N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
8/24/2020	V.W.	68	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Married	Ugesic – Hallucinations
Code Status	**Height**	**Weight**	
Full Code	160 cm	93 kg	

Medical History (5 Points)

Past Medical History: Anemia, Chronic Congestive Heart Failure, Chronic Kidney Failure, Diabetes Mellitus Type II, Hypertension, Hyperlipidemia

Past Surgical History: Cholecystectomy, Hysterectomy, Tonsillectomy

Family History: Alcohol Abuse (Father), Depression (Mother), Diabetes Mellitus (Mother), Hyperlipidemia, Hypertension, and Stroke (Both parents)

Social History (tobacco/alcohol/drugs): Patient denies use of tobacco, alcohol, and drugs

Assistive Devices: Walker

Living Situation: Home with spouse

Education Level: High school diploma – the patient is retired

Admission Assessment

Chief Complaint (2 points): Shortness of Breath

History of present Illness (10 points): The patient is a 68-year-old female with a past medical history of anemia, chronic congestive heart failure, chronic kidney failure, diabetes mellitus, hypertension, hyperlipidemia, and depression. The patient was brought to the emergency department by EMS on 8/24/2020 after she reported shortness of breath. The patient's husband said that the patient fell into the recliner and stopped breathing. The husband performed CPR on

the patient until EMS arrived and took over. Upon admittance to the emergency department, the patient was intubated and transferred to the critical care unit.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute Respiratory Failure with Hypoxemia

Secondary Diagnosis (if applicable): Cardiac arrest

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

Acute respiratory failure occurs when the pulmonary system fails to oxygenate the blood. Respiratory failure can be categorized as acute or chronic and hypoxemic or hypercapnic. Hypoxemic respiratory failure occurs when the pressure of oxygen (PaO2) is lower than 60 mm Hg with normal PaCO2. Hypercapnic respiratory failure occurs when carbon dioxide in arterial blood gases is greater than 50 mm Hg (Gulanick & Myers, 2017). A buildup of carbon dioxide can result in damage to the tissues and organs. Serial arterial blood gases (ABGs) should be evaluated in all patients with respiratory problems. The patient's labs show that she has elevated PaCO2, indicating respiratory acidosis due to fluid overload and shortness of breath.

The patient's respiratory failure symptoms depend on the underlying cause and level of carbon dioxide and oxygen in the bloodstream. Common symptoms include shortness of breath, tachycardia, accessory muscle use, diaphoresis, anxiety, cyanosis, loss of consciousness, and difficulty maintaining a regular respiratory rate despite oxygen administration (Cattamanchi, 2018). According to the patient’s husband, before the patient presented to the Emergency Department, she was short of breath and anxious. By the time EMS arrived, the patient had lost consciousness.

Diagnostic testing is a vital component of assessment for respiratory failure. ABGs are used to provide information about the patient's gas exchange. The patient's ABGs revealed respiratory and metabolic acidosis. This combination occurs when bicarbonate (HCO3) is low and partial pressure of carbon dioxide (pCO2) is high. Chest x-rays provide visualization of the chest and lungs. The patient received multiple chest x-rays, which revealed pulmonary edema secondary to chronic congestive heart failure. If chest x-rays are inadequate, computed tomography (C.T.) and magnetic resonance imaging (MRI) can be performed. If an infection is suspected, culture and sensitivity testing can be performed on sputum collections.

Treatment of acute respiratory failure involves addressing any underlying conditions the patient may have. In this situation, the patient's chronic congestive heart failure caused pulmonary edema and is being treated. The patient was intubated because she could not breathe adequately on her own. Endotracheal intubation maintains an open airway and helps avoid suffocation.

