N441 Care Plan

Lakeview College of Nursing

Jazmin Leal

Demographics (3 points)

Date of Admission 10/26/20	Patient Initials JO	Age 58-years-old	Gender Male
Race/Ethnicity White	Occupation Disabled	Marital Status Single	Allergies Penicillin
Code Status DNR	Height 180 cm	Weight 89.2 kg	

Medical History (5 Points)

Past Medical History: N/A

Past Surgical History: N/A

Family History: N/A

Social History (tobacco/alcohol/drugs): The Client is a past user of alcohol and a former smoker.

Assistive Devices: N/A

Living Situation: Lives at home with 5 other family members.

Education Level: N/A

Admission Assessment

Chief Complaint (2 points): "Abdominal pain"

History of present Illness (10 points): The Client states he has had constant abdominal pain in the upper epigastric region for two months. The pain has intensified in the last 2-3 days causing it to change into a constant, sharp, and burning pain. The pain is rated a 10/10 in severity on the numeric scale. No reported alleviating factors, but reports of breathing, moving, and palpitation are aggravating factors. The Client reports nausea and brownish emesis have been present in the last 2-3 days while he has not consumed any food or drink.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Perforated viscus

Secondary Diagnosis (if applicable): Portal vein thrombosis

Pathophysiology of the Disease, APA format (20 points): Individuals that experience a preexisting gastric issue are at risk for contamination of the peritoneal due to the perforation (Azer, 2018). Perforation is when the gastric juice is leaked into the peritoneal cavity, causing chemical peritonitis (Azer, 2018). The body's proximal part of the small bowel does not have many bacteria present. However, the distal part has aerobic organisms such as E. coli and even more anaerobic organisms such as B. fragilis (Azer, 2018). The bacteria in the peritoneal cavity cause the inflammatory cells to stimulate, increasing white blood counts, such as this client had today (Azer, 2018). The large bowel is typically perforated because the omentum and viscera localize the inflammation site to make phlegmon (Azer, 2018). Organisms that live without oxygen grow due to the hypoxia, and killing the bacteria is impaired (Azer, 2018). The impairment of granulocytes' bacteria-killing activity causes a decrease, cell degradation, osmotic effects, and more fluids into the abscess area; thus, causing it to become larger (Azer, 2018). This illness treatment, otherwise sepsis, multiorgan failure, and shock, has the potential to occur, and in this patient, all of these occurred (Azer, 2018). A perforated viscus's signs and symptoms are abdominal pain and a sudden onset of severe abdominal pain (Cutright, 2019). A previous history of abdominal pain with inflamed gallbladder and appendix conditions and a GI ulcer is found (Cutright, 2019). Individuals that are debilitated are at a greater risk of perforated viscus (Cutright, 2019). Today, the client did present with severe abdominal pain and was in bed for the last ten years, and did not receive a bath for nine years. The client from today did not state any past medical history and was the first time seen at this facility. A client with perforated viscus

can have a systemic inflammatory response syndrome, fever, tachycardia, increased respiratory rate, and low blood pressure, which will lead to sepsis and eventually transition to septic shock (Cutright, 2019). A perforated viscus will cause abdominal tenderness, which the client experienced and reported for the present illness (Cutright, 2019). If the client has diffuse peritonitis, any movement, including breathing, will cause pain (Cutright, 2019). The client from today stated that any movement and breathing caused severe abdominal pain and tachycardia upon arrival. Laboratory findings for septic shock include complete blood count with differential, CMP, urinalysis, lactate, and blood gases (Cutright, 2019). The client had all these labs done to observe his hgb, hct, platelets, WBCs, LFTs, BUN, creatinine, lactic acid level, and atrial blood gases to monitor his oxygen level and acid-base levels. Diagnostic testing for perforated viscus includes CT, X-ray, and ultrasound (Cutright, 2019). The client had a CT of his abdomen and a chest X-ray to observe any free air. Treatment for perforated viscus includes antibiotics and surgical consultation early, and resuscitation (Cutright, 2019). The client with a perforated viscus may require oxygen supplementation as well (Cutright, 2019). The client from today received antibiotics early upon arrival, and the on-call general surgeon was consulted. The general surgeon decided to take the client to surgery to repair the issues and relieve diverticulosis, as seen on the CT. The client was placed on a ventilator to help maintain a patent airway and help the client breathe.

