Emory Nell Hodgson Woodruff School of Nursing

Patient Care Report and Documentation Tool

Student's Name: Lillian Russo				Date: 11/30/18
	Gender: F	Age: 71	Clinical Site: EUMH	Admission Date: 11/29/18
Weight: 57.6 ☒ kg ☐ lbs		Height:157.5 cm		
Allergies:☐ NKA ☒ Other [List]: Lisinopril			Isolation Precautions: None.	
CODE STATUS: Full Code				
Admission Diagnosis: Hypotension, Pneumonia, Pleural Effusion				

HISTORY OF PRESENT ILLNESS [event leading to hospitalization]:

- Patient presented to hospital from Emory Midtown ED and complained of SOB and fatigue. SOB, exaggerated breathing, and breathing with stridor started 3 weeks ago. Denies pain while breathing. Exaggerated breathing present in upper respiratory system. Stridor is worse after eating and/or drinking. Fatigue has been constant throughout the day, but patient is unsure when it initially started.

PAST MEDICAL HISTORY:

- Patient has history of bilateral vocal cord paralysis, dysphonia, HTN, Type II Diabetes, ER + metastatic left breast cancer with residual left-sided effusion. Has known bony mets, hepatic mets, and pleural mets.
- Patient on chemotherapy, Abraxane. Last treatment was Early November.
- Surgeries: inspection of larynx, via natural or artificial opening endoscopically (2018), thyroidectomy (year unknown), colonoscopy (year unknown), left breast mastectomy (year unknown)

COURSE OF HOSPITAL STAY (pertinent diagnostic procedures, surgeries, etc.,):

- Right chest port insertion
- Right peripheral IV insertion
- O2 Nasal Cannula started
- Morse Assessment – Fall Risk Assessment
- Reposition q2hrs
- Ambulate q2hrs

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SOCIAL HISTORY:

Status: ☐ Single ☒ Married ☐ Widowed ☐ Divorced ☐ Feels Safe at Home

Smoke: ☒ Denies ☐ ½ pack/day ☐ 1 pack/day ☐ 1 ½ packs/day ☐ 2 or more packs/day

Alcohol: ☐ Denies ☐ rare ☒ occasional ☐ "social" ☐ daily ☐ weekly ☐ monthly

Recreational/Illicit Drug Use: ☒ No ☐ Yes Describe if yes:_____

PROVIDER ORDERS:

Diet: ☐ NPO ☒ Regular ☐ Cardiac ☐ Renal [2 gram Sodium] ☐ 1200 cal ADA ☐ Strict I&O ☐ Other: _____

BBG: ☐ NA ☒ Once Daily ☐ Twice Daily ☐ Before Meals ☐ Before Bedtime ☐ Sliding Scale: Describe _____

Activity: ☐ Up Ad Lib ☒ Up with Assistance ☐ Bedrest ☐ Other: _____

PHYSICAL ASSESSMENT:

NEUROLOGICAL ASSESSMENT:

Orientation:

☒ Person ☒ Time ☒ Place ☐ Disoriented

Behavior:

☒ Calm ☒ Cooperative ☐ Restless ☐ Combative

☐ Confused ☐ Agitated ☐ Unable to Respond

☐ Fall Risk (based on Hendrich II Fall Risk Score ≥5)

CARDIOVASCULAR ASSESSMENT:

Skin Color and Description: ☒ WNL (warm, dry, intact) ☐ Cyanotic ☐ Jaundiced ☐ Diaphoretic ☐ Pale ☐ Cool ☐ Flushed ☐ Clammy ☐ Fragile Other:_____

Heart Tones: ☒ S_1, S_2 ☒ Regular ☐ Irregular

Heart Rhythm: ☒ Sinus ☐ Bradycardia ☐ Tachycardia ☐ Pacemaker ☐ Other: _____

DVT Prophylaxis: Describe if applicable _____

Capillary Refill				
	ALL	LUE	RUE	
Less than 3 seconds		X	X	
Greater than 3 seconds				
Clubbing				
Absent				

