

N441 Care Plan

Lakeview College of Nursing

Ashley Miller

Demographics (3 points)

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|---------------------------------------|---------------------------------|----------------------------------|--|
| Date of Admission 9/27/2021 | Patient Initials M.G. | Age 77-years-old | Gender Female |
| Race/Ethnicity White | Occupation Retired | Marital Status Widowed | Allergies No Known Allergies |
| Code Status Full Code | Height 162 cm | Weight 89.5 kg | |

Medical History (5 Points)

Past Medical History: Patient has a past medical history of allergic rhinitis, arthritis, A-Fib, pacemaker, diabetes mellitus, fall risk, hyperlipidemia, infiltrating duct carcinoma of right breast, and estrogen receptor positive stage 2.

Past Surgical History: Patient has a past surgical history of tubal ligation, shoulder replacement, partial resection of colon, fracture of leg, fine needle biopsy of breast, colonoscopy, colon operation, cholecystectomy, cataract, carpal tunnel release, bilateral tubal ligation, lumpectomy breast-axillary node dissection, and sentinel node biopsy (11/05/19).

Family History: Patient's family history includes mother with diabetes mellitus and stroke, sister (s) with colon cancer, sister with breast cancer, and grandmother (m), uncle, and brother (s) with a history of other illness.

Social History (tobacco/alcohol/drugs): Patient is a former smoker of cigarettes but quit more than 30 days ago (10/21/19). Unable to assess how many packs per day, for how many years due to intubation and sedation. In patient's chart, stated that patient denies use of alcohol and illicit drugs.

Assistive Devices: Unable to assess due to intubation and sedation.

Living Situation: Unable to assess due to intubation and sedation.

Education Level: Unable to assess due to intubation and sedation.

Admission Assessment

Chief Complaint (2 points): Patient went to the ED from the cancer center with a complaint of a cough for the last week, shortness of breath, and fevers for the past two days. Patient is being treated for breast cancer.

History of present Illness (10 points): A 77-year-old Caucasian female on September 27, 2021, presented to the emergency department from the cancer center with a complaint of a cough for the last week, shortness of breath, and fever for the past two days. Patient had a fever over 101 degrees Fahrenheit associated with some dry cough and hypoxia. Patient denied recent travel or contact with sick people, no other systemic symptoms such as nausea, vomiting, diarrhea, and urinary symptoms. Patient is complaint with home medications.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pneumonia

Secondary Diagnosis (if applicable): Urinary Tract Infection

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

Pneumonia is the inflammation of the lung tissue in which alveolar air spaces fill with purulent, inflammatory cells, and fibrin (Capriotti & Frizzell, 2016). Infection by bacteria or viruses is the most common cause, although inhalation of chemicals, aspiration of contents from the oropharynx or stomach, or infection (Capriotti & Frizzell, 2016).

Pneumonia is most caused by inhaling droplets containing bacteria or pathogens (Capriotti & Frizzell, 2016). The droplets enter the upper airways and enter the lung tissue (Capriotti & Frizzell, 2016).

Pathogens adhere to the respiratory epithelium and stimulate an inflammatory reaction (Capriotti & Frizzell, 2016). Acute inflammation spreads to the lower respiratory tract and alveoli (Capriotti & Frizzell, 2016). The sites of inflammation and vasodilation occur with neutrophils' attraction out of capillaries and into the air spaces (Capriotti & Frizzell, 2016). There is excessive stimulation of respiratory goblet cells that secrete mucus (Capriotti & Frizzell, 2016). Mucous and exudative edema accumulate between the alveoli and capillaries (Capriotti & Frizzell, 2016). Alveoli attempt to open and lose against the purulent exudate, but some cannot open (Capriotti & Frizzell, 2016). When heard through the stethoscope over the alveoli opening and closing against the exudative fluid are crackles (Capriotti & Frizzell, 2016). A layer of edema and infection exudate at the capillary-alveoli interface hinders optimal gas exchange (Capriotti & Frizzell, 2016).

Signs and symptoms of pneumonia include cough, which may or may not be productive, fever, and chills (Capriotti & Frizzell, 2016). Decreased exercise tolerance develops as the disorder continues; pleuritic chest pain, pain with deep breaths, and dyspnea are other signs that may develop (Capriotti & Frizzell, 2016). Other signs and symptoms that are not specific may be headaches, abdominal pain, nausea, and vomiting (Capriotti & Frizzell, 2016). Physical examination of the disease includes fever, tachypnea, accessory muscles, tachycardia, and possible cyanosis (Capriotti & Frizzell, 2016). M.G. presented with symptoms of a cough and fever along with shortness of breath.

Expected findings related to pneumonia include tachycardia, tachypnea, low-pitched crackles on inspiratory, and cyanosis (Swearingen & Wright, 2019). With pneumonia, labs are expected to include increased white blood cell count, hypernatremia, hyperglycemia, increased BUN and creatinine, and hypotension (Swearingen & Wright, 2019).

Diagnostic testing includes a chest x-ray, CBC with differential, which suggests if that pneumonia is bacterial or viral infection, ABGs, and pulse oximetry can demonstrate oxygenation, sputum culture can exhibit the organism and antibiotic susceptibility (Capriotti & Frizzell, 2016). Urinary antigen tests may be performed (Capriotti & Frizzell, 2016).

The patient that observed with pneumonia had sputum and urinary culture performed, a CBC with differential was performed showing there was an increase in white blood cell count, the patient also had a chest x-ray performed to showing were pneumonia, there was also a C.T. of the chest without contrast to show a clearer picture of pneumonia.

Treatment of pneumonia includes antibiotic therapy and oxygenations are the critical priorities for the patient (Capriotti & Frizzell, 2016). If dehydrated, the patient may also need intravenous fluids, analgesia, antipyretics, and bronchodilators (Capriotti & Frizzell, 2016). M.G. was ventilated for better oxygenation.

Clinical data that correlates to this patient includes increased white blood cells, sputum culture showing Candide Albicans, increased

BUN and creatinine in the patient's labs, increased glucose, the chest x-ray. Furthermore, a C.T. scan of the chest was performed on the patient.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. (2016). *Pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and Psychiatric-Mental Health*. Elsevier.

