vertigo, feelings of dizziness,**	**Liver test, pain scale**	**Assess the patch for irritation/complications, Explain med/5**

on		**bleeding daily, monitor potassium level**	**monitor pulse rate, patient education**		**rights, med admin**
Client Teaching needs (2)	**Med Admin of how to use inhaler /Wait 5 min in between inhalers/prime unit before use**	**Do not stop drug w/out consulting, take with food or milk, educate about long term therapy**	**Do deep breathing exercises, avoid smoking**		**-take as directed, -follow up provider do not smoke, while on the patch**

Hospital Medications (5 required)

Brand/ Generic	**Bisacodyl**	**Diamox (acetazolamide)**	**Symbicort budesonide/fumarate dihydrate**	**Norco**	**Ondansetron**
Dose	**10mg**	**250mg**	**160-4.5 mcg/act**	**5-325mg**	**4mg**
Frequency	**1 X daily**	**1 X daily**	**2 times daily**	**As needed/prn**	**Every 12 hours**
Route	**PO**	**PO**	**Aero 1 puff**	**PO**	**PO**
Classification	**-Soften stool/Increases intestinal activity**	**diuretic**	**Asthma, COPD**	**Narcotic/ Pain reliever**	**antiemetic**
Mechanism of Action	**Stool softener**	**Promotes renal excretion of sodium**	**Open up airways/Bronchodilator**	**Pain relief/ works in the brain to change the way your body**	**To prevent nausea**

				responds to pain	
Reason Client Taking	**To soften stools/avoid straining**	**Excess fluid due to COPD**	**To open up airways**	**Pain associated to age related problems/arthritis**	**nausea**
Contraindications (2)	**Abdominal pain, GI bleed**	**Sensitivities to sulfonamide, hypersensitivity, angle closure glaucoma**	**Hypersensitivity, hypertension**	**Hypersensitivity, hepatotoxicity, respiratory depression**	**Hypersensitivity to drug, contraindicated with morphine**
Side Effects/Adverse Reactions (2)	**Monitor pt stools/for diarrhea, Nausea**	**Seizures, rash, black tarry stools, constipation**	**Headache, dizziness, nausea**	**Nausea or vomiting can occur, intolerance to pain medications due to age**	**Dizziness, fatigue, headache, chest pain,**
Nursing Considerations (2)	**Taken for constipation to avoid straining, monitor stools for effectiveness**	**Monitor I/O's, weight daily, drug may increase glucose level**	**Monitor vitals, drug may increase heart rate**	**Monitor respiratory statues of patient, monitor for hypersensitivity**	**Monitor vitals, may increase prolonged QT interval,**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Pt does not have an allergy to drug, 5 rights, Pt not having diarrhea**	**May increase uric acid level, may decrease potassium, may decrease iodine, platelet counts**	**Assess airway, vitals**	**Pulse ox, respiratory status**	**Vitals, ensure electrolytes are within normal ranges before admin, Monitor LTF results,**
Client Teaching	**Pt to report**	**Pt to report any**	**Med admin as directed/**	**Opioid pain medication/t**	**Medication education**

needs (2)	**signs of bowels not moving, Pt to report cramping or excessive diarrhea to provider**	**signs and symptoms for bleeding /Pt to avoid prolonged exposure to sunlight, do not perform hazardous activites**	**Do not take with stimulants**	**ell your doctor if you plan to stop/ Can be habit forming**	**take as directed, monitor heart rate and rhythm**

Medications Reference (APA):

Burlington: Jones & Bartlett Learning.*2018 Nurse's Drug Handbook*. (2018). 17th ed.

