

Respiratory Failure

Data Collection

History of Present Problem:

Juan-Carlos Ortiz is a [redacted] who presented to the ER with increasing shortness of breath ([redacted]) over the last [redacted] s. He also reports s [redacted], producing [redacted]. He is accompanied by his [redacted].

Personal/Social History:

Juan-Carlos lives with his [redacted] and [redacted]. He [redacted] a [redacted] of cigarettes a d [redacted] and [redacted] alcohol daily. His past medical history includes [redacted] [redacted] [redacted]. Upon returning home from work t [redacted] his coughing and SOB became s [redacted]. Although he was reluctant, his wife insisted they go to the ER.

What data from the histories is important & RELEVANT; therefore it has clinical significance to the nurse?

RELEVANT Data from Present Problem:	Clinical Significance:
53 yr old Male Increased SOB x several days Severe coughing Lg amt brown sputum Wife at bedside	Gender and age (in this patient's case male & over 50) have a higher incidence of Heart disease (MI). This patient's SOB of breath is at risk for hypoxia, pneumonia, and other respiratory complications. Coughing with expectorating lg amounts of brown sputum could indicate multiple respiratory problems (tar from smoking, infection, pneumonia, blood possibly). Wife with patient indicates a support system, she was the individual to insist he come to the hospital.
RELEVANT Data from Social History:	Clinical Significance:
Father- lives with wife and 2 teenagers Smoker 1ppd Etoh PMH – CAD, hx of MI w/stent, PVD, DMII, HTN, HLD Worsening of SOB	This is indicative of having responsibilities, something to live for to get better. The smoking with his other co-morbidities is certainly not healthy, it could be the cause of his problems and definitely making the problems worse. I would like to know how long he has been smoking. His alcohol consumption with his smoking indicates an unhealthy lifestyle and should be modified immediately – education. PMH – Collectively they contribute to poor tissue perfusion and pt should be following diet and exercise regime to alleviate symptoms or to manage own health. Separately CAD is significant due to not enough oxygen/blood perfusion of the heart muscle leading to cardiac

death (previous MI with stent, patient has higher risk of increased incidence of another), PVD patient has decreased tissue perfusion peripherally causing extremities to not get enough tissue perfusion. DMII – especially uncontrolled with diet/exercise is heart on all body system further compromised with smoking and alcohol. HTN in the long term sense it is hard on the heart and vessels there for contributing to the overall dysfunction of body systems. HLD – is the build up fatty plague that can lead to htn, stroke and complication throughout the cardio vascular system. Worsening of SOB indicates that the problem needs to be corrected or organ failure will occur without intervention.

Crystal, excellent job identifying the relevant data from the patient’s presenting problem, as well as relevant data from his social history. Looking at the clinical significance, you are correct in thinking that the patient possibly has a respiratory infection. BSc

What is the RELATIONSHIP of your patient’s past medical history (PMH) and current meds?

(Which medications treat which conditions? Draw lines to connect.)

PMH:	Home Meds:	Pharm. Classification:	Expected Outcome:
CAD	Furosemide 20 mg daily1.	1. Loop diuretic	Diuresis & Mobilize excess fluids and decrease BP.
PVD	ASA 81 mg daily 2.	2. Salicylates	Prophylaxis of TIA/MI
HTN	Enalapril 40 mg daily 3.	3. ACE inhibitors	Manage HTN, sx HF,
HLD	Simvastatin 40 mg daily4.	4. hmgCoa Reductase inhibitors	Manage HLD, prevent MI
	Plavix 75 mg daily5.	5. platelet Aggregation inhibitor	Inhibit clotting, inhibit platelet clumping aggregation
	Metoprolol 50 mg BID6.	6. Beta blockers	Decrease blood pressure What about heart rate? BSc
	Apidra q6h7.	7. Pancreatics	Manage blood glucose
	Pioglitazone 15 mg daily8.		

		8. Thiazolidi- nediones	Decrease insulin resistance decreasing blood sugar without causing hypoglycemia
--	--	----------------------------	---

Excellent job identifying the relationship of your patient's past medical history with his current medications. You also did a great job correctly identifying the pharmacologic classification of each medication, as well as the expected outcome. BSc

One disease process often influences the development of other illnesses. Based on your knowledge of pathophysiology, which disease likely developed FIRST that then initiated a "domino effect" in their life?