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 (Sarah Bush Lincoln, 2021). | 2.97 | 3.28 | A decrease in RBCs can be caused by M.G. having breast cancer. (Pagana et al., 2019) |
| Hgb | 11.3-15.2 (Sarah Bush Lincoln, 2021). | 9.7 | 9.9 | A decrease in Hgb can be caused by a nutritional deficiency. (Pagana et al., 2019) |
| Hct | 33.2-45.3 (Sarah Bush Lincoln, 2021). | 28.6 | 30.5 | A decrease in Hct can be caused by a dietary deficiency. (Pagana et al., 2019) |
| Platelets | 149-393 (Sarah Bush Lincoln, 2021). | 93 | 267 | A decrease in platelets can be caused by an acute infection. (Pagana et al., 2019) |
| WBC | 4-11.7 (Sarah Bush Lincoln, 2021). | 5.0 | 32.7 | An increase in WBCs can be caused by infection or inflammation. (Pagana et al., 2019) |
| Neutrophils | 45.3-79.0 | 84.0 | 95.2 | An increase in neutrophils can be |

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| | (Sarah Bush Lincoln, 2021). | | | caused by an infection. (Pagana et al., 2019) |
| Lymphocytes | 11.8-45.9 (Sarah Bush Lincoln, 2021). | 3.4 | 0.9 | A decrease in lymphocytes can be caused by dietary deficiencies or overwhelming infection. (Pagana et al., 2019) |
| Monocytes | 4.4-12.0 (Sarah Bush Lincoln, 2021). | 10.7 | 3.8 | A decrease in monocytes can be caused by drug therapy the patient may be on. (Pagana et al., 2019) |
| Eosinophils | 0.0-6.3 (Sarah Bush Lincoln, 2021). | 1.5 | N/A | N/A |
| Bands | 0-6 (Sarah Bush Lincoln, 2021). | N/A | 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- | 136-145 (Sarah Bush Lincoln, 2021). | 134 | 136 | A decrease in sodium can be caused by deficient in sodium intake. (Pagana et al., 2019) |
| K+ | 3.5-5.1 (Sarah Bush Lincoln, 2021). | 4.4 | 4.3 | N/A |
| Cl- | 98-107 (Sarah Bush Lincoln, 2021). | 99 | 100 | N/A |
| CO2 | 21-31 (Sarah Bush Lincoln, 2021). | 25 | 23 | N/A |

| | | | | |
|-------------------|---|-------------|-------------|--|
| Glucose | 74-109 (Sarah Bush Lincoln, 2021). | 271 | 139 | An increase in glucose can be caused by acute stress response or diuretic therapy. (Pagana et al., 2019) |
| BUN | 7-25 (Sarah Bush Lincoln, 2021). | 22 | 126 | An increase in BUN can be caused by dehydration. (Pagana et al., 2019) |
| Creatinine | 0.60-1.20 (Sarah Bush Lincoln, 2021). | 1.34 | 1.48 | An increase in creatinine can be caused by a reduced renal blood flow. (Pagana et al., 2019) |
| Albumin | 3.5-5.2 (Sarah Bush Lincoln, 2021). | 3.1 | N/A | A decrease in albumin can be caused by dehydration. (Pagana et al., 2019) |
| Calcium | 8.6-10.3 (Sarah Bush Lincoln, 2021). | 8.3 | 7.9 | A decrease in calcium can be caused by malabsorption. (Pagana et al., 2019) |
| Mag | 1.6-2.4 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| Phosphate | 2.5-4.5 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| Bilirubin | 0.3-1 (Sarah Bush Lincoln, 2021). | 0.8 | N/A | N/A |
| Alk Phos | 34-104 (Sarah Bush Lincoln, 2021). | 142 | N/A | An increase in alkaline phosphate can be caused by the patient having an history of arthritis. (Pagana et al., 2019) |
| AST | 13-39 (Sarah | 30 | N/A | N/A |

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| | Bush Lincoln, 2021). | | | |
| ALT | 7-52 (Sarah Bush Lincoln, 2021). | 12 | N/A | N/A |
| Amylase | 6.6-35.2 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| Lipase | 0-160 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| Lactic Acid | 10-25 (Sarah Bush Lincoln, 2021). | 1.7 | N/A | A decrease in lactic acid can be caused by the patient being on the ventilator due to the blood pressure being low. (Pagana et al., 2019) |
| Troponin | 0-0.3 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| CK-MB | 0.6-6.3 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| Total CK | 30-223 (Sarah Bush Lincoln, 2021). | N/A | 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 | 11-12.5 (Sarah Bush | N/A | N/A | N/A |

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|----------------------|--|------------|------------|--|
| | Lincoln, 2021). | | | |
| PT | 11-12.5 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| PTT | 30-40 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| D-Dimer | 0-0.62 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| BNP | 0-100 (Sarah Bush Lincoln, 2021). | 183 | N/A | An increase in BNP can be caused by congestive heart failure. (Pagana et al., 2019) |
| HDL | 23-92 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| LDL | <100 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| Cholesterol | <199 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| Triglycerides | 0-149 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| Hgb A1c | <6.4 (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |
| TSH | 0.45-5.33 (Sarah Bush Lincoln, 2021). | N/A | 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 | Clear/Yellow (Sarah Bush Lincoln, 2021). | Yellow/Clear | Yellow/Clear | N/A |
| pH | 5-8 (Sarah Bush Lincoln, 2021). | 5.0 | 5.0 | N/A |
| Specific Gravity | 1.005-1.034 (Sarah Bush Lincoln, 2021). | 1.001 | 1.018 | A decrease in specific gravity can be caused overhydration. (Pagana et al., 2019) |
| Glucose | Normal (Sarah Bush Lincoln, 2021). | 500 (A) | Normal | An increase in glucose can be caused by the patient having diabetes mellitus. (Pagana et al., 2019) |
| Protein | Negative (Sarah Bush Lincoln, 2021). | Negative | Trace (A) | An increase in protein can be caused by the patient having diabetes mellitus. (Pagana et al., 2019) |
| Ketones | Negative (Sarah Bush Lincoln, 2021). | Negative | Negative | N/A |
| WBC | <5 (Sarah Bush Lincoln, 2021). | 24 | 54 | An increase in WBC can be caused by a bacterial infection in the urinary tract. (Pagana et al., 2019) |
| RBC | Negative (Sarah Bush Lincoln, 2021). | <1 | 3 | An increase in RBC can be caused by renal trauma from having a foley catheter placed. (Pagana et al., 2019) |
| Leukoesterase | Negative (Sarah Bush Lincoln, 2021). | 2+ | 4+ (A) | An increase in leukoesterase can be caused by a UTI. (Pagana et al., 2019) |