Burlington:MA

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alert and orientated** **Orientation:X3** **Distress: None noted** **Overall appearance: cheerful and cooperative**	**Pt is sitting up in bed orientated times 3, Pt showing no distress at this time. Pt states he is doing well. Pt speaks good English with normal tone. Pt MAEW for current age and condition. Strength is bilateral and equal. Pt follows commands with no restrictions. Pt has no signs of neurological deficit.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor: Normal** **Rashes: N/A** **Bruises: N/A** **Wounds: N/A** **Braden Score: 20** **Drains present: Y☐ N X** **Type:**	**Pt has pale Caucasian color. Skin is fair to dry. Normal elasticity warm to touch. No signs of lesions or wounds. No open areas. No drainages. Patient states he is just tired and would like to rest. No rashes normal skin turgor. Hair is gray in color. Braden Scale 20**

HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is or normal shape with no apparent deviations. Hair is gray. Ears have no drainage or discomfort, tympanic membrane pearly gray. PEERLA within normal limits. Patient has only reading glasses. Pt eyes show no discharge. No deviation of the septum, turbinate equal bilaterally. No rhinorrhea. No complaints of congestion or nose bleeds. Oral mucosa is pink and moist with no discharge. Patient has false teeth. Patient states he is able to eat just fine.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: Regular no abnormalities** **Capillary refill: WNL** **Neck Vein Distention: Y ☐ N X** **Edema Y ☐ N X** **Location of Edema:** **Lower legs**	**Placement auscultated x5 for heart sounds. Pt has normal S1 and S2 no abnormalities, no murmurs, no thrills. Pt has normal cardiac rhythm with Regular cap refill, 2 plus swelling edema of lower extremities. Pt is on heart monitor. Radial pulses and pedal pulse 2+ . Negative for any vein distention at this time-patient is resting in bed with no distress noted at this time.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N X** **Breath Sounds: Location, character**	**Pt has Normal lung sounds No Crackles No rhonchi, Pt shows no signs of distress. No accessory muscle use during breathing. No deviations. Pt denies shortness of breath but does state that he does have shortness of breath at home sometimes. Minor wheezing noted on left side patient does have an albuterol order but has no signs of discomfort at this time. Assisted patient to change position reassessed lung sounds after and minor wheezing is not as evident. Patient currently on 3 liters of oxygen via nasal cannula. Pt states he feels better and is normally on oxygen at home. Patient does smoke 1 pack a day but is currently on the NicoDerm patch while in the hospital.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet Regular** **Height:** **Weight:** **Auscultation Bowel sounds: all 4 noted**	**Pt current regular diet. Pt denies alcohol use except for a few times socially. No abnormal distention. Bowel sounds in all four quadrants. No tenderness. No masses. No ostomy. No nasogastric tubes. No wounds. Pt has no signs of distress no diarrhea, no constipation, no**

Last BM: yesterday at 12pm **Palpation: Pain, Mass etc.:** **Inspection:** **Distention: N/A** **Incisions: N/A** **Scars: N/A** **Drains: N/A** **Wounds: N/A** **Ostomy: Y ☐ N X** **Nasogastric: Y ☐ N X** **Size:** **Feeding tubes/PEG tube Y ☐ N X** **Type:**	**bloating or irritability. Last bowel movement yesterday at 12pm. Patient was not hungry for lunch but felt he would be able to eat supper.**
GENITOURINARY (2 Points): **Color: yellow** **Character: Clear** **Quantity of urine:400ml** **Pain with urination: Y ☐ N X** **Dialysis: Y ☐ N X** **Inspection of genitals:** **Catheter: Y ☐ N X** **Type:** **Size:**	**Pt uses urinal. Urine clear no odor, no urgency, no dysuria. Patient denies pain. No irregularities or discharge. Output 400ml No dialysis or catheter. Patient was incontinent in the night.** **Lower Pelvic area no abnormalities no redness on bottom** **Male genitalia within normal limits no discharge or lesions. Patient is on I&O's**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM: within normal limits** **Supportive devices: walker** **Strength: equal** **ADL Assistance: YX N ☐** **Fall Risk: Y X N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment Y** **Needs support to stand and walk Y**	**.Pt exhibits normal active ROM bilaterally, Patient states he came in due to SOB and not being able to get up and do things. Pt is a fall risk. Pt needs help to stand and support. Pt states he lives alone. No clubbing noted, no effusions, no cyanosis —currently no neck or back pain. Patient does use a walker at home.**
NEUROLOGICAL (2 points): **MAEW: Y X N☐** **PERLA: Y X N☐** **Strength Equal: Y X N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:X3** **Mental Status:** **Speech:**	**.Pt is sitting up in bed orientated time 3, Pt showing no distress currently. Pt speaks good English with normal tone. PT MAEW for current age and condition. Strength is bilateral and equal. Pt follows commands with no restrictions. Pt has no signs of neurological deficit- Braden Scale 20 No headache, no gross focal neurological defects. No cranial nerve**