Pathophysiology References (2) (APA):

Azer, S.A. (2018). *What is the pathophysiology of intestinal perforation?* Retrieved from https://www.medscape.com/answers/195537-91591/what-is-the-pathophysiology-of-intestinal-perforation

Cutright, A. (2019). *Perforated Viscus.* Retrieved from https://www.saem.org/cdem/education/online-education/m4-curriculum/group-m4-gastrointestinal/perforated-viscus#:~:text=The%20onset%20of%20pain%20is,prior%20surgery%2C%20etc.

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	**3.9 – 4.98**	**4.8**	**2.3**	**Low RBC can indicate kidney disease and hemorrhage (Holman et al., 2019). Today, the client did not report past medical history but experienced septic shock, and when end-organ damage occurs in septic shock, AKI occurs (Hinkle & Cheever, 2018).**
Hgb	**12 – 15.5g/dl**	**14.8**	**7.2**	**Decreased Hgb indicates anemia, hemorrhage, and kidney disease (Holman et al., 2019). AKI occurs in septic shock when end-organ damage is inevitable (Hinkle & Cheever, 2018). The client today experienced MODS from septic shock.**
Hct	**34 – 45%**	**45.8**	**24.6**	**Elevated Hct indicates dehydration (Holman et al., 2019). Today, the client stated he had not drunk or ate anything for the last 2-3 days; thus, causing dehydration. Decreased Hct indicates hemorrhage, anemia, and kidney disease (Holman et al., 2019). The client today was experiencing end-organ damage related to septic shock.**
Platelets	**150 – 400**	**625**	**190**	**Elevates plates indicate malignancy, polycythemia vera, and rheumatoid arthritis (Holman et al., 2019). The client today had a secondary**

				diagnosis of portal vein thrombosis, which is an accumulation of platelets. The client was in a bed for the last ten years, putting him at risk for blood clots. SIRS causes blood clots to form when bleeding does not occur, which leads to sepsis (Hinkle & Cheever, 2018). The client today experienced a septic shock.
WBC	**4.0 – 9.0**	**28.5**	**33.8**	**Elevated WBC indicates inflammation and infection (Holman et al., 2019). The client today was seen to have diverticulosis on the CT performed. The client today also went into septic shock as a result of complications of his diverticulosis. The client reported upper epigastric pain, which could have indicated an inflamed pancreas or gallbladder that could have ruptured. SIRS is also indicated by WBC greater than 12,000 (Hinkle & Cheever, 2018).**
Neutrophils	**40 – 70%**	**95.5**	**N/A**	**Neutrophils are the body's first defense line in an infection (Hinkle & Cheever, 2018). The client went into septic shock, which first underwent sepsis.**
Lymphocytes	**20 – 50%**	**1.9**	**N/A**	**Decreased lymphocytes indicate sepsis, and if an extreme decrease is present, mortality is high (Hinkle & Cheever, 2018). The client experienced sepsis, went into septic shock, and later MODS, which lead to the client passing.**
Monocytes	**2 - 12%**	**2.2**	**N/A**	
Eosinophils	**0- 6.3%**	**0.1**	**N/A**	
Bands	**0 - 6**	**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-	**135 -145**	**126**	**135**	**Hyponatremia is an indication of diarrhea, liver, and renal diseases (Hinkle & Cheever, 2018). Today, the client presented with 3 days worth of diarrhea and experienced end-organ damage from septic shock.**
K+	**3.5 – 5**	**4.4**	**7.3**	**Elevated potassium is seen in metabolic acidosis, which the client today was in (Hinkle & Cheever, 2018). The client experiencing metabolic acidosis and septic shock leads to hyperkalemia.**
Cl-	**98 – 107**	**82**	**78**	**Low levels of chloride in the blood indicate heart failure, Addison's, and lung diseases (Hinkle & Cheever, 2018). The client did not report past medical history and did have an echo performed in the morning. The echo results were not documented due to the client passing.**
CO2	**22 – 30**	**18**	**8**	**Low levels of CO2 indicates kidney diseases and metabolic acidosis (Hinkle & Cheever, 2018). The client was in metabolic acidosis and experiencing end-organ damage from septic shock.**
Glucose	**70 -99**	**208**	**226**	**Elevated glucose can indicate hypermetabolism, which is seen in septic shock and MODS (Hinkle & Cheever, 2018). The client today experienced a septic shock and multiorgan dysfunction.**
BUN	**6 - 20**	**79**	**64**	**Elevated BUN is seen in multiorgan dysfunction syndrome (Hinkle & Cheever, 2018). The client today experienced MODS before passing.**
Creatinine	**0.5 – 1.0**	**1.57**	**1.83**	**Elevated creatinine is seen with renal dysfunction, which occurs 7-10 days after (Hinkle & Cheever, 2018). The client today experienced MODS, which caused his kidneys to fail; thus,**