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 (Sarah Bush Lincoln, 2021). | N/A | 7.42 | N/A |
| PaO2 | 75-85 (Sarah Bush Lincoln, 2021). | N/A | 79.9 | N/A |
| PaCO2 | 35-45 (Sarah Bush Lincoln, 2021). | N/A | 38.4 | N/A |
| HCO3 | 22-26 (Sarah Bush Lincoln, 2021). | N/A | 24.9 | N/A |
| SaO2 | 90-100 (Sarah Bush Lincoln, | N/A | 96.5 | N/A |

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| | 2021). | | | |
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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 (Sarah Bush Lincoln, 2021). | E. Coli | Pending | A urine culture is taken to find abnormalities in the urine. The urine culture for the patient back with E. coli. (Pagana et al., 2019) |
| Blood Culture | Negative (Sarah Bush Lincoln, 2021). | Negative | Negative | N/A |
| Sputum Culture | Negative (Sarah Bush Lincoln, 2021). | Negative | Candide Albicans | A sputum culture is taken to find abnormalities in the lungs. The sputum from the patient came back with Candide albicans. (Pagana et al., 2019) |
| Stool Culture | Negative (Sarah Bush Lincoln, 2021). | N/A | N/A | N/A |

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference*. Mosby.

Sarah Bush Lincoln. (2021). *Laboratory values*. Cerner PowerChart. Cerner.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

9/27/21

Chest X-ray: low O2 sats, low lung volumes with slight elevation of right hemidiaphragm and mild heart enlargement. No visual pneumothorax or pleural effusion.

EKG: 12-Lead, sinus tachycardia and normal EKG.

10/10/21

EKG: 12-Lead, normal sinus rhythm, nonspecific ST abnormality, abnormal EKG.

10/11/21

Chest X-ray: endotracheal tube placement. No visual pneumothorax or pleural effusion.

10/12

Chest X-ray: Ventilator placement. The patient is rotated, ET tube is approximately 2.1 cm above the carina. OG tube courses below the diaphragm, with the tip at right upper abdomen.

9/28/21

CT Chest without contrast: Pneumonia versus edema, respiratory failure. No pneumothorax or pleural effusion. Left subclavian approach pacemaker in place non-calcified.

Echocardiogram: EF: 55-65, grade 1 diastolic dysfunction or mild tricuspid valve regurgitation, mild pulmonary hypertension.

10/07/21

Chest X-ray without contrast: Routine, no pneumothorax or pleural effusion. Normal heart size.

Diagnostic Test Correlation (5 points):

The patient with a chest x-ray aids in assessing the perfusion scan, it visualizes the heart, lungs, and bones (Pagana et al., 2019). A chest x-ray can diagnose pneumonia, pleural fluid, and many other diseases involved in heart and lungs (Pagana et al., 2019). The

patient had a chest x-ray performed due to her diagnosis of pneumonia, and they also did a chest x-ray to monitor placement of the ET tube and placement for the OG tube.

The patient had a CT scan takes images of the body from different angles; it can help visualize more into the images than a normal x-ray can (Pagana et al., 2019). The patient had a CT scan performed to check for pneumonia and rechecked to see if the pneumonia was gone.

The patient had an echocardiogram detects the pattern of the blood flow and measures changes in velocity of blood flow within the heart and great vessels (Pagana et al., 2019). The patient had an echocardiogram performed due to her having respiratory failure.

The patient had an electrocardiography provides a comprehensive view of the flow of the heart's electrical currents in two different planes (Pagana et al., 2019). The patient had an EKG performed due the patient having a history of A-fib.

Diagnostic Test Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference*. Mosby.

**Current Medications (10 points, 1 point per completed med)
*10 different medications must be completed***

Home Medications (5 required)

| Brand/ Generic | Amiodarone Hydrochloride /Nexterone | Metoprolol Succinate/ Toprol-XL | Insulin Lispro/ Humlog | Furosemide/ Lasix | Apixaban/ Eliquis |
|-------------------|---|---------------------------------------|------------------------------|----------------------|----------------------|
| Dose | 200 mg | 12.5 mg | 4 units | 40 mg | 2.5 mg |

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| Frequency | Daily | Daily | AC | BID | BID |
| Route | Oral | Oral | Subcutaneous Injection | Oral | Oral |
| Classification | Benzofuran derivative; Class III antiarrhythmic (2020 Nurse's Drug Handbook, 2020) | Beta-adrenergic blocker; Antianginal, antihypertensive (2020 Nurse's Drug Handbook, 2020) | Fast-Acting Insulin (2020 Nurse's Drug Handbook, 2020) | Loop; Antihypertensive, diuretic (2020 Nurse's Drug Handbook, 2020) | Factor Xa inhibitor; anticoagulant (2020 Nurse's Drug Handbook, 2020) |
| Mechanism of Action | Acts on cardiac cell membranes, prolonging repolarization and the refractory period and raising ventricular fibrillation threshold. (2020 Nurse's Drug Handbook, 2020) | Inhibits stimulation of beta-receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand. (2020 Nurse's Drug Handbook, 2020) | Fast-acting insulin starts to work about 15 minutes after injection, peaks about an hour, and keeps working for 2 to 4 hours. Insulin is a hormone that works by lowering levels of glucose in the blood. (2020 Nurse's Drug Handbook, 2020) | Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation. (2020 Nurse's Drug Handbook, 2020) | Inhibits free and clot-bound factor Xa and prothrombinase activity. (2020 Nurse's Drug Handbook, 2020) |
| Reason Client Taking | Patient is taking medication for A-Fib | To treat hypertension | Diabetes Mellitus | To reduce edema | Prevent DVT |
| Contraindications (2) | 1. Bradycardia that causes | 1. Acute heart failure. | 1. Not to use if havi | 1. Anuria. 2. | 1. Active pathologica |