Pulses					
	ALL	LUE	RUE	LLE	RLE
Absent					
Irregular					
WNL (+2)	X				

Doppler					
Edema					
	ALL	LUE	RUE	LLE	RLE
Absent			X	X	X
Trace					
Present (describe)		X – non-pitting, but swollen; possibly due to mastectomy			

RESPIRATORY ASSESSMENT:

Respirations: ☐ Regular ☐ Irregular ☐ Shallow ☒ Labored

Cough: ☒ Yes ☐ No ☐ Productive ☒ Non-Productive

Sputum: Describe consistency, amount, and color: _____

Breath Sounds	RUL	RML	RLL	LUL	LLL
Clear					
Rales					
Rhonchi					
Wheeze					
• Inspiratory	X	X	X	X	
• Expiratory					
Decreased					
Absent					
Stridor	X		X		

Oxygen Delivery/Treatments

☐ Room Air
☒ Nasal Cannula
☐ Venti-Mask
☐ Non-Rebreather
☐ Trach Collar
☐ Face Mask
☐ Bi-PAP/C-PAP
☐ Incentive Spirometer

Oxygen Flow rate: ___2L/min_____

GASTROINTESTINAL ASSESSMENT:

Diet Tolerance: ☐ Good ☒ Fair ☐ Poor ☐ Dysphagia

GI Symptoms: ☒ None ☐ Anorexia ☐ Vomiting ☐ Nausea ☐ Constipation ☐ Diarrhea
☐ Abdominal Pain ☐ Flatulence ☐ Hiccups ☐ Incontinence Other: _____

Gastric Tubes: ☐ NG ☐ G-Tube ☐ J-Tube Other: _____

Ostomy: ☐ Yes ☒ No Describe stoma:_____

Emesis: ☐ Yes ☒ No Describe: _____

Date of last Bowel Movement:__11/30/18___ Describe: __one small (2in diameter), round, formed, soft, light brown BM, absent of smell_____

Abdominal Assessment

	ALL	LUQ	RUQ	LLQ	RLQ
WNL (soft, flat, non-tender)	X				
Firm					
Distended					
Tender/Guarding					
Other					

Bowel Sounds					
	ALL	LUQ	RUQ	LLQ	RLQ
Present	X				
Hypoactive					
Hyperactive					
Absent					

GENITOURINARY EXAM:

Urinary Symptoms: ☒ None ☐ Incontinence ☐ Dysuria: Describe_____

Abnormal frequency: Describe_____

Urine Color: ☒ WNL (Yellow) Other: describe:__amber color_____

Urine Character: ☒ Clear ☐ Cloudy Other: describe_____

Catheter: Describe type: _____

Dialysis: Describe if applicable _____

MUSCULOSKELETAL ASSESSMENT:

Symptoms: ☐ None Other: Describe pain, joint swelling, joint stiffness, and contractures:_____

Musculoskeletal Tone and Strength					
	ALL	LUE	RUE	LLE	RLE
Strong	X				
Weak					
Full ROM	X				
Impaired ROM					

Weight Bearing / Gait: ☐ Steady ☒ Independent ☐ Unsteady ☐ Dependent

Assisted Ambulatory Devices: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Bedfast Other: _____

INTEGUMENTARY:

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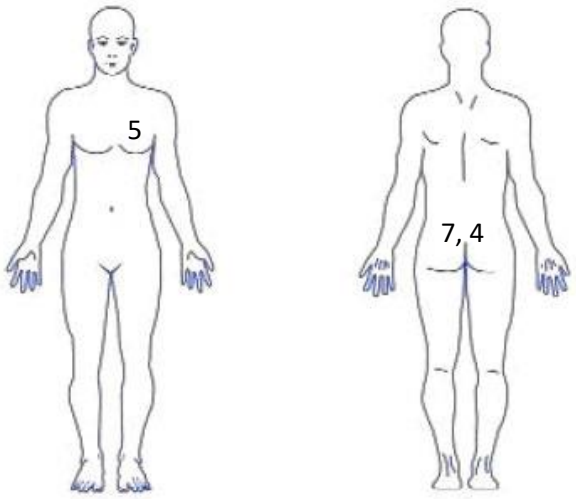

Please utilize diagram to the left to document finding/s with appropriate number for location.