Sensory: **LOC:**	**deficits.**
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):**	**Pt states slightly tired from being in the hospital .** **High school education** **Brother is at bedside and Patient does have a daughter that helps with home care.** **Patient is catholic.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1131	**65**	**112/59**	**19**	**98.6**	**96**
1301	**70**	**118/64**	**20**	**98**	**96**

Vital Sign Trends: Patient had stable vitals during my clinical and denied pain at this time. Patient was on oxygen at 3 liters via nasal cannula with no distress at this time. Patient resting in bed with brother at bedside.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1300	**0**	**N/A**	**N/A**	**N/A**	**Pt denies pain at this time**
1400	**0**	**N/A**	**N/A**	**N/A**	**Pt denies pain at this time**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:**	Patient currently has an 18-gauge IV Single Lumen 10.17 median cubital vein (antecubital fossa)—No signs of redness or irritation-

IV dressing assessment:	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
120+120+=240 ml	**400ml**

Nursing Care

Summary of Care (2 points)

Overview of care: Narrative of nursing care provided, patient status throughout the day, any major concerns, etc. (2 points): Patient is very interactive with staff. Patient has a good support system. Patient seems satisfied with care. Patient not in any pain. Patient breathing unlabored and he showed no signs of distress throughout the day. Vitals are stable. Pt abnormal labs are consistent with diagnosis and past medical history. Patient oxygen levels stayed within normal ranges. No labored breathing or difficulty as this time. Patient very cooperative but tired and wanting to rest.

Procedures/testing done: Labs and Xray of the hip and chest—were all clear of any abnormalities.

Complaints/Issues: Patient had no complaints at this time.

Vital signs (stable/unstable): Vital signs were stable throughout the clinical time I was there. Patient did not have any complaints of pain and vitals were within normal ranges.

Tolerating diet, activity, etc.: Patient on regular diet.

Physician notifications: Patient to follow up with provider.

Future plans for patient: Patient will probably return home since oxygen levels are remaining stable. Family is very active with care of their brother. Currently brother has been at bedside all afternoon today. Daughter is also involved with care.

Discharge Planning (2 points)

Patient will need medication administration education along with caregivers (brother and daughter). Patient should be evaluated to see if he qualifies for continued home health or helping hands. Patient currently does drive states family will provide transportation to and from doctor appointments. Patient does currently qualify for home health services such as in-home assistance with bath or ambulation skills which will be helpful until he regains his strength. Patient currently has an oxygen concentrator at home that he uses. Patient does smoke and was informed patient of the risks of smoking while on the patch. Patient was given the NicoDerm patch to help him quit smoking. Home and in public oxygen use safety precaution education will also be helpful but will need to be reeducated upon discharge. Family education on throw rugs, shower chairs, grab bars, and other assistive devices to reduce the chances of patient falls and encourage oxygen safety.

Discharge location: Home - requested per family-Home rehab services

Home health needs (if applicable): Patient has current home healthcare and family members that attend to help him with his daily routines. Brother lives close by patient.

Equipment needs (if applicable): Patient has necessary equipment at home-Patient needs to include oxygen use signs at home

Follow up plan: Patient to follow up with provider in a week and patient to attend or have home care for any rehabilitative services—home care as scheduled

Education needs: Patient education on oxygen safety and smoking.