				increasing his creatinine.
Albumin	**3.5 – 5.2**	**2.4**	**< 1.5**	**Low albumin indicates shock, inflammation, and malnutrition (Hinkle & Cheever, 2018). The client today experienced septic shock.**
Calcium	**8.4 – 10.5**	**7.7**	**4.5**	**Hypocalcemia indicates kidney disorders, and the client demonstrated elevated BUN and creatinine levels from MODS (Hinkle & Cheever, 2018).**
Mag	**1.6 – 2.4**	**2.7**	**N/A**	**Hypermagnesemia indicates the kidney's inability to secrete magnesium (Hinkle & Cheever, 2018). The client's BUN and creatinine were elevated upon arrival after blood draws were done, indicating kidney dysfunction.**
Phosphate	**2.5 – 4.5**	**N/A**	**N/A**	
Bilirubin	**0 – 1.2**	**1.6**	**1**	**Elevated bilirubin levels indicate hepatic dysfunction (Hinkle & Cheever, 2018). Septic shock individuals have hepatic dysfunction, which the client was experiencing today (Hinkle & Cheever, 2018).**
Alk Phos	**35 - 105**	**102**	**102**	
AST	**0 – 32**	**53**	**1,196**	**Elevated AST indicates hepatic dysfunction, which is seen in MODS (Hinkle & Cheever, 2018). The client experienced septic shock, which ended up causing MODS.**
ALT	**4-36**	**17**	**128**	**ALT is a liver function test that indicates hepatic dysfunction (Hinkle & Cheever, 2018). Elevated ALT indicates MODS, which the client experienced.**
Amylase	**23 - 85**	**N/A**	**N/A**	
Lipase	**0 - 160**	**N/A**	**N/A**	

Lactic Acid	**0.5 - 1**	**6.4**	**13.7**	**Elevated lactic acid indicates the misdistribution of blood, as seen in septic shock (Hinkle & Cheever, 2018). The client today was in septic shock and experiencing end-organ damage.**
Troponin	**<0.03 ng/ml**	**0.02**	**N/A**	
CK-MB	**0%**	**N/A**	**N/A**	
Total CK	**30 – 170 units/L**	**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	**0.8 – 1.2**	**1.14**	**N/A**	
PT	**11.5 – 15 sec**	**15**	**N/A**	
PTT	**23.5 – 37.5 sec**	**N/A**	**N/A**	
D-Dimer	**< 0.4**	**N/A**	**N/A**	
BNP	**0 -100**	**N/A**	**N/A**	
HDL	**>40 mg/dl**	**N/A**	**N/A**	
LDL	**<130 mg/dl**	**N/A**	**N/A**	
Cholesterol	**<200 mg/dl**	**N/A**	**N/A**	
Triglycerides	**<150 mg/dl**	**N/A**	**N/A**	
Hgb A1c	**0 – 5.7**	**N/A**	**N/A**	
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	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
Color & Clarity	**Yellow & clear**	**Cloudy & light orange**	**N/A**	**Cloudy urine indicates infection, and light orange indicates dehydration (Hinkle & Cheever, 2018). The client was not diagnosed with a UTI, but was experiencing sepsis, reported being unable to drink for the last 3 days, and found kidney dysfunction.**
pH	**6.0**	**5.5**	**N/A**	**Acidosis occurs from diabetes, diarrhea, dehydration, and not eating (Hinkle & Cheever, 2018). The client did not report diabetes in past medical history. However, his blood glucose levels were elevated; he reported diarrhea and was unable to drink or eat in the last 3 days.**
Specific Gravity	**1.005-1.034**	**1.014**	**N/A**	
Glucose	**Normal**	**Normal**	**N/A**	
Protein	**Negative**	**Trace**	**N/A**	**Trace amounts of protein in the urine indicates dehydration and inflammation (Hinkle & Cheever, 2018). The client reported not being able to drink or eat for 3 days and diverticulosis with suspected inflamed appendix or gallbladder ruptured.**
Ketones	**Negative**	**Negative**	**N/A**	
WBC	**<5**	**N/A**	**N/A**	
RBC	**0-3**	**N/A**	**N/A**	
Leukoesterase	**Negative**	**Negative**	**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**	**7.18**	**7.04**	**Acidic pH indicates that the body has more carbon dioxide (Hinkle & Cheever, 2018). Metabolic acidosis is seen in septic shock, which the client experienced.**
PaO2	**80 – 100 %**	**499**	**155**	**High PaO2 indicates inhaled air is increased and is influenced by FiO2 (Hinkle & Cheever,2018). The client was on a ventilator that was doing the breathing for him with a FiO2 of 50.**
PaCO2	**35 – 45**	**46.3**	**34.1**	**An increase in PaCO2 indicates respiratory depression, and a decrease in PaCO2 is demonstrated by ventilation (Hinkle & Cheever, 2018). The client was in respiratory depression before being ventilated, and the ventilator was doing the breathing for him.**
HCO3	**22 -26**	**15.5**	**9.4**	**Low bicarbonate indicates**