Pathophysiology References (2) (APA):

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

Cattamanchi, A. (2018, September 17). *Acute Respiratory Failure: Causes, Symptoms, and Diagnosis*. https://www.healthline.com/health/acute-respiratory-failure

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	3.8-5.41	2.67	2.71	The patient's RBC count could be low due to the patient's medical history of anemia (Kee, 2018).
Hgb	11.3-15.2	7.9	8.0	he patient's Hgb count could be low due to the patient's medical history of anemia (Kee, 2018).
Hct	33.2-45.3	24.3	24.3	he patient's Hct count could be low due to the patient's medical history of anemia (Kee, 2018).
Platelets	149-393	190	173	
WBC	4-11.7	7.0	5.9	
Neutrophils	2.4-8.4	5.0	4.2	
Lymphocytes	11.8-45.9	12.1	15.2	
Monocytes	4.4-12	14.6	12.9	The patient's monocyte count could be low due to aplastic anemia (Kee, 2018. The patient does have a history of anemia, but the chart does not specify which type.
Eosinophils	0-6.3	0.7	0.4	
Bands	0.1.0	2.0	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-	136-145	148	149	The patient's sodium level could be high due to her medical history of CHF (Kee, 2018).
K+	3.5-5.1	3.6	3.7	
Cl-	98-107	116	116	The patient's Cl- could be high due to her chronic kidney disease. Another reason her Cl- could be increased is a result of hypernatremia (Kee, 2018).

CO2	21-31	24	26	
Glucose	74-109	162	180	The client's glucose is elevated due to her controlled diabetes mellitus (Kee, 2018).
BUN	7-25	42	42	The patient's BUN is elevated due to reduced renal perfusion resulting from her CHF (Kee, 2018).
Creatinine	0.5-0.9	1.10	1.01	
Albumin	3.5-5.2	2.4	n/a	The patient's albumin level could be low due to her kidney failure, or it could be low due to her prescription for aspirin (Kee, 2018).
Calcium	8.6-10.3	n/a	n/a	
Mag	1.5-2.5	1.7	1.8	
Phosphate	35-105	2.9	n/a	
Bilirubin	0.3-1.0	0.4	n/a	
Alk Phos	20-140	62	n/a	
AST	0-32	24	n/a	
ALT	0-33	16	n/a	
Amylase	23-85	n/a	n/a	
Lipase	0-160	1.9	n/a	
Lactic Acid	0.5-1.0	n/a	n/a	
Troponin	0-.0.4	2.151	n/a	The patient's troponin was high due to cardiac arrest (Kee, 2018).
CK-MB	3-5%	9.93	n/a	The patient's CK-MB is elevated due to acute MI or cardiac ischemia (Kee, 2018).
Total CK	22-198	447	n/a	The patient's total C.K. is elevated due to acute MI or cardiac ischemia (Kee, 2018).

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	2-3	1.15	n/a	The patient's INR could be low due to myocardial infarction (Kee, 2018).
PT	11-12.5	15.1	n/a	The patient's P.T. could be elevated due to her heart failure history or her use of aspirin (Kee, 2018).
PTT	30-40	36.2	n/a	The patient's PTT could be elevated due to her P.T. being elevated (Kee, 2018).
D-Dimer	<0.50	n/a	n/a	
BNP	<100	n/a	n/a	
HDL	23-92	n/a	n/a	
LDL	<100	n/a	n/a	
Cholesterol	<130	n/a	n/a	
Triglycerides	0-149	n/a	n/a	
Hgb A1c	< = 6.4	8.1	n/a	The client's Hgb A1C is elevated due to her controlled diabetes mellitus (Kee, 2018).
TSH	0.45-5.33	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	Yellow/Clear	Yellow & Clear	n/a	
pH	4.5-8.0	5.0	n/a	
Specific Gravity	1.010-1.030	1.010	n/a	
Glucose	0 – 0.8	50	n/a	

Protein	0-20mg/dL	2+	n/a	
Ketones	Negative	Negative	n/a	
WBC	Negative	1	n/a	
RBC	Negative	1	n/a	
Leukoesterase	Negative	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	7.35-7.45	n/a	n/a	
PaO2	80-100	98.1	n/a	
PaCO2	35-45	51.8	n/a	The patient's PaCO2 is elevated because she has respiratory acidosis related to shortness of breath, fluid overload, and vomit aspiration during her cardiac arrest episode (Kee, 2018).
HCO3	22-28	15.5	n/a	The patient's HCO3 is low because the patient has metabolic acidosis from DKA and hyperglycemia (Kee, 2018).
SaO2	95-100	n/a	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	Negative	n/a	n/a	
Blood Culture	Negative	Negative	n/a	
Sputum Culture	Negative	Negative	n/a	
Stool Culture	Negative	n/a	n/a	

Lab Correlations Reference (APA):

Kee, J. L. F. (2018). *Laboratory and Diagnostic Tests with Nursing Implications*. Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest x-ray

Diagnostic Test Correlation (5 points): The patient received multiple chest x-rays for various reasons. The main reason is for endotracheal tube (E.T.) placement. The chest x-ray will allow the provider to verify that the tube was placed correctly. The E.T. tube is in place overlying the lower thoracic trachea with tip 5cm above the carina. Another chest x-ray was performed to rule out other underlying causes of her cardiac arrest. The patient has a history of congestive heart failure, which could have caused her respiratory failure. The chest x-ray revealed the patient has pulmonary edema.