1. WNL ☐ Yes ☐ No
2. Abrasions/Lacerations/Skin Tears
3. Rash
4. Pressure Ulcers (PU)
5. Surgical Incision Sites
6. Drains
7. Bruising
8. Petechia
9. Other

Description of Drains, PU, Skin Incisions, Etc.

7, 4 – darkened, discolored, flat & scaly skin around the sacrum; worried about potential PU
5 – Left-sided mastectomy

IV ACCESS

Type of Access (Central Line, Peripheral, PICC, Port)	Location	Site Assessment	Fluids Infusing: Type and Rate
Peripheral	Forearm R	Pink around the needle, no tenderness or temperature change from rest of skin; WNL	LR continuous infusion; 75 mL/hour over 13.3 hours
Implanted Single Port	Chest R	Skin is dry and intact, no tenderness or discoloration; WNL	Potassium Chloride; 40mEq/100mL infused over 4 hours

Intake Total: (PO, IV, TF): ___1,765_____mL Output Total: (urine, stool, NG, drains, other): _____900_____mL

MENTAL HEALTH ASSESSMENT:

Behavioral / Affect: ☒ WNL (calm, cooperative, appropriate) ☐ Restless ☐ Combative ☐ Confused ☐ Agitated ☐ Anxious
☐ Depressed ☐ Crying ☐ Fearful ☐ Hostile ☐ Inappropriate ☐ Other: _____

Stressor: ☐ Condition ☐ Hospitalization ☐ Diagnosis ☐ Procedure ☐ Family Death ☐ Family Illness ☐ Family Problems
☐ Finances ☐ Surgery ☐ Unknown Causes ☐ Other: _____

Coping: ☒ Well ☐ Fair ☐ Poor ☐ Ineffective ☐ Other: _____

Mental Health Consults/Evaluations: ☐ Chaplain ☐ Social Work ☐ Psychiatry

VITAL SIGNS AND BLOOD GLUCOSE

Procedure Must be your Assessments	Time 09:00	Time 14:18	Comments – Describe trends and abnormalities
Temperature	36.7 C	36.8 C	
Blood Pressure	99/65	121/82	BP increased substantially once we increased her LR infusion rate around 11:00.
Heart Rate	109	103	
Respiratory Rate	20	18	
Pulse Ox	100%	100%	
Blood Glucose	149		Blood glucose was not checked a second time before we left
Pain Scale	0	0	