				kidney disease, liver failure, and diarrhea (Hinkle & Cheever, 2018). The client today experienced septic shock with demonstrates metabolic acidosis. The client also reported diarrhea for 3 days and demonstrated abnormalities in LFTs and kidney function tests.
SaO2	**92 – 100%**	**98.8**	**97.3**	

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**	**Negative**	**N/A**	
Blood Culture	**Negative**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (APA):

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14 ed.). Wolters Kluwer.

Holman, H. C., Williams, D., Johnson, J., Ball, B. S., Wheless, L. K., Leehy, P., Lemon, T. (2019). *RN adult medical surgical nursing: review module* (11th ed.). Assessment Technologies Institute.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- EKG
    - The heart's electrical activity is recorded through electrocardiography to identify any myocardial injury, ischemia, infection, dysrhythmias, and enlarged heart chambers (Holman et al., 2019).
- Chest X-Ray
    - The lungs and heart are visualized by a chest X-ray to rule out any obstructions due to fluid, foreign bodies, tumors, and make sure there are no other pathologic conditions (Hinkle & Cheever, 2018).
- CT of the abdomen with contrast
    - A CT of the abdomen with contrast demonstrates the blood vessels, organs, and bones (Hinkle & Cheever, 2018). The Client presented with abdominal tenderness and epigastric pain that was sharp, burning and had several abnormalities seen in his blood draw, including elevated WBC.
- Echocardiogram
    - An echo visualizes the chamber and valves of the heart to see how they are functioning and pumping the blood (Hinkle & Cheever, 2018). The client was in septic shock and developed MODS, which warranted for an echo to visualize what his ejection fraction was and how much his heart was working or not working at pumping the blood to the rest of the body.

Diagnostic Test Correlation (5 points):

- EKG: The Client presented with upper epigastric region pain that was sharp, burning, and constant and abdominal tenderness. The presented symptoms warranted an EKG as the cause of symptoms was unknown. The Client demonstrated to be tachycardic with a heart rate of 130 bpm, which is a sign of sepsis (Hinkle & Cheever, 2018).
- CXR: The Client presented with upper epigastric pain that was sharp, constant, and burning, along with elevated WBC count, which warranted an order for a CXR to rule out any cardiovascular abnormalities. The CXR demonstrated that the Client had hyperinflated lungs and left basilar scarring or atelectasis. The Client received another CXR to demonstrate his endotracheal tube placement, which was 5.6 cm above the carina.
- CT of the abdomen with contrast: The client's symptoms regarding abdominal tenderness and a sharp burning pain along with WBC count warranted a CT of the abdomen to rule out any abnormalities in the blood vessels, organs, and bones of the abdomen. The results include lower thoracic centrilobular emphysema. Diverticulosis in the colon with a small collection for gas and fluid in the sigmoid colon; a small volume of free fluid in the abdomen and pelvis was observed.
- Echo: The client stated he had upper epigastric pain that was sharp and burning. The client developed septic shock after admission to the facility and was developing symptoms of MODS. The development of MODS caused an echo to visualize the heart's function and how well it was pumping the blood. The results of the echo were not charted before the clinical ended.

Diagnostic Test Reference (APA):

Hinkle, J.L., & Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14 ed.). Wolters Kluwer.

Holman, H. C., Williams, D., Johnson, J., Ball, B. S., Wheless, L. K., Leehy, P., Lemon, T. (2019). *RN adult medical surgical nursing: review module* (11th ed.). Assessment Technologies Institute.

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

Patient stated no past medical history and no at home medications were prescribed.