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with “related to” and “as	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse’s

evidenced by" components			actions? • Client response, status of goals and outcomes, modifications to plan.
1. Pt at risk for Ineffective breathing pattern/related to ineffective inspiration and expiration occurring with chronic airflow limitations	**Respiratory instability related to COPD**	**1.Oxygen PRN 2. Check Pulse Ox 3. Head of bed elevated 4. Bed alarm on for safety precautions 5.check for signs of hypoxia**	**Pt to show stable vitals and oxygen levels Pt to have no respiratory distress during care/Pt to show compliance with routine and setting goals/Respiratory therapy and Physical therapy can be consulted**
2. Patient at risk for Activity intolerance related to imbalance between oxygen supply and demand	**Oxygen levels to remain stable during activity such as walking 10 feet with standby assistance**	**1. Pt to tolerate light mobility without signs of distress/allow extra time for adjustment to repositioning/ safety 2.Stand by 2 assists with walk patient to be able to walk to bathroom 10 feet without distress wheezing or fatigue**	**Pt to be able to increase activity to complete tasks as tolerated daily Pt to help create goals with staff that will help him upon returning home**
3. Self-care deficit related to fatigue from the increased work of breathing	**ROM activities as tolerated to improve mobility/breathing exercises**	**1. Pt goal to assist with ROM's without exhaustion or fatigue 2. Pt to have therapy consult to improve mobility**	**Pt to perform ROM's with increased mobility/Consult with Occupational therapy**
4. Chronic low self-esteem	**As evidenced by COPD and lack**	**1.Pt to meet with social service for coping skills**	**Pt to exhibit positive**

related to chronic illness (COPD)	**of activity or mobility**	**2. Pt to have positive attitude toward health improvement/increasing social interaction**	**expression with completing tasks Pt to interact with home activity as tolerated daily/ Pt also to comply with proper rest periods for safety**

Other References (APA):

Swearington, P. (2018). *All-In-One Nursing Care Planning Resource.* [S.I.]: MOSBY. St. Louis, Missouri: Mosby, Inc.

Sorenson, M., Quinn, L., Klein, D. (2019). Pathophysiology: concepts of human disease. Hoboken, NJ: Pearson, Education, Inc

Concept Map (20 Points):

Subjective Data

Pt is 69 year old male that became short of breath at home and was unable to get up and perform tasks due to increased weakness. Pt has COPD , is a current smoker. Patient states he is notably exhausted and weak.

Nursing Diagnosis/Outcomes

Pt at risk for fall due to SOB and weakness while standing- Pt to have side rails up and alarm on while in bed—Pt to remain free of falls while in the hospital undergoing treatment—patient may need further assistance from staff when completing ADL's
Pt at risk for ineffective breathing pattern that does not provide adequate ventilation-Pt to use incentive spirometer and oxygen as needed –Pt to maintain adequate oxygen levels/COPD/monitoring for signs of hypoxia
Pt at risk for fluid volume overload due age, smoker, and COPD. Pt to maintain adequate fluid intake in regards to I/O'S-Pt to not show signs of respiratory distress. Patient daily weight to help maintain proper nutrition levels. Protein shake.

Objective Data

Patient states he is in no pain -–— 2 plus edema on lower legs- having difficulties with tasks at home-pt has COPD –Patient is thin with pale skin. Patient does have periods of difficulty breathing with activities. Patient has to take frequent breaks while eating meals. Patient is tired and has been sleeping throughout the shift.

Patient Information

69 year old male patient –Shortness of breath unable to get up from chair at home due to weakness. Pt was having difficulties maintaining stable O2 levels/Smoker and has COPD

Nursing Interventions

Vitals, I/O's, daily weights, turning, and positioning monitoring for signs and symptoms of pain (pain scale), teach non pharmacologic therapeutic pain options. Safety precautions to avoid falls. Oxygen education –Patient education on medications. Teach breathing exercises and proper use of incentive spirometer. Head of bed elevated—patient to eat multiple small meals a day to avoid getting exhausted during meal time and activities—scheduled periods of rest are helpful to maintain energy levels