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| | <p>syncop e.</p> <p>2. Cardio genic shock. (2020 Nurse's Drug Handb ook, 2020)</p> | <p>2. Hyper sensi tivity to metop rolol and its compo nents. (2020 Nurse' s Drug Handb ook, 2020)</p> | <p>ng an episo de of hypo glyce mia.</p> <p>2. Aller gic react ion. (202 0 Nurs e's Drug Han dboo k, 2020)</p> | <p>Hyper sensi tivity to furose mide or to comp onents . (2020 Nurse 's Drug Hand book, 2020)</p> | <p>l bleedi ng.</p> <p>2. Sever e hyper sensit ivity to apixa ban or its comp onent s. (2020 Nurse 's Drug Hand book, 2020)</p> |
| <p>Side Effects/A dverse Reactions (2)</p> | <p>1. Arrhyt hmias.</p> <p>2. Cardia c arrest. (2020 Nurse's Drug Handb ook, 2020)</p> | <p>1. Arteri al insuffi ciency.</p> <p>2. Heart failure . (2020 Nurse' s Drug Handb ook, 2020)</p> | <p>1. Weig ht gain.</p> <p>2. Swell ing in your hand s or feet. (202 0 Nurs e's Drug Han dboo k, 2020)</p> | <p>1. Arrhy thmia s.</p> <p>3. Hyper glyce mia. (2020 Nurse 's Drug Hand book, 2020)</p> | <p>1. Hemo rrag ic strok e.</p> <p>2. Exces sive bleedi ng. (2020 Nurse 's Drug Hand book, 2020)</p> |
| <p>Nursing Considera tions (2)</p> | <p>1. Check patient' s implant</p> | <p>1. Use metop rolol with</p> | <p>1. Chec k bloo d</p> | <p>1. Obtai n patien t's</p> | <p>1. Know that apixa ban</p> |

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| | <p>able cardiac device, as ordered, at the start of and during amiodarone therapy .</p> <p>2. Expect patient to be switched to oral therapy from intravenous therapy as soon as possible with dosage dependent on the dose of intravenous drug already administered. (2020 Nurse's Drug Handbook, 2020)</p> | <p>extreme caution in patient with bronchospastic disease who do not respond to or cannot tolerate other antihypertensive.</p> <p>2. Use cautiously in patient with angina or hypertension who have congestive heart failure . (2020 Nurse's Drug Handbook, 2020)</p> | <p>sugar level regularly to ensure the medication is working correctly.</p> <p>2. Draw Humalog into the syringe first when mixing it with another type of insulin like insulin NPH . (2020 Nurse's Drug Handbook)</p> | <p>weight before and periodically during furosemide therapy to monitor fluid loss.</p> <p>2. Monitor blood pressure and hepatic and renal function as well as BUN, blood glucose, and serum creatinine, electrolyte, and uric acid levels. (2020 Nurse's Drug Handbook)</p> | <p>should not be given to patients with severe hepatic dysfunction.</p> <p>2. Expect apixaban to be discontinued 48 hours before an invasive procedure or surgery if patient has a moderate or high risk of hemorrhage and 24</p> |
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| | | | <p>k, 2020)</p> | <p>book, 2020)</p> | <p>hours before an invasi ve proce dure or surge ry if patie nt has a mild risk of hemo rrhag e. (2020 Nurse 's Drug Hand book, 2020)</p> |
| <p>Key Nursing Assessme nt(s) Prior to Administra tion</p> | <p>Monitoring liver enzymes, continuous ECGs, check for increased heart rate and QRS intervals, and heartbeat below 60 beats per minutes. (2020 Nurse's Drug Handbook, 2020)</p> | <p>Assess ECG of patients who take metoprolol. Check for signs of poor glucose control in patients with diabetes mellitus. (2020 Nurse's Drug Handbook, 2020)</p> | <p>Assess patient taking insulin concurrentl y with a thiazolidine dione for signs and symptoms of heart failure. (2020 Nurse's Drug Handbook, 2020)</p> | <p>The nurse should check the patient's blood pressure and hepatic and renal function, monitor patient for hypokalemia. (2020 Nurse's Drug Handbook, 2020)</p> | <p>Monitor patient closely for bleeding. Expect to give the antidote, coagulation factor Xa. Know that effects of apixaban may persist for at least 24 hours after the last dose. (2020 Nurse's Drug Handbook,</p> |

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| <p>Client Teaching needs (2)</p> | <p>1. Advise patient to report cough, fainting, fatigue, wheezing, or sudden change in quality or rapidity of pulse. 2. Instruct patient to report abnormal bleeding or bruising. (2020 Nurse's Drug Handbook, 2020)</p> | <p>1. Instruct patient to take metoprolol with food at the same time each day. 2. Caution patient not to stop drug abruptly. (2020 Nurse's Drug Handbook, 2020)</p> | <p>1. Have patient check their blood sugar level before administering the insulin. 2. Have patient rotate injection sites to prevent hard lumps from forming. (2020 Nurse's Drug Handbook, 2020)</p> | <p>1. Advise patient to change position slowly to minimize effects of orthostatic hypertension. 2. Take furosemide with food or milk to reduce GI distress. (2020 Nurse's Drug Handbook, 2020)</p> | <p>2020) 1. Emphasize the importance of taking apixaban exactly as prescribed. 2. Advise patient to report any unusual bleeding or bruising to the prescriber. (2020 Nurse's Drug Handbook, 2020)</p> |
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Hospital Medications (5 required)

| Brand/ Generic | Propofol/ Diprivan | Fentanyl citrate/ Actiq | Lovenox/ Enoxaparin sodium | Protonix/ pantoprazol e sodium | Norepinephri ne bitartrate/ Levophed |
|----------------------------|---|--|--|--|---|
| Dose | 13.4 mL/hr Titratable | 20 mL/hr Titratable | 40 mg | 40 mg | 18.74 mL/hr Titratable |
| Frequenc y | Continuous | Continuous | HS | Daily | Continuous |
| Route | IV | IV | Subcutaneous Injection | IV Push | IV |
| Classifica tion | Phenol derivative; sedative- hypnotic (2020 Nurse's Drug Handbook, 2020) | Opioid; opioid analgesic (2020 Nurse's Drug Handbook, 2020) | Anticoagulant ; low- molecular- weight heparin (2020 Nurse's Drug Handbook, 2020) | Proton pump inhibitor; antiulcer (2020 Nurse's Drug Handbook, 2020) | Sympathomi metic; vasopressor (2020 Nurse's Drug Handbook, 2020) |