Medications	Dose	Route	Indication	Pre and post-administration assessment priorities
Enoxaparin	40mg = 0.4 mL	SubQ qDay	Prevention of thrombus formation & VTE, anticoagulant	Assess blood pressure prior and post administration; post administration, assess for signs of bleeding or hemorrhage, dizziness, and worsened edema (Emory University Hospital Midtown PowerChart, 2018) (Vallerand, Sanoski, & Quiring, 2018)
Insulin lispro corrective dosing	BG-100/50 = # of units BG >180	SubQ q4hr	Hyperglycemia	Check Blood Glucose level before and after administration; monitor for signs of hypoglycemia post admin. (Emory University Hospital Midtown PowerChart, 2018) (Vallerand, Sanoski, & Quiring, 2018)
Magnesium oxide	400 mg = 1 tab	PO qDay	Magnesium supplement, laxative	Check Labs for magnesium, calcium, and potassium levels pre and post administration; assess bowel movements for diarrhea/consistency, amount, and frequency (Emory University Hospital Midtown PowerChart, 2018) (Vallerand, Sanoski, & Quiring, 2018)
Albuterol	2 puffs	Inhale q4hr, PRN	Treatment/prevention of bronchospasm	Assess lung sounds, pulse, chest pain, and BP before administration and during peak of medication (Emory University Hospital Midtown PowerChart, 2018) (Vallerand, Sanoski, & Quiring, 2018)
Prochlorperazine	10 mg = 1 tab	PO q6hr, PRN	Management of nausea/vomiting	Monitor orthostatic BP, respiratory rate, and pulse before and during medication administration; assess for fall risk (Emory University Hospital Midtown PowerChart, 2018) (Vallerand, Sanoski, & Quiring, 2018)
LR (lactated Ringer's)	1,000mL 75 mL/hr over 13.3 hrs	IV, continuous infusion	Management of electrolytes and fluid intake; promote secretion movement in lungs	Monitor BM and urine output pre and post administration; monitor lung sounds and cough for sputum post administration; Monitor BP prior to and after administration (Emory University Hospital Midtown PowerChart, 2018) (Vallerand, Sanoski, & Quiring, 2018)

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NURSING PROCESS WORKSHEET

All information must relate to your patient during this admission and must be cited using APA. List references in APA format on a separate sheet. If more space is needed for any question below, attach a separate sheet.

1. Based on the collected data, describe the patient's primary pathophysiology [related to primary diagnosis] for this admission.

Pneumonia is a lower respiratory tract infection that affects the lung parenchyma. The source of the infection can be caused by variety of microorganisms, including bacteria, viruses, fungi, protozoa, or parasites. Depending on where the infection is acquired, pneumonia is classified into four categories: community-acquired (CAP), health care-associated (HCAP), hospital-acquired (HAP), or ventilator-associated (VAP). One of the most common reasons for hospitalization in the United States is due to symptoms relating to CAP. Some of the most common microorganisms that cause CAP include *Streptococcus pneumoniae*, *Mycoplasma pneumoniae*, and *Staphylococcus aureus*. The causative agent will determine how the pneumonia is presented clinically as well as the type of treatment plan the provider puts into place (Huether, McCance, Brashers, & Rote, 2017).

The most common routes of infection include aspiration of a foreign microorganism from the oropharynx or nasopharynx, and the result of inhaling the pathogen from the air that was released by an infected individual. Generally, in individuals who are healthy or not immunocompromised, the pathogen would be controlled by the body's own self-defense systems. However, for individuals who have comorbid diagnoses, are immunosuppressed, or are at an age where they are more susceptible to infection, such as young children or older adults, they have a decreased chance of fighting off pneumonia by themselves (Huether et al., 2017).

Once the microorganism is inhaled or aspirated, the first line of defense is to expel it from the upper respiratory airway by coughing or mucociliary clearance. If the pathogen passes on to the lower respiratory system, it is recognized by the alveolar macrophages present in the alveolar wall and will activate the immune response. Proteins are recruited to destroy the pathogen, such as chemokines and cytokines; however, they also cause and result in widespread inflammation of the lung tissue. Inflammation is caused by both the immune response and the colonization of the infectious microbe in the alveoli. This inflammation triggers the

recruitment of white blood cells (WBCs) into the alveoli, causing further damage to the mucous membrane and alveolocapillary membrane. Damage of these membranes can result in the terminal bronchioles to fill with infectious exudate and fluid, making it harder for gas exchange to occur. The culmination of lung tissue damage, excessive exudate, and triggering of the immune and inflammatory response causes lung tissue to consolidate and become strong and stiff. In a clinical setting, the result of extensive damage and infection can cause dyspenea, fever, chest pain and hypoxemia (Huether et al., 2017).