Home Medications (5 required)

Brand/Generic	**N/A** **Pt stated no past medical history and no at home medications were prescribed**	**N/A** **Pt stated no past medical history and no at home medications were prescribed**	**N/A** **Pt stated no past medical history and no at home medications were prescribed**	**N/A** **Pt stated no past medical history and no at home medications were prescribed**	**N/A** **Pt stated no past medical history and no at home medications were prescribed**
Dose	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Frequency	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Route	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Classification	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Mechanism of Action	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Reason Client Taking	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Contraindications (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Side Effects/Adverse Reactions (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Key Nursing Assessment(s) Prior to Administration	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Client Teaching needs (2)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Hospital Medications (5 required)

Brand/Generic	**Protonix/ pantoprazole**	**Firvanq/ vanomycin**	**Flagyl/ metronidazole**	**Dilaudid/ hydromorphone**	**Adrenalin/ epinephrine**
Dose	**40 mg**	**1000 mg**	**500 mg**	**1 mg**	**1mcg/kg/ min**
Frequency	**Daily**	**Q12H**	**Q24H**	**Q2H, PRN**	**Continuous**
Route	**IV push**	**IV piggyback**	**IV piggyback**	**IV push**	**IV drip**
Classification	**Proton pump inhibitor**	**Glycopeptide**	**Antibiotic**	**Opioid analgesic**	**Alpha-/ Beta-Agonist**
Mechanism of Action	**Inhibits the hydrogen/potassium ATP pump to suppress the gastric acid secretion (SBLHC, 2020).**	**Inhibits the synthesis of the bacterial cell wall via glycopeptide polymerization blockage (SBLHC, 2020).**	**Inhibits protein synthesis and causes cell death by interacting with the DNA; DNA helix is lost and DNA**	**Inhibits the ascending pain pathways to change the pain's response and perception (SBLHC, 2020).**	**Constricts the vascular and skeletal smooth muscle to raise the blood pressure**

			strand breaks (SBLHC, 2020).		**(SBLHC, 2020).**
Reason Client Taking	**To prevent a gastric ulcer while immobile**	**To treat abdominal perforation**	**Used prophylactically and to treat septic shock.**	**To treat moderate-severe pain.**	**To treat hypotension from his septic shock -- increase the MAP.**
Contraindications (2)	**Hypersensitivity; Concurrent use with rilpivirine.**	**Hypersensitivity; Low WBC count**	**Disulfiram use within the last 2 weeks; Alcohol use.**	**Acute/severe bronchial asthma; Significant respiratory depression.**	**No contraindications during life-threatening situations, but hypersensitivity could occur.**
Side Effects/Adverse Reactions (2)	**Headache; fever**	**Hypotension; nephrotoxicity**	**Headache; nausea**	**Bradycardia; Cognitive dysfunction**	**CVA; Anxiety**
Nursing Considerations (2)	**Flush the IV with D5W, 0.9% NS, or LR before and after administer the medication. When giving the medication via IV over 2 minutes, reconstitute it with 10 mL of 0.9% NS.**	**Draw trough concentrations to ensure therapeutic level. Do not infuse at a rapid rate.**	**Monitor the client carefully for any neurologic symptoms. Monitor the client's CBC from beginning to end to compare values.**	**Monitor the client's blood pressure and respirations closely. Initiate fall risk precautions.**	**Monitor the client's intake and output as prescribed. Assess the client's IV site routinely.**
Key Nursing Assessment(s) Prior to Administration	**Urine output; Bone strength; Diarrhea; Any signs of bleeding**	**CBC; BUN; Creatinine**	**CBC; LFTs; Assess peripheral neuropathy; Monitor for any bloody diarrhea; Obtain a**	**Blood pressure; GI side effects like constipation; Nausea, vomiting, muscle cramps,**	**IV site for any signs of infiltration; Assess intravascular volume; monitor**

			culture and sensitivity	**pupillary dilation, or irritability.**	**for cardiac arrhythmias; Cardiac status, Respiratory status; CNS status.**
Client Teaching needs (2)	**Advise the client to report any signs of blood in the urine, or a decrease in urine output immediately. Advise the client to report any diarrhea, especially if it is prolonged or severe.**	**Educate the client on reporting any signs and symptoms of a reaction to the infusion immediately. Educate the client to report any hearing impairment, or nephrotoxicity signs and symptoms.**	**Educate the client on reporting any blood in stools, especially if loose stools, immediately. Instruct the client to report any numbness or tingling sensation in extremities immediately.**	**Educate the client on reporting any signs of GI dysfunction like constipation. Educate the client on safety precautions regarding sedation effects of hydromorphone.**	**Educate the client on reporting any cardiac or respiratory abnormalities immediately. Educate the client that the medication needs to be carefully stored as it is sensitive**

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses Drug Handbook* (18th ed.). Jones & Bartlett Learning.