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| <p>Mechanism of Action</p> | <p>Decreases cerebral blood flow, cerebral metabolic oxygen consumption, and intracranial pressure and increasing cerebrovascular resistance, which may play a role in propofol's hypnotic effects. (2020 Nurse's Drug Handbook, 2020)</p> | <p>Binds to opioid receptor sites in the CNS, altering perception of and emotional response to pain by inhibiting ascending pain pathways. (2020 Nurse's Drug Handbook, 2020)</p> | <p>Potentiates the action of antithrombin III, a coagulation inhibitor. (2020 Nurse's Drug Handbook, 2020)</p> | <p>Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphatase enzyme system, or proton pump, in gastric parietal cells. (2020 Nurse's Drug Handbook, 2020)</p> | <p>At more than 4 mcg/min, inhibits adenylyl cyclase and directly stimulates alpha-adrenergic receptors, which inhibits cAMP constricts arteries and veins and increases peripheral vascular resistance and systolic blood pressure. (2020 Nurse's Drug Handbook, 2020)</p> |
| <p>Reason Client Taking</p> | <p>To provide sedation</p> | <p>Patient is taking the medication for pain</p> | <p>To prevent DVT</p> | <p>To treat erosive esophagitis associated with GERD</p> | <p>To manage blood pressure</p> |
| <p>Contraindications (2)</p> | <ol style="list-style-type: none"> 1. Hypersensitivity to propofol or its components. 2. Allergic reactions | <ol style="list-style-type: none"> 1. Hypersensitivity to fentanyl, alfentanil, sufentanil | <ol style="list-style-type: none"> 1. Active major bleeding. 2. History of heparin-induced thrombocytopenia. | <ol style="list-style-type: none"> 1. Concurrent therapy with rilpivirine-containing products. 2. Hypertension | <ol style="list-style-type: none"> 1. Concurrent use of hydrocarbon inhalation anesthetics. 2. Hypersensitivity to |

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| | <p>on to eggs or egg products, or to soybeans or soy products. (2020 Nurse's Drug Handbook, 2020)</p> | <p>nta nil, or their components .</p> <p>2. Significant respiratory depression. (2020 Nurse's Drug Handbook, 2020)</p> | <p>(2020 Nurse's Drug Handbook, 2020)</p> | <p>rsensitivity to panto prazole, substituted benzimidazoles, or their components. (2020 Nurse's Drug Handbook, 2020)</p> | <p>norepinephrine or its components. (2020 Nurse's Drug Handbook, 2020)</p> |
| <p>Side Effects/Adverse Reactions (2)</p> | <p>1. Hypotension.</p> <p>2. Involuntary muscle movement. (2020 Nurse's Drug Handbook,</p> | <p>1. Seizures.</p> <p>2. Hypotension. (2020 Nurse's Drug Handbook,</p> | <p>1. Pulmonary edema.</p> <p>2. Hemorrhage. (2020 Nurse's Drug Handbook, 2020)</p> | <p>1. Hepatic failure.</p> <p>2. Anaphylaxis. (2020 Nurse's Drug Handbook, 2020)</p> | <p>1. Bradycardia .</p> <p>2. Hypotension. (2020 Nurse's</p> |

| | 2020) | 2020) | | | Drug Handbook, 2020) |
|-----------------------------------|--|--|--|---|---|
| Nursing Considerations (2) | <ol style="list-style-type: none"> 1. Use propofol cautiously in patients with cardiac disease, peripheral vascular disease, impaired cerebral circulation, or increased intracranial pressure. 2. Shake container well | <ol style="list-style-type: none"> 1. Use with caution in patients with significant chronic obstructive pulmonary disease or cor pulmonale. 2. Use caution when titrating | <ol style="list-style-type: none"> 1. Use extreme caution in patients with an increased risk of hemorrhage, as from active ulcerative or angiodyplastic. 2. Use cautiously in those with bleeding diathesis, diabetic retinopathy, hepatic or renal impairment | <ol style="list-style-type: none"> 1. Ensure the continuity of gastric acid suppression during transition from oral to I.V. pantoprazole. 2. Administer delayed-release oral suspension 30 minutes before a meal mixed in apple | <ol style="list-style-type: none"> 1. Make sure resolutions contain no particles and is not discolored before administration. 2. Give drug |

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| | before using, administer drug promptly after opening and use vial for a single patient. (2020 Nurse's Drug Handbook, 2020) | infused only. (2020 Nurse's Drug Handbook, 2020) | ment. (2020 Nurse's Drug Handbook, 2020) | juice only. (2020 Nurse's Drug Handbook, 2020) | drug with a flow-control device. (2020 Nurse's Drug Handbook, 2020) |
| Key Nursing Assessment(s) Prior to Administration | Monitor patient for propofol infusion syndrome, especially with prolonged high-dose infusions. (2020 Nurse's Drug Handbook, 2020) | Monitor patient's respiratory status closely, especially during the first 24 to 72 hours after therapy starts or with dosage increases. (2020 Nurse's Drug Handbook, 2020) | Keep protamine sulfate nearby in case of accidental overdose. Check serum potassium level for elevation. (2020 Nurse's Drug Handbook, 2020) | Know that proton pump inhibitors such as pantoprazole should not be given longer than medically necessary. (2020 Nurse's Drug Handbook, 2020) | Check blood pressure every 2 to 3 minutes, preferably by direct intraarterial monitoring, until stabilized and then every 5 minutes. (2020 Nurse's Drug Handbook, 2020) |
| Client Teaching needs (2) | 1. Urge patient | 1. Warn patient | 1. Advise patient to | 1. Instruct patient | 1. Urge patient |