- Highlight what PMH problem likely started **FIRST**

Great job! Remember, long term complications of DM includes disease of the large and small blood vessels in the body which leads to CAD, PVD, and HTN. Patients who have DM are also always at higher risk for infection because elevated glucose encourages bacterial growth. Therefore, it was the patient's diagnosis of DM that most likely influenced the development of the other illnesses. BSc

- Underline what PMH problem(s) **FOLLOWED** as domino(s)

Patient Care Begins:

Current VS:
T: 102.6
P: 122
R: 32
BP: 166/108
SpO2: 82% room air
Pain: 3 (chest)

What VS data is RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT VS Data:	Clinical Significance:
SpO2 – 82% Elevated RR32 Elevated BP 166/108 & HR 122 T102.6 Chest pain 3	Not enough gas exchange is occurring in the pulmonary system. The pulmonary system is being overworked The elevated HR and BP do not allow for sufficient cardiac output complicating problem with possibility of cardiac ischemia, MI, stroke from embolism Elevated temp can be an indication of infectious process, over taxing of vital organ systems Pain in the chest needs further investigation – quality, relieving factors/aggravating factors/ etc.

Excellent job! You identified all relevant vital sign data as well as the clinical significance. BSc

Current Assessment:	
General Appearance:	Patient appears anxious, diaphoretic.
Respiratory:	Crackles throughout, respirations labored. Unable to lie flat.
Cardiac:	Edema to lower extremities. Tachycardic at 118. Radial pulses bounding, pedal pulses weak bilaterally.
Neuro:	Alert and oriented, equal hand grasps.
GI:	Abdomen soft/non-tender, bowel sounds audible per auscultation in four quadrants.
GU:	Patient reports low urine output the past week.
Integumentary:	Patient diaphoretic. Edema to lower extremities. Skin intact.

What assessment data is RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Assessment Data:	Clinical Significance:
<p>Anxious & diaphoretic</p> <p>Crackles t/o lung fields, labored respirs, inability to lie flat</p> <p>Edema to BLE, tachycardia bounding radial pulses, weak BLE pedal pulses</p> <p>Low urine output past week</p>	<p>These are clinical signs & symptoms of respiratory problems. <i>If a patient is anxious, does it further compromise their oxygenation? If so, how? BSc</i></p> <p>These symptoms are crucial to assess and investigate/treat patient is heading to respiratory failure or shunting occurs <i>What do crackles in the lungs indicate? BSc</i></p> <p>Patient is having to work to hard for breathing this leading to increase in cardiac work-load, decreasing cardiac output there by the sympathetic nervous system regulating blood to most vital organs.</p> <p>This can give an indication of when the problems were starting, that the kidneys have a problem as well contributing to overall condition, damage or ischemia or kidneys <i>How is the edema in the patient's lower extremities clinically significant? BSc</i></p>

Clinical Reasoning Begins:

What is the primary problem that your patient is most likely presenting with? Acute Respiratory Failure – Impaired Gas Exchange

Your thinking is on the right track, however, let's back up and think about what could be occurring that is essentially leading to respiratory failure? Do you think it is possible the patient has pneumonia? What signs/symptoms does the patient have that would support this as a primary problem? Can pneumonia lead to respiratory failure? BSc

What is the underlying cause/pathophysiology of this concern? This patient is showing signs/symptoms of respiratory distress, the underlying cause for the impaired gas exchange is due to infection, lifestyle habits and comorbidities lend their hand to this patient's condition.

Great job! What is the pathophysiology of pneumonia? BSc

What nursing priority(s) will guide your plan of care? (if more than one-list in order of PRIORITY)

Assessing need for O2 therapy/causative agent, respiratory assessment, maintain high fowlers position, mobilization of secretions – suction within reach/bedside, Cardiac monitoring continuous, positive pressure ventilation (ppv), antibiotic therapy, lab draws

What nursing diagnoses would guide your plan of care for this patient? BSc

What interventions will you initiate based on this priority?