Diagnostic Test Reference (APA):

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

Current Medications (10 points, 1 point per completed med)

10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Lasix/ Furosemide	Coreg/ Carvedilol	Cozaar/ Losartan	Lipitor /Atorvastatin	Plavix/ Clopidogrel
Dose	80mg	6.25mg	100mg	80mg	75mg
Frequency	Daily	BID	Daily	Daily	Daily
Route	P.O	P.O.	P.O.	P.O.	P.O.
Classification	Loop Diuretics	Beta-Blocker	Angiotensin II Receptor Blockers (ARBs)	Lipid-Lowering Agents, Statins	Antiplatelet Agent
Mechanism of Action	Inhibits reabsorption of sodium and chloride ions at proximal and distal renal tubules and loop of Henle; by interfering with chloride-binding cotransport-system causing increases in water, calcium, magnesium, sodium, and chloride.	Nonselective beta-adrenergic blocking agent with no intrinsic activity for use in congestive heart failure and hypertension.	Blocks binding of angiotensin II to type 1 angiotensin II receptors; blocks the vasoconstrictor and aldosterone-secreting effects of angiotensin II.	HMG- CoA reductase inhibitor; inhibits the rate-limiting step in cholesterol biosynthesis by inhibiting HMG-CoA reductase.	Inhibitor of adenosine diphosphate (ADP)-induced pathway for platelet aggregation.
Reason Client Taking	The patient is taking this medication for her chronic CHF.	The patient is taking this medication for her chronic CHF.	The patient is taking this medication for hypertension.	The patient is taking this medication to control lipid levels.	The patient is taking this medication to reduce the risk of MI.
Contraindications (2)	Anuria Hypersensitivity to furosemide or sulfonamides.	COPD Bronchial asthma, bronchospasm	Coadministration with aliskiren in patients with diabetes mellitus Hypersensitivity to losartan	Active liver disease or unexplained transaminase elevation Hypersensitivity to atorvastatin	Active pathologic bleeding such as peptic ulcer Hypersensitivity
Side Effects/Adverse	Hyperuricemia	Dizziness	Cough	Diarrhea	Upper respiratory tract

Reactions (2)	Hypokalemia	Fatigue	Upper respiratory tract infection	Nasopharyngitis	infection Chest pain
Nursing Considerations (2)	Monitor fluid intake and output and electrolyte, BUN, and carbon dioxide levels frequently. Watch for signs of hypokalemia, such as muscle weakness and cramps.	Monitor diabetic patiently closely; drug may mask symptoms of hypoglycemia, or hyperglycemia may worsen. Hypotension may occur. Observe patient for dizziness or light-headedness.	Monitor patients who are also taking diuretics for symptomatic hypotension. Monitor the patient's blood pressure closely to evaluate the effectiveness	Monitor diabetic patient's blood glucose levels because atorvastatin therapy can affect blood glucose control. Expect to measure lipid levels 2 to 4 weeks after therapy starts until lipid levels are within the desired range.	Monitor blood pressure and pulse rate frequently. Elderly patients may be more sensitive than younger ones to drug's hypotensive effects.
Key Nursing Assessment(s) Prior to Administration	Monitor weight, B.P., and pulse rate routinely with long-term use.	Monitor patients with H.F. for worsened condition, renal dysfunction, or fluid retention.	Regularly assess the patient's renal function (via creatinine and BUN)	Expect liver function tests to be performed before atorvastatin therapy begins and then after.	Monitor blood pressure and pulse rate frequently. Dosage is usually adjusted to the patient's blood pressure and tolerance.
Client Teaching needs (2)	Advise patients to take drug in the morning to prevent the need to urinate at night. Inform the patient of the possible need for potassium or magnesium supplements.	Advise patients to take this medication with food. Inform patients that they may break the capsule and sprinkle on a spoonful of applesauce; to be eaten immediately.	Advise the patient to take this medication with or without food. Tell the patient to avoid salt substitutes.	Advise patients with diabetes to monitor blood glucose levels closely. Tell the patient to take the drug at the same time each day to maintain its effect.	Advise patients that stopping the medication abruptly may cause severe high rebound blood pressure. Tell the patient to take the last dose immediately before bedtime.