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| | <p>and family to voice concerns and ask questions before administration.</p> <p>2. Reassure patient that she will be monitored closely during administration and that vital functions will be supported as needed. (2020 Nurs</p> | <p>ent not to take more drug than prescribed.</p> <p>2. Instruct patient to avoid alcohol and other CNS depressants including benzodiazepines during any therapy</p> | <p>notify provider about adverse reactions, especially bleeding.</p> <p>2. Teach patient or family member how to give enoxaparin at home. (2020 Nurse's Drug Handbook 2020)</p> | <p>nt to swallow pantoprazole tablets whole and not to chew or crush them.</p> <p>2. Instruct patient to notify prescriber if diarrhea occurs and become prolonged or severe. (2020 Nurse's Drug Handbook, 2020)</p> | <p>tient to immediately report burning, leaking, or tingling around I.V. site.</p> <p>2. Have patient check blood pressure every 4 hours</p> |
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| | e's Drug Hand book, 2020) | unl ess pre scri bed. (20 20 Nur se's Dru g Ha ndb ook, 202 0) | | | up le of mi nu tes . (20 20 Nur se 's Dr ug Ha nd bo ok, 20 20) |
|--|---------------------------------------|---|--|--|--|

Medications Reference (APA):

Jones & Bartlett Learning. (2020). *2020 Nurse's Drug Handbook*.

Assessment

Physical Exam (18 points)

| | |
|---|---|
| GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance: | Patient was unable to assessed due to being intubated and sedated. Patient was not showing signs of distress and was clean and appropriate for the situation. |
| INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: | The patient's skin color was normal for ethnicity, Caucasian. Her skin was warm, dry, and intact. Patient's skin was elastic, and less than 3 seconds for tenting. The patient had generalized bruising on her arms. Patient had no signs of rashes or wounds. The patient had a place on her coccyx that the nurses considered to be a deep tissue injury. Braden |

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| <p>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A</p> | <p>score for the patient was 14, which places her at a high risk for pressure ulcers.</p> |
| <p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p> | <p>Patient's head and neck were symmetrical and no deviation. The trachea was midline. The patient's eyes were PERRLA. There was not discharge from ears or eyes. There was no deviated septum, equal turbinates, bilateral. The oral mucosa was pink, moist, and intact, with no teeth showing signs of decay.</p> |
| <p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p> | <p>S1 and S2 were heard with normal sinus rhythm. No presence of S3 or S4. No murmur was present. Patient's radial pulses were +3 bilaterally. Patient's pedal pulses were +2 bilaterally. The capillary refill was less than 3 seconds bilaterally in both radial and pedal pulses. Patient presented with low extremity edema bilaterally, which was +2. The hands had slight edema of a possible +1 bilaterally. Patient had no neck vein distention.</p> |
| <p>RESPIRATORY (2 points): Accessory muscle use: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character ET Tube: Size of tube: Placement (cm to lip): Respiration rate: FiO2: Total volume (TV): PEEP: VAP prevention measures:</p> | <p>Patient's breath sounds were irregular, clear, and were heard anterior and posterior all lobes bilaterally. Patient had some accessory muscle usage. Patient had an ET tube in place, and the size was 7.5. The placement to the lip was 23 cm. The respiratory rate was set to 20 breaths per minute. FiO2 was set 50%. Total volume was set to 300. PEEP was set to 8.0. VAP prevention measures include provide excellent oral care every 2 hours or as needed, suctioning the ET tube as needed or every 2 hours, and maintain optimal positioning.</p> |
| <p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains:</p> | <p>I was not able to assess the patient's diet from home, due to the patient being intubated and sedated. Patient's current diet is NPO. Patient started to receive continuous tube feeding shortly before the clinical ended. Patient's height was 162cm and weight is 89.5kg. Patient had hypoactive bowel sounds in all four quadrants. Patient's last bowel movement is unknown due to patient being intubated and sedated and was not charted in patient's chart. Upon palpating the patient's abdomen there was no masses, distention, drains, or pain. Patient did not present with incisions, scars, or</p> |

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| <p>Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: N/A Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A</p> | <p>wounds on the abdomen. Patient had a orogastric tube and the size was 16 French. The patient did not present with an ostomy, nasogastric, or feeding tube/ PEG tube.</p> |
| <p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Size: CAUTI prevention measures:</p> | <p>Patient’s urine was clear and yellow. Patient had voided 350 mL during clinical shift. Patient did not show signs of pain with urination, due to intubation and sedation. Patient is not on dialysis. Patient’s genitals were normal for ethnicity. Patient did have a catheter in place. The size of the catheter was 16 French and it is a indwelling catheter. CAUTI prevention measures includes handwashing, barrier precautions such as sterile gloves, drape, sponges, antiseptic solution, and single use lubricant, proper care of catheters, and remove any unnecessary catheters.</p> |
| <p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p> | <p>Patient was not able to be assessed due to being intubated and sedated. Nursing provided care for passive range of motion. Patient was weak overall. Patient was on bedrest due to intubation and sedation. Patient is considered a high fall risk due to the intubation and sedation. Patient’s fall risk score was 95. Patient is not up ad lib. Patient needs full assistance with equipment and ADLs. Patient is intubated and sedated, unable to assess support to stand and walk.</p> |
| <p>NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p> | <p>The patient is unable to follow commands, patient is not able to perform MAEW. The patient is not able to move extremities due to sedation and intubation, but the nurse is able to move the patient’s extremities without difficulty. Patient’s extremities are weak in both upper and lower bilaterally. Unable to assess orientation, mental status, speech, and sensory due to the patient being sedated an intubated. The patient’s LOC is drowsy or comatose.</p> |
| <p>PSYCHOSOCIAL/CULTURAL (2</p> | <p>Patient’s psychosocial and cultural portion is</p> |

| | |
|---|--|
| <p>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):</p> | <p>unable to be assessed and is unknown. The chart does not state this portion for the patient. Due to the patient being intubated and sedated it is unable to be assessed.</p> |
|---|--|

Vital Signs, 2 sets (5 points)

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|-------------|----------------------------|-------------------|-------------------------------|--|-----------------------------|
| 1000 | 70 beats per minute | 94/44 mmHg | 25 breathes per minute | 36.5 degrees C (97.7 degrees F) | 93% O2 on ventilator |
| 1122 | 70 beats per minute | 84/45 mmHg | 26 breathes per minute | 36.5 degrees C (97.7 degrees F) | 93% O2 on ventilator |

Vital Sign Trends/Correlation:

Patient’s vital signs remained stable throughout the clinical. Patient’s blood pressure was low, but that was due to her being intubated and sedated. Patient’s respiratory rate was high, the ventilator settings for respirations were set at 20, so the patient was breathing over the ventilator. The rest of the patient’s vitals were within normal limits.