Nursing Interventions:	Rationale:	Expected Outcome:
Assess causative/contributing factors (Skyscape, 2019)	Gas exchange problems can be related to multiple factors, including anemias, anesthesia, surgical procedures, high altitude, allergic response, altered level of consciousness, anxiety, fear, aspiration, decreased lung compliance, excessive or thick secretions, immobility, infections, medication and drug toxicity of overdose, neuromuscular impairment of breathing pattern, pain, and smoking.	Able to understand how to treat patient for ventilation and adequate O2 exchange by removing or treating the causative agent/factors.
Respiratory assessment	Note respiratory rate, depth, use of accessory muscles, pursed lip breathing, areas of pallor/cyanosis, such as peripheral edema (nailbeds), venous central (circumoral) or general dusky skin	Patient has elevated respiratory rate, uses pursed lip breathing, lung sounds bilat have crackles t/o
Administer O2 therapy to assist with oxygenation via ppv or O2 nasal canula/rebreather	When gas exchange compromised supplemental O2 will assist patient to not exert as much energy trying to breathe or take in O2 on	Patient to show signs of less effort being used to maintain gas exchange.

<p>Auscultate breath sounds note areas of decreased/adventitious breath</p>	<p>their own</p> <p>Ventilatory effort is compromised and unable to deliver enough O₂ or get rid of CO₂. Abnormal breath sounds indicate numerous problems and must be evaluated for further intervention.</p>	<p>Patient to have inspiratory or expiratory breath sounds.</p>
<p>Monitor vital signs and cardiac rhythm (Skyscape, 2019)</p>	<p>All Vitals signs are impacted by oxygenation Expands diaphragm allowing for better oxygenation</p>	<p>Patient to have improving vital signs with cardiac rhythm uncompromised</p>
<p>Maintain high/semi fowlers Position</p>		<p>Increased oxygen exchange</p>
<p>Have patient Cough and deep breath/administer medication to loosen secretions Have suction machine within reach/at bedside</p>	<p>This encourages patient to eliminate the buildup of excess sputum/phlegm to maintain patent airway</p>	<p>Allows for proper gas exchange if air patent Allows for proper gas exchange if air patent</p>
<p>Administer Antibiotics per doctor order</p>	<p>If bacterial infection noted administering antibiotic therapy will combat infection allowing for optimum gas exchange</p>	<p>Patient will show signs of improvement after administration of IV atb.</p>
<p>Assess mentation of patient</p>	<p>Lack of O₂ can initiate confusion in patient</p>	<p>Patient to be able to answer question associated with name, date of birth, date/day, time of day.</p>
<p>Monitor Labs/ABGs</p>	<p>Labs/ABG's all indicative of infection or possible infection, or of acid/base balance of blood</p>	<p>Respiratory acidosis in ABG's, CBC, BMP, will all be out of range.</p>

--	--	--

Great job, Crystal. You listed all pertinent nursing interventions. Are there any medications we might want to give to help with the patient's fever? BSc

What body system(s) will you most thoroughly assess based on the primary/priority concern?
Pulmonary system, cardiac system, neurological system,

What is the worst possible/most likely complication to anticipate? Most likely complication foreseen for this patient is patient unable to get adequate gas exchange will need to be intubated to have breaths facilitated for him – or death of patient if unable to maintain adequate gas exchange causing decreased cardiac output and eventually cardiac death.

If we think the patient has an infection (Pneumonia), most likely the worst possible complication to anticipate is going to be that the patient goes into respiratory failure and possibly arrests. Excellent job! BSc

What nursing assessment(s) will you need to initiate to identify this complication if it develops? Continuous monitoring of adequate gas exchange/pulmonary system, as well as, related body systems.

Medical Management: Rationale for Treatment & Expected Outcomes

Care Provider Orders:	Rationale:	Expected Outcome:
Chest X-ray (CXR)	To assist in the evaluation of cardiac, respiratory and skeletal structures within the pulmonary cavity – diagnostic tool for diseases such as pneumonia & heart failure	This patients xray would show infiltrates in bibasilar lung fields or at the very least the lung bases.
Complete Blood Count (CBC)	Used to show if inflammation, infection and response to medication intervention.	Elevated white blood cells, decrease in hgb.
Basic Metabolic Panel (BMP)	BMP to determine any elevated or reduced levels specifically BUN/creatinine for kidney function and blood glucose. To assess nutritional, hydration, oxygenation.	All indications of metabolic process altered
Arterial Blood Gas (ABGs)	To assess oxygenation and acid base balance.	Respiratory acidosis would be indicated
Furosemide 40 mg IVP	To diuresis the body of excess fluid	Patient has peripheral edema, this would need to be assessed further to ensure output is appropriate and edema has lessened.