Sarah Bush Lincoln Health Center. (2020). *Lexicomp*. Wolters Kluwer.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**A&O x0** **No distress noted.** **Client is mildly disheveled and in a hospital gown.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	**Pale, cool, clammy, and mottled skin** **Skin is intact.** **No rashes or bruises noted.** **Wound noted in the medial abdomen, running vertically and another wound on the left lateral side of abdomen.** **Client has an art line in his left wrist artery.** **Client has 20 g IV in the right and left peripheral.** **Client has a16 indwelling urinary catheter.** **Client has a 14F NG tube.** **Braden score: 9**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Normocephalic.** **Ears equal bilaterally and intact. No drainage or trauma noted.** **Pupils fixed.** **Nose dry and intact.** **No nasal drainage.** **Teeth appear intact.** **Other components were unable to be obtained.**
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 ☐**	**Heart sounds, peripheral pulses, and capillary refill were unable to be obtained.** **Client had edema in bilateral upper and lower extremities. Unable to inspect degree of edema.**

Location of Edema:	
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	**Unable to auscultate breath sounds and identify characteristics.** **26 breaths/min on ventilator.** **7.5 ET tube size** **28 cm to the lip** **FiO2: 50** **Peep: 5** **Oral hygiene and suction, NPO, and proper hand hygiene from nursing personnel for VAP prevention.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size: 14F** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	**Unable to determine diet home.** **The current diet at the hospital was NPO due to being on a ventilator.** **180 cm tall and 89.2 kg in weight.** **Unable to auscultate bowel sounds, and it is unknown when last BM was.** **Tenderness was reported upon arrival to the facility.** **Abdomen is distended, has a surgical incision vertically down mid-abdomen with another surgical wound on the left lateral side. Left lateral side wound is set up in the event an ostomy is needed.** **Client has an NG tube of size 14F.**
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 was dark yellow, almost orange, and cloudy.** **Unable to determine quantity of urine due to all drains needing to remain intact when the Client was sent to the morgue.** **Genitals had mild trauma from incision for placement of an indwelling catheter. Genitals had slight bleeding.** **The Indwelling catheter was in place, of size 16.**

	Proper hand hygiene from care staff, catheter bag secured below Client's waistline, proper catheter care for CAUTI prevention.
MUSCULOSKELETAL (2 points): **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☐**	Unable to assess neurovascular status except bilateral lower and upper extremities were pale and cool. Unable to assess ROM, strength, or use of supportive devices. Client required full assistance of ADLs and was a high fall risk. Fall Score: 50. Client was bedridden. Unable to assess the need of assistance with equipment or the Client's need for support to stand and walk.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Alert & oriented x0.** **The Client's pupils had no reaction. Client had sclera edema and jaundice.** **Client has altered mental status.** **Client is unable to speak.** **Sensory is not intact.** **LOC is comatose.**
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):**	Unable to assess psychosocial/cultural of the Client he was on a ventilator and expired.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	**87 bpm**	**66/47 mm Hg**	**26 breaths/min**	**37 C**	**70% on FiO2 50 - ventilator**
0807	**33 bpm**	**37/33 mm**	**26**	**37 C**	**50% on FiO2**

		Hg	**breaths/min**		**50 - ventilator**

Vital Sign Trends/Correlation:

The client's pulse dropped significantly within an hour timeframe. The Client was severely hypotensive and tachypneic as the ventilator was set at 26 breaths/min; therefore, the Client was not breathing on his own whatsoever. The client's oxygen was low, but as his body was receiving poor oxygen perfusion, this reading is accurate as his body was not receiving adequate oxygen supply. The oxygen was being perfused to the client's vital organs. The Client went into MODS, which correlates with the vital signs trends. The Client was receiving 4 pressors to raise his blood pressure but was unsuccessful. The Client eventually expired due to MODS from septic shock.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	**FLACC**	**N/A**	**0**	**N/A**	**N/A**
0807	**FLACC**	**N/A**	**0**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g	Norepinephrine: 30 mcg/min.