Pain Assessment, 2 sets (2 points)

| Time | Scale | Location | Severity | Characteristics | Interventions |
|-------------|--------------|-----------------|--------------------|------------------------|----------------------|
| 1000 | Flacc | N/A | 0 out of 10 | N/A | N/A |
| 1122 | Flacc | N/A | 0 out of 10 | N/A | N/A |

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: | Patient did not have any peripheral IVs. |
| Other Lines (PICC, Port, central line, etc.) | PICC Line |
| Type: Size: Location: Date of insertion: Patency: Signs of erythema, drainage, etc.: Dressing assessment: Date on dressing: CUROS caps in place: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> CLABSI prevention measures: | Triple Lumen Central Line 5 French Right Occipitoanterior Position (ROA) 10/08/2021 PICC line is patent, flushed easily, and blood return was assessed from PICC. Patient showed no signs of erythema, drainage, or pain at sight of PICC line. Patient dressing is clean, dry, and intact. 10/08/2021 CLABSI prevention measures include, perform hand hygiene, apply appropriate skin antiseptic, use all five maximal sterile barrier precautions: sterile gloves, sterile gown, cap, and mask, ensure the skin prep agent has completely dried before inserting the central line, and CUROS caps. |

Intake and Output (2 points)

| | |
|---|--|
| Intake (in mL) – List what type of intake and how much | Output (in mL) – List what type of output and how much |
| Tube Feeding: 25 mL NG Flush: 100 mL Propofol: 94 mL Fentanyl: 140 mL Norepinephrine: 132 mL Total: 491 mL | Urine: 350 mL Residual: 50 mL Total: 350 mL |

Nursing Care

Summary of Care (2 points)

Overview of care: During the shift, the patient was intubated and sedated. The patient had continuous propofol, fentanyl, and norepinephrine on IV. The patient was started on tube feeding about two hours before the shift ended. The patient had Protonix IV push given through the triple lumen PICC line. The PICC line was patent, flushed easily, and showed no signs of erythema or drainage from the line. A CUROS cap placed back over the central line for CLABSI prevention measures. Patient was turned every two hours during the shift. Endotracheal tube and ventilator care was performed during the shift every two hours. ET tube was suctioned, oral care was performed, and her tube was repositioned to prevent pressure ulcer on her mouth. Patient was also given atorvastatin through the orogastric tube and flushed with normal saline before and after. The nurse performed a sedation vacation to see how the patient would tolerate coming off the ventilator. There were no plans suggesting when the patient would be discharged in the future.

Procedures/testing done: No procedures or tests were performed.

Complaints/Issues: Patient was unable to verbalize any complaints and issues due to being sedated and intubated.

Vital signs (stable/unstable): Patient's vital signs were stable for the shift. The patient's heart rate was 70 for both times the vitals were taken. Respirations remained

high, but stable with being 25 and 26 breaths per minute. Patient’s temperature remained stable the shift of being 37.5 degrees Celsius. The patient’s oxygen saturation remained at 93% for both times the vitals were taken. The patient’s blood pressure was 94/44 mmHg during the first set of vitals and 84/45 mmHg for the second set of vitals, the blood pressure was low, but stable due to the patient being intubated and sedated.

Tolerating diet, activity, etc.: Patient is tolerating the NPO diet and bedrest.

Physician notifications: Latest notification for the patient from the Physician was that on Thursday there would be a discussion about a Trach/PEG for the patient.

Future plans for patient: Future plans have not been discussed yet for the patient, besides the discussion of the Trach/PEG and they started today doing the sedation vacation.

Discharge Planning (2 points)

Discharge location: The discharge location is not known at this time, but more than likely will be going to a rehabilitation facility.

Home health needs (if applicable): Not known for this patient yet.

Equipment needs (if applicable): Not known for this patient yet.

Follow up plan: The patient will remain under sedation and intubation; each day will do the sedation vacation to wean the patient off the ventilator.

Education needs: Not known for this patient yet.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

| Nursing Diagnosis | Rational | Intervention (2 per dx) | Evaluation |
|--|--|--------------------------------|---|
| <ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” | <ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen | | <ul style="list-style-type: none"> How did the patient/family respond to the nurse’s actions? Client response, status |

| components | | | of goals and outcomes, modifications to plan. |
|---|--|--|---|
| <p>1. Ineffective airway clearance related to the patient having pneumonia/ respiratory failure as evidenced by the patient being intubated. (Phelps, 2020)</p> | <p>This nursing diagnosis was chosen because the patient is at risk for ineffective airway clearance due to the patient being intubated.</p> | <p>1. Turn patient every 2 hours.</p> <p>2. Assess respiratory status at least every 4 hours or per facility policy. (Phelps, 2020)</p> | <p>Goal: That the patient's airway will remain patent.</p> <p>The nurse performed oral care every 2 hours or PRN, also endotracheal tube suctioning to clear patient secretions. The patient tolerated the care well. (Phelps, 2020)</p> |
| <p>2. Ineffective breathing patterns related to respiratory muscle fatigue as evidenced by the patient stating they were short of breath and had a cough for the past week. (Phelps, 2020)</p> | <p>The nursing diagnosis was chosen because the patient has ineffective breathing patterns due to being intubated.</p> | <p>1. Assess and record respiratory rate and depth at least every 4 hours.</p> <p>2. Observe for signs of respiratory distress. (Phelps, 2020)</p> | <p>Goal: The patient's respiratory rate remains within established limits. The nurse monitored the patient's respiratory status as needed or per facility protocol. (Phelps, 2020)</p> |
| <p>3. Risk for aspiration related to decrease in gastrointestinal motility as evidenced by the patient having an orogastric tube and being intubated. (Phelps, 2020)</p> | <p>The nursing diagnosis was chosen because the patient has an orogastric tube and is intubated being under could cause the patient to relax to much making patient at risk for aspiration.</p> | <p>1. Monitor and record vital signs.</p> <p>2. Assess patient for gag and swallow reflex. (Phelps, 2020)</p> | <p>Goal: Patient's respiratory secretions remain clear and odorless.</p> <p>The nurse would suction the patient as needed or every 2 hours and watch for the patient's secretions as the nurse would suction the patient. To be sure the secretions were not abnormal. (Phelps, 2020)</p> |
| <p>4. Risk for electrolyte imbalance related to insufficient</p> | <p>The nursing diagnosis was chosen because the patient is at risk for the</p> | <p>1. Collect and evaluate serum electrolyte results as ordered.</p> | <p>Goal: Patient's electrolyte levels remain within normal limits.</p> <p>The nurse has been monitoring labs,</p> |