Hospital Medications (5 required)

Brand/ Generic	Norvasc/ Amlodipine	Aspirin/ Acetylsalicylic Acid	Celexa/ Citalopram	Sublimaze/ Fentanyl	Divprivan/ Propofol
Dose	5mg	81mg	40mg	1250 mcg	100 mL
Frequency	Daily	Daily	H.S.	Continuous Infusion	Confusion Infusion
Route	P.O.	P.O.	P.O.	I.V.	I.V.
Classification	Calcium Channel Blockers – Antianginal Agents	Antiplatelet Agent	Antidepressants, SSRIs	Opioid Analgesic	General Anesthetic, Systemic
Mechanism of Action	Inhibits transmembrane influx of extracellular calcium ions across membranes of myocardial cells and vascular smooth muscle cells without changing serum calcium concentrations	Inhibits synthesis of prostaglandin by cyclooxygenase; inhibits platelet aggregation; has antipyretic and analgesic activity	Inhibits the reuptake of serotonin in presynaptic neurons; little or no affinity for dopamine, alpha-adrenergic histamine, or cholinergic receptor	Narcotic agonist-analgesic of opiate receptors; inhibits ascending pain pathways, thus altering response to pain; increases pain threshold; produces analgesia, respiratory depression, and sedation	Short-acting, lipophilic sedative/hypnotic; causes global CNS depression, presumably through agonist actions on GABAa receptors
Reason Client Taking	The patient is taking this medication for hypertension.	The patient is taking this medication to reduce the risk of MI.	The patient is taking this medication for depression.	The patient is taking this medication for severe pain.	This patient is on this medication for sedation while being mechanically ventilated.
Contraindications (2)	Use cautiously in patients receiving other peripheral vasodilators. Contraindicated in patients hypersensitive to drug.	Bleeding G.I. ulcers Hemorrhoids	Coadministration with pimozide Hypersensitivity	Significant respiratory depression Acute or bronchial asthma	Egg allergy Soybean/soy allergy
Side Effects/Adverse Reactions	Edema Headache	Angioedema Bronchospasm	Dry mouth Nausea	Asthenia Confusion	Hypotension Apnea lasting

(2)					30-60 seconds
Nursing Considerations (2)	Notify the prescriber if signs of H.F. occur. Abrupt withdrawal of drug may increase the frequency and duration of chest pain.	Monitor elderly patients closely because they may be more susceptible to aspirin's toxic effects. Monitor patients for hypersensitivity reactions such as anaphylaxis and asthma.	Reduce the risk of overdose by limiting the amount of drug available per refill. At least 14 days should elapse between MAO inhibitor therapy and citalopram therapy.	Respiratory depression or death can occur. High doses can produce muscle rigidity.	If the drug is used for prolonged sedation in ICU, urine may turn green. Monitor patients at risk for hyperlipidemia for elevated triglyceride levels.
Key Nursing Assessment(s) Prior to Administration	Monitor B.P. frequently during initiation of therapy.	Monitor the salicylate level.	Correct electrolyte disturbances before starting drug.	Monitor patients for signs of adrenal insufficiency such as nausea, vomiting, and loss of appetite.	Continuously monitor vital signs.
Client Teaching needs (2)	Caution patient to report all adverse reactions and to continue taking drug, even when feeling better. Tell patient S.L. nitroglycerin may be taken as needed when angina symptoms are acute.	Advise patients to take this medication with food or milk. Tell the patient not to crush or chew medication; swallow whole.	Advise the patient's family to communicate any abrupt changes in behavior to the health-care provider. Although improvement may take 1 to 4 weeks, inform the patient to continue therapy as prescribed.	When drug is used for pain control, instruct the client to request medication before the pain becomes intense. Encourage patients to report all medications being taken.	Tell the patient that abnormal dreams or anesthesia awareness may occur. Advise patients that the performance of activities requiring mental alertness may be impaired after drug use.