Oxygen (titrate for SpO2>93)	To provide assistance to the patient to contribute to the patient effort in gas exchange	Patient possibly does well sating at 93%spo2, then more effort needed to get spo2 93%
Pipercillin/tazobactam (Zosyn) 4.5 g q6h	Antibiotic therapy initiated to decrease bacterial load to alleviate respiratory infection.	Anitcipate patient to respond with better gas exchange
Place Foley catheter	Patient is having difficulty breathing making going to the bathroom use too much energy, in place in the event patient is sedated and due to diuretics relieving excess fluid.	Allows patient to use energy to breath.
Blood Culture	To ensure that patient does not have infection in the urine as well	The patient could possibly have UTI with the decreased output the last few day(retent)
Urine Analysis/Urine Culture (UA/UC)	Analgesic/antipyretic given to alleviate elevated body temp	Temp decreased to 99, depending on the bacterial load of infection.
Acetaminophen 650 mg. q6h for temp > 100.1		

Excellent job! BSc

PRIORITY Setting: Which Orders Do You Implement First and Why?

Care Provider Orders:	Order of Priority:	Rationale:
Place Foley Catheter	Oxygen	Patient needs O2 to maintain all organ function.
Pipercillin/tazobactan 4.5 g q6h	CXR	To confirm infection in lungs
Oxygen (titrate for SpO2>93)	ABG	To understand the severity to the hypoxia
ABGs	CBC	To understand/diagnose the severity of hypoxia
CBC	Pipercillin/tazobactam	To initiate fight against bacteria causing the infection
CXR	Foley insertion	To limit energy spent on going to bathroom to allow patient to use energy to breath deeper, also due to the medications causing diuresis.

Great job with your priority setting and rationales. BSc

Radiology Reports:

What diagnostic results are RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Results:	Clinical Significance:
<i>CXR: Infiltrates present in lower lobes bilaterally. Significant right and left pleural effusions.</i>	This is indications that the patient is experiencing infectious lung process. What infectious lung process do you think is specifically occurring? BSc

Lab Results:

Complete Blood Count (CBC):	Current:	High/Low/WNL?
WBC (4.5-11.0 mm ³)	17.5	High
Hgb (13.5-17.5 g/dL)	9.8	Low
HCT (41-49%)	32	WNL Is this WNL? BSc
Platelets (150-450 X 10 ³ μL)	175	High

What lab results are RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Lab(s):	Clinical Significance:
WBC	Elevated WBC indication of inflammatory response measuring infectious process. WBCs are key factors in infection presentation.
hgb	Part of the RBC that bind with iron to carry oxygen systemically. With lower levels there is decrease in the bloods ability to carry the oxygen
Platelets	Platelets are involved in clotting factors and become elevated with the inflammatory process.
	Great job! How is HCT relevant? What is the clinical significance? BSc

Basic Metabolic Panel (BMP):	Current:	High/Low/WNL?
Sodium (135-145 mEq/L)	135	Wnl
Potassium (3.5-5.0 mEq/L)	3.1	Low
Chloride (95-105 mEq/L)	95	Wnl
CO2 (Bicarb) (21-31 mmol/L)	25	Wnl
Glucose (70-110 mg/dL)	188	High
Calcium (8.4-10.2 mg/dL)	7.8	Low
BUN (7-25 mg/dL)	42	High

Creatinine (0.6-1.2 mg/dL)	1.38	high
----------------------------	------	------

RELEVANT Labs:	Clinical Significance:
Potassium – 3.1	<p>low potassium levels can cause cardiac issues rapidly and need to be addressed immediately Any medications the patient is taking that could cause this lab value to be decreased? BSc</p> <p>Though not directly an imergent priority it needs to be monitored to not cause further stress on the body</p> <p>Low Calcium levels can cause problems throughout the body but higher risk for affecting the heart muscle</p> <p>Elevated BUN indicates the kidneys are being effected by the infection, medication, or secondary infections</p> <p>This test is more in detail of how the kindeys are functioning and this being elevated indicates that damage is occurring and needs to be addressed.</p>
Glucose 188	
Calcium 7.8	
BUN -42	
Creatinine – 1.38	

ABGs:	Current:	High/Low/WNL?
pH (7.35-7.45)	7.15	low
pO2 (80-100)	72	low
pCO2 (35-45 mmHg)	88	High
HCO3 (22-26)	25	wnl

RELEVANT Labs:	Clinical Significance:
pH – 7.15	<p>This decrease indicates the blood is more acidic than it should be.</p> <p>This indicates there is not enough circulating O2 in the blood.</p> <p>This elevation indicates that there is too much CO2 circulating in the blood.</p> <p>Interpretation: Respiratory Acidosis Excellent job! BSc</p>
pO2	
PCO2	

Clinical Reasoning-Lab Results:

Does your initial nursing priority or plan of care need to be modified in any way after obtaining these lab results? The main priority is to maintain a patent airway, though with the a change as this the physician needs to be made aware for further medical treatment. Possibly intubation.