Location of IV: Right and left peripheral **Date on IV: 10/26/20** **Patency of IV: Fluids run easily.** **Signs of erythema, drainage, etc.: No swelling, phlebitis, infiltration, redness or infection noted** **IV dressing assessment:Dry and intact. tape and securement device.**	Dobutamine: 50 mcg/kg/min Dextrose 5% & sodium bicarb: 1000 mL Epinephrine: 1mcg/kg/min Phenylephrine: 1.5 mcg/kg/min Vasopressin: 0.04 units/min
Other Lines (PICC, Port, central line, etc.)	
Type: Central - Multi lumen central venous catheter **Size: Triple** **Location: N/A - not documented** **Date of insertion: 10/26/20** **Patency: N/A** **Signs of erythema, drainage, etc.: No signs of swelling, phlebitis, infiltration, redness, or infection noted.** **Dressing assessment: Clean, dry, intact** **Date on dressing: 10/26/20** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures: Proper hand hygiene, chlorhexidine, full-barrier precautions, and proper care.**	Client also had an arterial line placed. 6 ft on 10/26/20: 14 mmHg/14 mmHg. Proper hand hygiene, chlorhexidine, full-barrier precautions, and proper care for CLABSI prevention measures.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
1364.92 mL - IV	**N/A**

Nursing Care

Summary of Care (2 points)

Overview of care: The client was admitted on 10/26/20 with a complaint of "abdominal pain." the client's vitals have remained unstable throughout the clinical. The client had low blood

pressure reading, and pulse lowered to 33 bpm. The client received 4 pressors to increase his blood pressure, which did not work. The client had low oxygen saturation readings due to inadequate oxygen perfusion throughout the body. The client experienced tachypnea of 26 breaths/min due to the setting on the ventilator. The ventilator was doing the client's breathing in its entirety. The FLACC scale was used for pain assessment, which indicated a score of 0 throughout the clinical shift. The client was NPO throughout the clinical due to being on a ventilator - to prevent aspiration. The client's output was not documented but had an intake of 1364.92 mL through his IV. The client has an art line, NG tube, catheter, and ET tube inserted to sustain life.

Procedures/testing done: The client had an echo performed, but the results were not documented before completing the clinical.

Complaints/Issues: The client had no complaints before expiring during the clinical shift. MODS caused low oxygen perfusion, and eventually, the client was unable to sustain life.

Vital signs (stable/unstable): The client's vital signs were unstable. The client was hypotensive at 66/47 and 37/33, his pulse rate dropped to 33 bpm, respirations of 26 breaths/min, and O2 Sat readings of 70% and 50%. The client had low oxygen perfusion due to MODS.

Tolerating diet, activity, etc.: The client was NPO before expiring during the clinical shift. The client was bedridden and unable to tolerate any activating or toileting independently.

Physician notifications: The provider was notified of the client's passing.

Future plans for patient: The client is scheduled for an autopsy.

Discharge Planning (2 points)

Discharge location: The morgue, and then the body will be released to the coroner's office.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: N/A

Education needs: N/A

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. Ineffective airway clearance related to endotracheal intubation and accumulation of secretions as evidenced by excessive secretions.	This diagnosis was chosen because the client is comatose, experiencing MODS, and relies entirely on a ventilator to do his breathing. The client demonstrated the inability to	**1.** Suction and provide oral hygiene to the client at least every 2 hours and as needed. **2.** Hyperoxygenate as needed and ordered to decrease the risk of cardiac dysrhythmias and	The client maintained a patent airway until his passing with the assistance of the ventilator. The client was unable to verbalize understanding of interventions.

	maintain a patent airway, no gag or cough reflex when suctioned.	hypoxia during suctioning.	
2. Risk for impaired gas exchange as related to decreased cardiac output as evidenced by the state of shock.	This diagnosis was chosen because the skin was experiencing septic shock and required a ventilator to breathe.	**1.** Monitor ABGs, pulse ox, and respirations frequently. **2.** Maintain a patent airway and position the client 30-45 degrees.	The client could not meet the outcomes before passing as the client had mottled, pale, cool, and clammy skin. The client remained in a metabolic acidosis state. The client was unable to verbalize understanding of interventions.
3. Decreased multisystem tissue perfusion related to decreased circulating blood volume as evidenced by septic shock.	This diagnosis was chosen because the client demonstrated mottled skin throughout his body, had cool, clammy, and pale skin. The client had cyanotic lips. The client experienced MODS from septic shock.	**1.** Monitor and assess blood pressure readings, and report any significant findings immediately. **2**. Monitor lab results for increased creatinine and BUN levels.	The client could not maintain an SBP greater than 90, SaO2 greater than 92%, a MAP of 70/100, or normalized lab results. The client subdued to MODS and passed during clinical.
4. Risk for infection related to invasive procedures, compromised immune system, and failure to treat infection as evidenced by diverticulosis and septic shock.	This diagnosis was chosen because the client had a prolonged colon infection that he did not get treated. The client had a perforated viscus. The client developed septic shock due to failure or recognized his infection.	**1.** Maintain sterile technique when suctioning, changing dressings, and providing urinary catheter or invasive line care. **2.** Inspect sites and wounds of invasive devices every day for any warmth, redness, or infiltration.	The client could not achieve timely healing as he went into MODS due to health complications and passed during clinical.
5. Deficient knowledge related to	This diagnosis was chosen as the client is unable to	**1.** Review the risk factors, mode of transmission, and	The goal is that the Client will verbalize understanding of the