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is sedated and intubated. Unable to obtain alertness and orientation prior to intubation. The patient will rarely wiggle her toes in response to verbal commands. According to the FLACC scale, the patient is not in any distress. She is well dressed and covered.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin is pink, warm, and dry and appropriate for ethnicity. The patient's temperature ranged between 37.3 and 37.6˚C during shift. Skin turgor was assessed on arms bilaterally and were both less than 3 seconds. No rashes or bruises are present. The patient has a red and closed pressure ulcer on the buttocks. The Braden score is 14, which makes the patient a mild skin risk. No drains are present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The head is normocephalic, with no visible deformities or abnormalities. Ears are normal and symmetric to face. PERLA is present with no visual disturbances. The nose is normal and symmetric to the face. The patient has an endotracheal tube that is secured to her face. Teeth are normal. Lips, mucosa, and tongue all normal. The patient is receiving oral care every 2 hours.
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:**	Regular rate and rhythm with S1 and S2 present. No murmurs, gallops, or rubs present upon auscultation at aortic, pulmonary, tricuspid, and mitral valve. Peripheral pedal pulses are 3+ bilaterally. Radial pulses are 3+ bilaterally. Capillary refill is less than 3 seconds on both hands. No chest tenderness or deformities. No neck vein distention or edema.

RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **E.T. Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (T.V.):** **PEEP:** **VAP prevention measures:**	The patient is mechanically ventilated. No accessory muscle use. Right, and left lung sounds are clear, bilaterally. E.T. Tube: 7 ½ 25 cm at the lip 16/min 50 344 8.0 VAP: Provide oral care to the patient every 2 hours or as needed.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last B.M.:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☒ N ☐** **Type:**	The patient is on a regular diet at home and enteral feedings inpatient. The patient is receiving Glucerna for nutrition. Height is 160 cm, and weight is 93kg. Bowel sounds are present and active in all four quadrants. The abdomen is soft and non-tender upon palpitation in all four quadrants. No masses, distention, incisions, scars, drains, or wounds. The patient is at high risk for aspiration. The patient's last bowel movement was 8/31/20. The patient is receiving enteral feedings via an Orogastric Tube.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	Urine is clear and yellow. The patient is voiding on the pad in the bed. The patient urinated twice during shift. She was cleaned and changed by the staff. Genitals look normal with no abnormalities. CAUTI prevention: Limit inappropriate use of catheters, maintain asepsis during insertion, and while the catheter is in place, ensure no obstruction by no kinks or loops in the tube.
MUSCULOSKELETAL (2 points):	Neurovascular status is normal. The patient has

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 ☐**	bilateral, equal passive range of motion in all four extremities. The patient is a fall risk. The patient was independent and up ad-lib before intubation. The fall score is 75 indicating high fall risk. Fall risk interventions were initiated. No joint abnormalities, cyanosis, or edema.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	No sensory deficits. No hearing-aid or glasses. Unable to assess the patient's speech and mental status. The patient is taking Citalopram for depression.
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):**	The patient lives at home with her husband. I was unable to talk with the patient about her coping methods and religion. Based on information from the patient's husband, she enjoys going on vacation with her family.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	62 bpm	179/73 mm/Hg	20/min	37.6 ˚C Tympanic	95% Ventilator
1130	61 bpm	162/70 mm/Hg	16/min	37.3 ˚C Tympanic	93% Ventilator

Vital Sign Trends/Correlation:

The patient's blood pressure is elevated due to her medical history of hypertension. Her blood pressure was elevated from when she was admitted into the E.R. and throughout my entire shift. The patient's blood pressure is being treated with losartan daily. The patient is intubated, which is maintaining the rest of her vital signs and keeping them within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	FLACC	n/a	0	n/a	No interventions are taken because the patient does not have any pain.
1130	FLACC	n/a	0	n/a	No interventions are taken because the patient does not have any pain.