Great job, yes we need to notify the physician. BSc

What are your current nursing priorities that will determine your plan of care? Complete respiratory assessment, Adjust oxygen to accommodate patient O2, contact physician to initiate intubation if O2 sats do not remain within normal limits.

Evaluation:

One hour later, all physician orders have been implemented.

Current VS:	Most Recent:
T: 102.2	T: 102.6
P: 134	P: 122
R: 34	R: 32
BP: 170/110	BP: 166/108
SpO2: 80% on 10L via non-rebreather	SpO2: 82% room air
	Pain: 3 (chest)

Physical assessment is unchanged with the exception of 500 mL dark yellow urine in the Foley drainage bag.

What clinical data is RELEVANT that must be recognized as clinically significant?

Relevant VS and Assessment Data:	Rationale:
Temp 102.2 P -134 R-34 Bp – 170/110 Spo2 – 80% 500ml output of dark yellow urine	With an infection of any kind, sepsis is identified by having 2 or more of these criteria of Systemic Inflammatory Response Syndrome (SIRS): Temp >100.4 or < 96.8 HR >90 RR >20 WBC >12,000 or < 4,000 All of these VS components meet SIRS criteria, therefore it should be recognized the patient is septic with respiratory infection and is a clinical red flag. <i>This is good thinking. However, based on the data we have already obtained, and the patient’s signs and symptoms, do you agree that we have already determined that the patient has pneumonia? Therefore, do you think these vital signs are indicative of respiratory failure rather than sepsis? BSc</i>

Has the status improved or not as suspected to this point? The infection has gone from localized to systemically. This patient has become exceptionally ill and needs treated rapidly. It is possible that the patient is experiencing intrapulmonary shunt which happens when blood flows through pulmonary capillaries without participating in gas exchange. (Lewis, 1611) O2 therapy alone will not be as effective at increasing PaO2.

Again, do you think the patient is going septic, or is the pneumonia just causing respiratory failure? BSc

Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment? Maintaining airway and proper oxygen is top priority.

Based on your current evaluation, what are your nursing priorities?

Need to call the MD or MET to get this patient intubated.

Because you have not seen the level of improvement you were expecting in the medical interventions, you decide to update the physician and give the following SBAR:

Situation:
53 year old male, came to ER with wife for increased SOB over the past 2 days, severe coughing with lg amt of brown sputum, Pt has crackles t/o with labored respirations. Temp 102.2, P -134, R-34, Bp – 170/110, Spo2 – 80%, on 10L non-rebreather, 500ml output of dark yellow urine. Patient is worsening since arrival. CXR revealed - <i>Infiltrates present in lower lobes bilaterally. Significant right and left pleural effusions.</i>
Background:
he is a smoker 1ppd, has hx CAD, MI with stent placement, PVD, DMII, HTN, HLD. Also consumes alcohol regularly.
Assessment:
Temp 102.2, P -134, R-34, Bp – 170/110, Spo2 – 80%, on 10L non-rebreather, 500ml output of dark yellow urine, patient diaphoretic, edema present in BLE. <i>You would also want to inform the physician of any treatments that have been initiated for the patient up until this point. For example, what medications have you administered? How did the patient respond? BSc</i>
Recommendation:
Intubation with mechanical ventilation

The physician agrees with your concerns and decides to intubate the patient to protect his airway and improve his oxygenation. The patient is successfully intubated with an 8 mm ET tube, 24 cm. at the teeth. The ventilator was set to Assist Control with the following settings: tidal volume 500, rate 12, FiO2 40%, PEEP 5. An OG tube was also placed. There is a new order for ABGs to be drawn in a half-hour.

