N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/27/2021	P.L.S.	79 years old	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	No known drug allergies
Code Status	**Height**	**Weight**	
DNR	157 cm	78.7 kg	

Medical History (5 Points)

Past Medical History: Diabetes Meletus type II, hypertension (HTN), Lewy body dementia, congestive heart failure (CHF), pulmonary hypertension, hoarding disorder, chronic kidney disease (CKD) stage III.

Past Surgical History: Appendectomy 2007

Family History: Paternal: Diabetes Meletus type II, myocardial infarction, hypertension. **Maternal:** Hypertension **Brother:** Diabetes Meletus II.

Social History (tobacco/alcohol/drugs): Client never smoked, drank alcohol, or used drugs.

Assistive Devices: Walker, cane, and spectacles.

Living Situation: Lives in home with husband. All assistive care performed at home by husband and client's adult children.

Education Level: High School Graduate

Admission Assessment

Chief Complaint (2 points): Chest pain and shortness of breath.

History of present Illness (10 points):

A 79-year-old female was brought to the emergency department by her husband on October 27, 2021, at 15:45, with worsening chest pain and shortness of breath. The symptoms had begun 1 day prior. The client is a poor historian due to Lewy body dementia. The client

denies any loss of consciousness. The client states shortness of breath and chest pain are constant and worsened with any exertion. The client has a nonproductive cough. The patient gets some relief with rest. Her husband decided to bring her to the E.D. when her dyspnea became progressively worse. Elevated troponins and abnormal ECG in the E.D. imply that the client had suffered a non-ST-elevation myocardial infarction (NSTEMI). At 17:30 in the E.D. client exhibits increase anxiety as she goes into respiratory distress. At this time client was tachypneic with inspiratory stridor. Husband agrees to emergency intubation. The provider could not fit a size 6.5 ET tube and switched to a 6.0 ET tube. The client tolerates well and is admitted into the CCU for further monitoring.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute respiratory failure

Secondary Diagnosis (if applicable): CHF exacerbation

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

Acute respiratory failure (ARF) is a life-threatening medical emergency caused by the inability to properly ventilate and/or oxygenate (Holman et al., 2019). In this client's case, the ARF is related to failure to facilitate proper gas exchange due to pulmonary edema brought on by exacerbated congestive heart failure (CHF). At some point, between 10/26-10/27, she suffered an NSTEMI, leading to systolic and diastolic congestive heart failure exacerbation. This inadequate pumping of the heart causes fluid to back up into the lungs leading to pulmonary edema. With pulmonary edema, the cells in the alveolar sac in the lung cannot properly exchange CO2 with oxygen, leading to the cells in the body becoming hypoxemic and hypercapnic. This builds up of CO2 in the body puts the body in a state of respiratory acidosis (Hinkle & Cheever, 2017).

Common signs and symptoms of ARF are restlessness, fatigue, dyspnea, sudden “hunger for air.” As the hypoxemia worsens, there will be orthopnea, central cyanosis, confusion, adventitious breath sounds (wheezing, stridor, etc.), and diaphoresis (Hinkle & Cheever, 2017). Expected vital signs for ARF are hypotension, tachycardia, tachypnea, and hypoxia (SaO2 below 90%) (Holman et al., 2019). Arterial blood gasses (ABGs) are the primary tool to diagnose this condition. ABGs during ARF will show PaO2 less than 60 mm hg, CO2 above 50, and a pH less than 7.35, which were all apparent in this client on admission. Chest X-ray (CXR) is a diagnostic imaging tool utilized to identify this disease. This may show pulmonary edema and cardiomegaly (Holman et al., 2019). The CXRs performed in this client show pulmonary edema that worsens over time. Troponin labs and ECG confirm MI as the catalyst of other deteriorating conditions.

Treatment for ARF involves correcting the underlying condition, causing inadequate gas exchange (Hinkle & Cheever, 2017). To stabilize this client, an endotracheal (ET) tube was placed to initiate mechanical ventilation so she could be adequately oxygenated. Correcting her underlying condition includes a continuous amiodarone IV drip to prevent her from going into cardiac dysrhythmia and the use of diuretics to remove excess fluid from the body. On top of treating the cause, CCU nurses must also routinely monitor the client’s respiratory status, ABGs, perform oral care, frequent turns, and peri care to prevent further complications that may arise from long-term sedation and intubation (Hinkle & Cheever, 2017).

Pathophysiology References (2) (APA):

Hinkle, J. L., & Cheever, K. H. (2017). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Lippincott Williams & Wilkins.