References

Emory University Hospital Midtown PowerChart (2018). Retrieved November 30th, 2018, from the PowerChart.

Huether, S. E., McCance, K. L., Brashers, V. L., & Rote, N.S. (2017). Understanding pathophysiology (6th ed. P. 2101-2107). St. Louis, MO: Elsevier.

Vallerand, A. H., Sanoski, C.A., & Quiring, C. (2018). Davis drug guide for nurses. Philadelphia, PA: F.A. Davis Company.

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CAREPLAN

*Diagnosis*__Ineffective Airway Clearance_____ *Student Name*_____Lillian Russo_____

Assessment R/T Diagnosis	Planning
Subjective: • Dyspnea, shortness of breath • Denies pain when breathing Objective: • Adventitious breath sounds (inspiratory wheezing and stridor) present bilaterally in upper and lower lobes of lungs • Cough without sputum • Hypertension • Pulse Ox remaining at 100% • Respiratory Rate: 20 breaths/min.	Goal Statement (Broad Statement) 1. Client will demonstrate a reduction of congestion in lungs as evidenced by clear breath sounds heard in all lobes of the lungs at the end of 2 weeks. 2. Client will verbalize understanding of therapeutic management and demonstrate behaviors to improve or maintain a clear airway 2 weeks post-discharge. Desired Outcome (Specific Criteria) 1. Client will be free of dyspnea before being discharged, as evidenced by decreased Respiratory Rate (RR). 2. Client will demonstrate proper coughing/deep breathing techniques to enhance secretion removal, as evidenced by sputum discharge during hospital stay.

Priority Nursing Interventions (interventions you implemented; minimum of 3 required)	Rationale (for each intervention)	Evaluation Goal: *Partially met*
1. Elevate head of bed and change position of client every 2 hours.	1. Help maintain adequate, open airway by using gravity to decrease pressure on diaphragm, enhance full expansion of lungs, and to mobilize secretions through movement of the body.	AEB: Goals were partially met. Patient had their bed elevated and was ordered to reposition in bed every 2 hours. Patient received an increase of IV fluids from 75 mL/hr to 200mL/hr and we saw an increase in blood pressure and decrease in RR as a result. Patient's respiratory rate decreased slightly from 20 in the morning, to 18 after interventions were used. Patient maintained an unproductive cough, and wheezing and stridor sounds remained bilaterally in upper and lower lobes of the lungs. We did not have an opportunity to use an incentive spirometer. However, patient states that she requires less exertion to breath and doesn't feel as short of breath after sitting up and receiving fluids. Patient also has an understanding and knowledge of maintaining therapeutic and deep breathing exercises at home, after discharge, as evidenced by her repeating the exercises back to me after being educated on them.
2. Use of inceptive spirometer twice daily.	2. To encourage the patient to take full deep breathes in order to fully maintain adequate airway, mobilize secretions, and improve respiratory function.	
3. Increase fluid intake (either PO or via IV fluids) to help hydrate secretions.	3. Increased fluid will help hydrate and liquify dry secretions in the lungs and improve secretion clearance.	
4. Assess client's knowledge of contributing causes and therapeutic procedures to maintain/improve respiratory function and educate client on appropriate measures, such as maintaining active, drinking fluids, and focus on deep breathing exercises.	4. Educating client on therapeutic procedures to improve lung expansion and secretion movement will help ensure continuance of these practices after discharge and prevent re-admittance for ineffective airway clearance.	Should your interventions be continued? Yes Why or Why not? Because the patient has seen improvements over the course of a short period of time and I believe she will improve even more drastically with continue practice of movement, deep breathing exercises, and increase in fluid intake. List new interventions appropriate as identified by you or the patient: In addition to maintaining the therapeutic & deep breathing exercises we discussed, I recommend the use of incentive spirometer if the opportunity is available, a consult with a respiratory therapist, and to return to hospital if airway clearance does not improve or worsens within two weeks post-discharge.