Eric Andrade

Patient Care Scenario

You are the nurse working in the Medical Intensive Care Unit (MICU) this morning and you receive the following report on one of your assigned patients:

Freddy Mack is a 64-year-old retired farmer from Olton with a history of Type I diabetes, CHF, and Renal failure requiring outpatient dialysis 3 times a week. He was admitted to MICU yesterday following a below the knee amputation of his right leg due to a non-healing wound that advanced to gangrene.

In PACU he was slow to wake up. Once awake, he experienced nausea, vomiting and severe pain requiring high doses of pain medication.

During the night he was restless and irritable. He refuses to look at the operative leg and has voiced concerns that he may have difficulty caring for himself at home. His blood sugar has been running in the 200's despite sliding scale Regular insulin being given subcutaneously every 4 hours per protocol.

He has a right arm AV fistula that has a palpable thrill and audible bruit and a left forearm peripheral IV with NS infusing at 150 ml/hr.
The right leg stump dressing is clean, dry and intact.
He has coarse crackles to the bilateral lower lobes of his lungs.
Current vital signs are: BP 150/90, HR 88, RR 22, SaO2 91% on room air and temp 99.2 F.

Today's lab:

Lab	Patient	Ref. Range	Lab	Patient	Ref. Range
Glucose	346	60 – 100 mg/dL	**WBC**	14	5.5 – 15.5 x 10^9/L
Calcium	10.0	8.6 – 10.2 mg/dL	**RBC**	3.4	3.9 -5.3 – RBC x $10^6/\mu$L
Sodium	140	135 – 145 mEq/L	**Hgb**	8	11.5 – 16.5 g/dL
Potassium	5.1	3.5 – 5.0 mEq/L	**Hct**	25	35 - 45%
CO_2	17	23 – 29 mEq/L	**Platelets**	160	150 – 400 x 10^9/L
Chloride	101	96 – 106 mEq/L	**Neut.**	60	54 – 62%
BUN	52	2.1– 7.1 mg/dL	**Lymphs**	33	25 – 33%
Creatinine	4.3	0.6 – 1.3 mg/dL	**Mono**	6.7	3% – 7%
			Eos	0.2	1 – 3%
			Baso	0.1	0.0 – 0.75%

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CSON Clinical Judgement Model

NCSBN Clinical Judgement	Application of CJM
1. **Recognize Cues** (assessment) – The filtering of information from different sources (i.e., signs, symptoms, health history, environment). **What matters most?**	• BKA (severe pain, restlessness, and refusal to look at the operative leg). • Poor blood sugar control (glucose of 346 despite insulin therapy). • CHF and renal failure • Elevated creatinine (4.3) and BUN (52) indicating poor kidney function. • Low hemoglobin (8) and hematocrit (25) • Bilateral lung crackles, suggesting fluid overload from CHF. • His emotional distress and concerns about future self-care are also cues.
2. **Analyze Cues** (analysis) – The linking of recognized cues to the client's clinical presentation and establishing probable client needs, concerns, and problems. **What does it mean?**	• Freddy is struggling emotionally and physically with his condition, possibly leading to his restlessness and refusal to look at his leg. • His blood sugar is elevated, likely to his slow healing and risk for infection. • Elevated BUN and creatinine suggest worsening renal function. • Crackles in the lungs could indicate fluid retention, a common issue in heart failure patients, which could worsen without proper intervention
3. **Prioritize Hypotheses** (analysis) – Establishing priorities of care based on the client's health problems (i.e., environmental factors, risk assessment, urgency, signs/symptoms, diagnostic tests, lab values). **Where do I start?**	• Control blood glucose levels • Fluid overload and CHF (monitor lung sounds, adjust fluid balance). • Manage pain and emotional support (pain control, psychological support). • Renal monitoring and support, managing fluid intake due to impaired kidney function.
4. Generate Solutions (planning) – Identifying expected outcomes and related nursing interventions to ensure a client's needs are met. **What can I do?**	• Administer insulin more frequently or adjust the dosage based on blood sugar levels. • Continue pain management with medications, monitor for side effects due to renal impairment. • Collaborate with a dietitian to manage blood sugar and fluid restrictions. • Provide emotional support to help him cope with the amputation. • Monitor respiratory status and assess if diuretics are necessary for CHF
5. **Take Actions** (implementation) – to implement appropriate interventions based on nursing knowledge, priorities of care, and planned outcomes to promote, maintain, or restore a client's health. **What will I do?**	• Administer insulin and adjust according to his blood glucose. • Implement a pain management plan • Monitor fluid status • Offer support by discussing his concerns about self-care • Monitor lab values
6. **Evaluate Outcomes** (evaluation) – To evaluate a client's response to nursing interventions and reach a nursing judgment regarding the extent to which outcomes have been met. **Did it help?**	• Evaluate glucose levels • Assess for improvement in pain and emotional response • Monitor lung sounds and respiratory rate to check for fluid overload reduction. • Review lab values to assess kidney function and hemoglobin levels.

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