Following intubation:

Current VS:	Most Recent:
T: 100.8	T: 102.2

P: 86	P: 134
R: 16	R: 34
BP: 145/90	BP: 170/110
SpO2: 99% on mechanical ventilation	SpO2: 80% on 10L via non-rebreather

ABGs:	Current:	Most Recent:
pH (7.35-7.45)	7.25	7.15
pO2 (80-100)	88	72
pCO2 (35-45 mmHg)	52	88
HCO3 (22-26)	24	25

Has the status of the patient improved or not as expected to this point? Patient status is improving.

What data supports this evaluation assessment?

VS have come down to a manageable level ABG's are wnl patient is sating at 99% with mechanical ventilation.

Your patient who is still in the ED is now being transferred to the intensive care unit (ICU) for close monitoring. Effective and concise handoffs are essential to excellent care and if not done well can adversely impact the care of this patient. You have done an excellent job to this point, now finish strong and give the following SBAR report to the nurse who will be caring for this patient:

Situation: Mr. Ortiz is a 53 year old male, came to ER with wife for increased SOB over the past 2 days, severe coughing with lg amt of brown sputum, Pt has crackles t/o with labored respirations. Patient was intubated to protect his airway and improve his oxygenation. Intubated with an 8 mm ET tube, 24 cm. at the teeth. The ventilator was set to Assist Control with the following settings: tidal volume 500, rate 12, FiO2 40%, PEEP 5. An OG tube was also placed. Current VS. T: 100.8 P: 86 R: 16 BP: 145/90 SpO2: 99% on mechanical ventilation, Most recent ABG is partially compensated respiratory acidosis.
Background: Previous VS. Temp 102.2, P -134, R-34, Bp – 170/110, Spo2 – 80%, on 10L non-rebreather, 500ml output of dark yellow urine. Upon evaluation in the ER. Patient has history of smoker 1ppd, has hx CAD, MI with stent placement, PVD, DMII, HTN, HLD. Also consumes alcohol regularly.
Assessment: VS. T: 100.8 P: 86 R: 16 BP: 145/90 SpO2: 99% on mechanical ventilation, Most recent ABG is partially compensated respiratory acidosis. Edema noted lower extremities, pedal pulses weak bilaterally, Crackles t/o lung fields, CXR revealed <i>Infiltrates present in lower</i>

lobes bilaterally. Significant right and left pleural effusions. He was started on Piperacillin/Tazobactam 4.5 g Q6H. Given Lasix 40mg IVP, had blood cultures done, UA w/C&S. Had Tylenol 650mg x 1 dose.

Recommendation:

Monitor lab WBC(17.5), hbg (9.8), and BS (188) , Calcium 7.8, BUN 42, Creatinine 1.38. ua is still pending and all labs will need to be reevaluated.

Education Priorities/Discharge Planning

What will be the most important discharge/education priorities you will reinforce with their medical condition to prevent future readmission with the same problem?

- 1. Smoking Cessation***
- 2. DMII – education on diet and exercise/controlling the progression of disease***
- 3. Oxygen use if needed at home***
- 4. Disease processes – Htn, hld, etc.***
- 5. Knowing what s/sx to look for – for another respiratory episode***

Excellent job! BSc

What are some practical ways you as the nurse can assess the effectiveness of your teaching with this patient? The teach back method is always a good way to understand that the patient heard what you said and can put it into use. Having the patient explain how they would go about modifying their lifestyle to meet goals.

Caring and the “Art” of Nursing:

What is the patient likely experiencing/feeling right now in this situation? This patient is probably anxious/fearful. He is probably concerned if he will live or die leaving his wife and girls alone to have to support themselves.

What can you do to engage yourself with this patient’s experience, and show that he/she matters to you as a person? Speak to the patient at their level of understanding. Use a gentle tone and use culturally specific guidelines. Listen to their fears (patient and family), show empathy, understanding, and accurate information when discussing patient treatment and care. Let the family know you are there for them and mean what you say. Smile when

appropriate and offer yourself to their service. Patient and family need to know they can trust your with their loved ones life by doing the above things opens a door to trust and cooperation. The nurse will be their trusted advisor once this occurs.

Crystal,

You did an excellent job with this unfolding case study. Please take the time to revisit the areas in which I identified there may have been some missing information, or more information that could be added after further deliberation and deeper thinking. This will greatly benefit you and your care in the clinical setting in the future. Keep up all your hard work! BSc