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.:** **IV dressing assessment:**	The patient does not have a peripheral IV inserted. She only has a PICC line, which is listed below.
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:**	PICC Line – continuous infusion of propofol (100 ml/hr) and fentanyl (1250 mcg/hr)

Location: **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☒ N ☐** **CLABSI prevention measures:**	Triple lumen Right, Upper Arm 8/24/2020 Patent - currently infusing, flushes easily, good blood return No phlebitis, infiltration, erythema, or drainage present 8/31/2020 To prevent CLASBI perform good hand hygiene before and after performing any care

Reference:

Intake and output (2 points)

Intake (in mL)	**Output (in mL)**
2950 ml IV Medication and Enteral Feedings	2700 ml Urine Output Bowel Movement: 8/31/20

Nursing Care

Summary of Care (2 points)

Overview of care: Today, I took 0730 and 1130 vitals on my patient. Her blood pressure was high during both assessments. The patient is receiving losartan to control her blood pressure. My patient is mechanically ventilated via Endotracheal Tube and is receiving enteral feedings via Orogastric Tube. I practiced suctioning the E.T. tube by hyperventilating my patient first and suctioning no longer than ten seconds. The purpose of this is to clear any secretions the patient may have. I worked side by side with my nurse to perform a head to toe assignment. The patient

has a pressure ulcer on her bottom so, I applied barrier cream and changed her linens. By the end of the shift, I checked on my patient and provided oral care to prevent any ventilator-associated pneumonia.

Procedures/testing done: A chest x-ray was performed on the patient multiple times to ensure proper placement of her E.T. tube. Each time the results revealed that the tube was correctly placed. The Chest X-Ray also revealed that the patient was positive for pulmonary edema. This is expected since the patient has chronic congestive heart failure. The patient is receiving furosemide to drain the fluid from her lungs.

Complaints/Issues: Due to the patient being intubated, she is not able to communicate verbally. The patient's sedation is maintained with propofol. Therefore, no complaints or issues were expressed directly from the patient. My next protocol was to use the FLACC scale to monitor for pain. At 0730 and 1130, the score was 0.

Vital signs (stable/unstable): The patient's blood pressure is elevated due to her medical history of hypertension. Her blood pressure was elevated from when she was admitted into the E.R. and throughout my entire shift. The patient's blood pressure is being treated with losartan daily. The patient is intubated, which is maintaining the rest of her vital signs and keeping them within normal limits

Tolerating diet, activity, etc.: The patient is sedated and is under the total care of her professional medical team. The patient is receiving Glucerna via O.G. tube because she is an uncontrolled type II diabetic.

Physician notifications: The physician was not notified of any information during shift.

Future plans for patient: The future plans for this patient are unknown at this time. If the patient is discharged, it will most likely be with home health care provided. The nurses are going to continue to monitor.

Discharge Planning (2 points)

Discharge location: The discharge location is unknown at this time.

Home health needs (if applicable): The patient will need home health aid following discharge.

Equipment needs (if applicable): The patient will need oxygen at home if she cannot maintain her SpO2 levels on her own. The patient may also need a walker to help support her ambulation.

Follow up plan: The patient is advised to follow up with her primary care provider within one to two weeks following discharge.

Education needs: The patient will need education on the importance of maintaining her blood glucose levels within the acceptable range. The patient should be aware of medication compliance, as well. If the patient is discharged on oxygen therapy, she will need education on maintenance, such as no smoking in the home.

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. Impaired Spontaneous Ventilation related to acute respiratory failure as evidence by increased PaCO2 level and decreased tidal volume.	The patient is mechanically ventilated as a result of her acute respiratory failure with hypoxemia.	**1.**Assess for correct endotracheal (E.T.) tube placement: auscultation of bilateral breath sounds. **2.** Assess for patient comfort and the ability to cooperate with therapy.	The patient did well with E.T. tube placement. When auscultating breath sounds, the patient does not interfere. The patient did not seem to be in any distress using the FLACC pain scale. In the beginning, the patient was tugging at the tube, and soft wrist restraints were applied. She has since stopped.
2. Impaired Gas Exchange related to ventilation-perfusion mismatch as evidence by abnormal arterial blood gases.	The patient has respiratory and metabolic acidosis related SOB, fluid overload, DKA, and hyperglycemia. All of the above contribute to impaired gas exchange.	**1.** Monitor serial ABGs and note changes. **2.** Monitor the chest x-ray reports.	The patient's ABG levels were taken on admission, and they had not been drawn again during my shift. The x-ray revealed pulmonary edema.
3. Ineffective Airway Clearance related to endotracheal intubation as evidence by excessive secretions.	The patient has CHF and pulmonary edema. She is carrying a lot of excess fluid. The E.T. tube will allow staff to suction any excessive	**1.** Hyperoxygenate as ordered. **2** Turn the patient every 2 hours.	Hyperoxygenating, the patient before E.T. tube suctioning, decreases hypoxia, and cardiac dysrhythmias. The patient reacted well to suctioning. She was turned every 2 hours with no complications.