	cognitive limitation as evidenced by development of preventable complications of being placed on a ventilator and comatose response.	verbalize the knowledge related to septic shock. The Client is cognitively impaired with no gag or cough response when suctioning or pupil reflex.	portal of entry of infections with the client. **2.** Review the disease process with the client and what the future expectations are.	disease process, the prognosis of the disease, and potential complications related to the disease before discharge. The client could not reach the goal or verbalize any understanding as he succumbed to MODS and passed during clinical.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The client reports 3 month long abdominal pain, located in the upper epigastric region that has intensified to a sharp, burning pain in the last 2-3 days. The client reports any movement, breathing, and palpitation makes the pain worse. The increased pain caused the client to seek medical attention. The client reports pain 10/10 on a numeric scale. The client states nausea, diarrhea, and brownish emesis accompanies.

Nursing Diagnosis/Outcomes

Ineffective airway clearance related to endotracheal intubation and accumulation of secretions as evidenced by excessive secretions.
The client maintained a patent airway until his passing with the assistance of the ventilator. The client was unable to verbalize understanding of interventions.
Risk for impaired gas exchange as related to decreased cardiac output as evidenced by the state of shock.
The client could not meet the outcomes before passing as the client had mottled, pale, cool, and clammy skin. The client remained in a metabolic acidosis state. The client was unable to verbalize understanding of interventions.
Decreased multisystem tissue perfusion related to decreased circulating blood volume as evidenced by septic shock.
The client could not maintain an SBP greater than 90, SaO2 greater than 92%, a MAP of 70/100, or normalized lab results. The client subdued to MODS and passed during clinical.
Risk for infection related to invasive procedures, compromised immune system, and failure to treat infection as evidenced by diverticulosis and septic shock.
The client could not achieve timely healing as he went into MODS due to health complications and passed during clinical.
Deficient knowledge related to cognitive limitation as evidenced by development of preventable complications of being placed on a ventilator and comatose response.
The goal is that the Client will verbalize understanding of the disease process, the prognosis of the disease, and potential complications related to the disease before discharge. The client could not reach the goal or verbalize any understanding as he succumbed to MODS and passed during clinical.

Objective Data

The client has low RBC, hgb, increased hct, platelets, WBC, neutrophils, and lymphocytes. The client had hyponatremia, hyperkalemia, increased lactic acid, elevated LFTs, elevated BUN and creatinine, and was in metabolic acidosis. The client had a pulse rate of 33bp m, blood pressure reading of 66/47 and 37/33, RR of 26bpm, and oxygens ats of 70%AND 50%. The client was on a ventilator. The client had cool, pale, clammy, mottled skin. The CXR showed hyperinflated lungs and left basilar scarring or atelectasis. The CT showed diverticulosis and small amounts of gas and free fluid in the sigmoid colon, abdomen, and pelvis.

Patient Information

58-year-old male with no past medical history is admitted for perforated viscus. The client has been bedridden for the last 10 years. No past surgical history is known.

Nursing Interventions

1. Suction and provide oral hygiene to the client at least every 2 hours and as needed.
2. Hyperoxygenate as needed and ordered to decrease the risk of cardiac dysrhythmias and hypoxia during suctioning.
1. Monitor ABGs, pulse ox, and respirations frequently.
2. Maintain a patent airway and position the client 30-45 degrees.
1. Monitor and assess blood pressure readings, and report any significant findings immediately.
2. Monitor lab results for increased creatinine and BUN levels.
1. Maintain sterile technique when suctioning, changing dressings, and providing urinary catheter or invasive line care.
2. Inspect sites and wounds of invasive devices every day for any warmth, redness, or infiltration.
1. Review the risk factors, mode of transmission, and portal of entry of infections with the client
2. Review the disease process with the client and what the future expectations are.