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| <p>fluid volume as evidenced by the patient's labs such as sodium, calcium, BUN, creatine, albumin, and lactic acid, and BNP. (Phelps, 2020)</p> | <p>electrolytes to become imbalanced and effect the body in different manners that could harm the patient if not corrected quickly enough.</p> | <p>2. Assess patient's fluid status. (Phelps, 2020)</p> | <p>watching input and output, started feedings, and assessed the patient for edema. (Phelps, 2020)</p> |
| <p>5. Risk for infection related to status of body fluids as evidenced by the patient having can Candide Albicans in the sputum and the patient being admitted for pneumonia. (Phelps, 2020)</p> | <p>The nursing diagnosis was chosen because the patient is admitted for pneumonia and is intubated due to respiratory failure.</p> | <p>1. Minimize patient's risk for infection. 2. Identify risk factors predisposing patient to infection. (Phelps, 2020)</p> | <p>Goal: Patient's WBC count and differential remain within normal range. The nurse is monitoring closely on the patient's labs when they are being drawn. (Phelps, 2020)</p> |

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Patient on September 27, 2021, presented to the emergency department from the cancer center with a complaint of a cough for the last week, shortness of breath, and fever for the past two days. Patient had a fever over 101 associated with some dry cough and hypoxia. Patient denied shortness of breath, recent travel or contact with sick people, no other systemic symptoms such as nausea, vomiting, diarrhea, and urinary symptoms. Patient is complaint with home

Objective Data

Patient's vitals were B/P: 94/44 mmHg, 84/45 mmHg. Pulse was 70 beats per minute. Temperature was 36.5 C. Oxygen 93%. Respiratory rate 25 and 26 breaths per minute. Patient labs that were abnormal: Na, RBC, Hct, Hgb, platelets, WBC, neutrophils, lymphocytes, monocytes, glucose, BUN, creatinine, albumin, calcium, alk phos, lactic acid, BNP, urinalysis, sputum culture with candida albicans, urine culture with e. coli. Patient diagnostics, chest x-ray to diagnosis the pneumonia, CT scan of the chest to get a clearer picture of the pneumonia. Echo that showed an EF of 55-65%. EKG showed NSR with nonspecific ST abnormality.

Patient Information

A 77-year-old Caucasian widowed female, who presented to the ED from the cancer center with a cough, SOB, and fever for the past two days. Patient has no known allergies. Patient denies the use of alcohol and illicit drugs but is a former cigarette smoker. Patient has a diagnosis of pneumonia and UTI. Patient is intubated and sedated.

Nursing Diagnosis/Outcomes

1. Ineffective airway clearance related to the patient having pneumonia/ respiratory failure as evidence by the patient being intubated. (Phelps, 2020)
 Goal: That the patient's airway will remain patent.
 The nurse performed oral care every 2 hours or PRN, also endotracheal tube suctioning to clear patient secretions. The patient tolerated the care well. (Phelps, 2020)
2. Ineffective breathing patterns related to respiratory muscle fatigue as evidenced by the patient stating they were short of breath and had a cough for the past week. (Phelps, 2020)
 Goal: The patient's respiratory rate remains within established limits.
 The nurse monitored the patient's respiratory status as needed or per facility protocol. (Phelps, 2020)
3. Risk for aspiration related to decrease in gastrointestinal motility as evidenced by the patient having an orogastric tube and being intubated. (Phelps, 2020)
 Goal: Patient's respiratory secretions remain clear and odorless.
 The nurse would suction the patient as needed or every 2 hours and watch for the patient's secretions as the nurse would suction the patient. To be sure the secretions were not abnormal. (Phelps, 2020)
4. Risk for electrolyte imbalance related to insufficient fluid volume as evidenced by the patient's labs such as sodium, calcium, BUN, creatine, albumin, and lactic acid, and BNP. (Phelps, 2020)
 Goal: Patient's electrolyte levels remain within normal limits.
 The nurse has been monitoring labs, watching input and output, started feedings, and assessed the patient for edema. (Phelps, 2020)
5. Risk for infection related to status of body fluids as evidenced by the patient having can Candide Albicans in the sputum and the patient being admitted for pneumonia. (Phelps, 2020)
 Goal: Patient's WBC count and differential remain within normal range.
 The nurse is monitoring closely on the patient's labs when they are being drawn. (Phelps, 2020)

Nursing Interventions

1. Turn patient every 2 hours. (Phelps, 2020)
2. Assess respiratory status at least every 4 hours or per facility policy. (Phelps, 2020)
3. Assess and record respiratory rate and depth at least every 4 hours. (Phelps, 2020)
4. Observe for signs of respiratory distress. (Phelps, 2020)
5. Monitor and record vital signs. (Phelps, 2020)
6. Assess patient for gag and swallow reflex. (Phelps, 2020)
7. Collect and evaluate serum electrolyte results as ordered. (Phelps, 2020)
8. Assess patient's fluid status. (Phelps, 2020)
9. Minimize patient's risk for infection. (Phelps, 2020)
10. Identify risk factors predisposing patient to infection. (Phelps, 2020)