	secretions to allow for better breathing.		
4. Decreased cardiac output related to impaired contractility as evidence by cardiac arrest.	The patient went into cardiac arrest as a result of acute respiratory failure. The events could have resulted in decreased cardiac output.	**1.** Assess the cardiac rate and rhythm and the 12-lead EKG. **2.** Administer prescribed medications.	The patient is receiving furosemide to reduce intravascular fluid volume. Upon cardiac assessment, the patient exhibits strong peripheral pulses and heart rate within normal limits.
5. Risk for aspiration related to decreased level of consciousness as evidence by enteral tube feeding.	Aspiration is always a risk when the patient is intubated.	**1.** Elevate the head of the bed to 30 degrees during and for one hour after each feeding. **2.** Auscultate breath sounds for the development of crackles and wheezes.	The patient responded well to laying in a semi-fowlers position. Lungs were clear upon auscultation.

Other References (APA):

Gulanick, M., & Myers, J. L. (2017). *Nursing Care Plans: Diagnoses, Interventions, & Outcomes*. Elsevier.

Concept Map (20 Points):

Subjective Data

The patient is intubated and unable to provide subjective data.
Prior to admission and in the emergency department, the patient stated she felt shortness of breath and chest pain.

Nursing Diagnosis/Outcomes

Impaired Spontaneous Ventilation related to acute respiratory failure as evidence by increased PaCO2 level and decreased tidal volume.
By discharge, the patient will maintain spontaneous gas exchange resulting in normal ABGs.
Impaired Gas Exchange related to ventilation-perfusion mismatch as evidence by abnormal arterial blood gases.
By discharge, the patient maintains optimal gas exchange, as evidence by arterial blood gases within the patient's usual range.
Ineffective Airway Clearance related to endotracheal intubation as evidence by excessive secretions
By discharge, the patient will maintain a clear, open airway, as evidence by normal breath sounds after suctioning.
Decreased cardiac output related to impaired contractility as evidence by cardiac arrest
By discharge, the patient maintains adequate cardiac output, as evidence by strong peripheral pulses and systolic pressure within normal limits.
Risk for aspiration related to decreased level of consciousness as evidence by enteral tube feeding.
By discharge, the patient maintains a patent airway and no aspiration.

Objective Data

0730 vital signs:
B.P.: 179/73 mmHg
H.R.: 62 bpm
R: 20/min
T: 37.6 ℃
O2: 95%
1130 vital signs:
B.P.: 162/70 mmHg
H.R.: 61 bpm
R: 16/min
T: 37.3℃
O2: 93%
Chest X-Ray: Verified correct placement of E.T. Tube
Abnormal labs: RBC, HGB, HCT, Platelets, Monocytes, Na-, K+, Cl-, Glucose, BUN, Albumin, Troponin, CK-MB, Total C.K., INR, P.T., PTT, Hgb A1C

Patient Information

- Patient Initials: V.W.
- 68-year-old white female
- Admitted: 8/24/20
- Full Code
- Allergies: Ugesic (Hallucinations)
- Height: 160 cm
- Weight: 93 kg

Nursing Interventions

Assess for correct endotracheal (E.T.) tube placement: auscultation of bilateral breath sounds.

Assess for patient comfort and the ability to cooperate with therapy.

Monitor serial ABGs and note changes.

Monitor the chest x-ray reports.

Hyperoxygenate as ordered.

Turn the patient every 2 hours.

Assess the cardiac rate and rhythm and the 12-lead EKG.

Administer prescribed medications.

Elevate the head of the bed to 30 degrees during and for one hour after each feeding.

Auscultate breath sounds for the development of crackles and wheezes.