Holman, H. C., Williams, D., Sommer, S., Johnson, J., Ball, B., & Wheless, L. (2019). *RN adult medical surgical nursing review module* (11th ed.). Assessment Technologies Institute, LLC.

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	3.80-5.41	3.87	3.40	Client is anemic possibly from malnutrition (Capriotti, 2020).
Hgb	11.3-15.2	10.1	9.2	Client is anemic (Capriotti, 2020).
Hct	33.9-45.3	31.1	27.6	Client is anemic (Capriotti, 2020).
Platelets	149-393	301	209	N/A
WBC	4.0-11.7	23.1	8.7	Leukocytosis caused from infection or stress (Capriotti, 2020).
Neutrophils	45.3-79.0	89.0	63.6	Neutrophilia caused from infection or inflammation in the body (Capriotti, 2020).
Lymphocytes	11.8-45.9	5.7	18.7	Lymphopenia causes indicate severe infection or some other autoimmune malfunction (Capriotti, 2020).
Monocytes	4.4-12.0	4.9	8.7	N/A
Eosinophils	0-6.3	0.1	8.1	Eosinophilia indicates allergic reaction or parasitic infection (Capriotti, 2020).
Bands	0-5.1	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-	135-145	135	139	N/A
K+	3.5-5.1	4.5	4.4	N/A
Cl-	98-107	101	110	Hyperchloremia is an indication of possible kidney damage (Capriotti,

				2020).
CO2	21-31	23	21	N/A
Glucose	74-109	260	253	Hyperglycemia is common in situations of high stress. Client is diabetic (Capriotti, 2020).
BUN	7-25	13	22	N/A
Creatinine	0.70-1.30	1.06	0.95	N/A
Albumin	3.5-5.3	3.5	N/A	N/A
Calcium	8.5-10.3	8.9	7.7	Hypocalcemia is common with clients with renal disease or receiving diuretic therapy (Capriotti, 2020).
Mag	1.6-2.4	1.7	1.8	N/A
Phosphate	2.5-5.0	3.4	N/A	N/A
Bilirubin	0.3-1.0	0.5	N/A	N/A
Alk Phos	34-104	43	N/A	N/A
AST	10-30	25	N/A	N/A
ALT	10-40	14	N/A	N/A
Amylase	30-110	N/A	N/A	N/A
Lipase	0-160	N/A	N/A	N/A
Lactic Acid	0.5-2.2	3.1	N/A	Client was in acidosis (Capriotti, 2020).
Troponin	0.000-0.030	17.981	N/A	Elevation in troponin indicates injury to the heart. This critically high levels indicate the client suffered an MI (Capriotti, 2020).
CK-MB	0.60-6.30	83.70	N/A	Elevation in this enzyme indicates client has suffered an MI (Capriotti, 2020).
Total CK	30-223	611	N/A	Elevation in this enzyme indicates client has suffered an MI (Capriotti,

				2020).

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	0.86-1.14	1.09	N/A	N/A
PT	11.9-15.0	14.6	N/A	N/A
PTT	22.6-35.3	27.4	N/A	N/A
D-Dimer	</= 250	N/A	N/A	N/A
BNP	<100	370	N/A	Elevation in this protein is used to diagnose heart failure (Capriotti, 2020).
HDL	>60	41	N/A	N/A
LDL	<130	74	N/A	N/A
Cholesterol	<200	138	N/A	N/A
Triglycerides	<150	115	N/A	N/A
Hgb A1c	4-5.6	N/A	N/A	N/A
TSH	0.4-4	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	Pale yellow-deep amber/ clear	Light yellow/ clear	N/A	N/A
pH	5-8	5.5	N/A	N/A
Specific Gravity	1.005-1.035	1.032	N/A	N/A
Glucose	Negative	Negative	N/A	N/A
Protein	Negative	Negative	N/A	N/A

Ketones	Negative	Negative	N/A	N/A
WBC	</=5	6	N/A	Client is suffering an active UTI (Capriotti, 2020).
RBC	0-3	1`	N/A	N/A
Leukoesterase	0-5	N/A	N/A	N/A

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	7.29	7.52	Client was in acute respiratory failure which put her in respiratory acidosis. Long-term ventilation has put client into respiratory alkalosis (Capriotti, 2020).
PaO2	80-100	55.3	68.6	Client is hypoxemic due to ARF on admission. Client continues to be hypoxemic implying the lungs are malfunctioning or kidneys are unable to remove waste (Capriotti, 2020).
PaCO2	35-45	52.5	30.4	Acute respiratory failure puts client in respiratory acidosis. Long term ventilator use has caused the client to enter respiratory alkalosis (Capriotti, 2020).
HCO3	22-26	19.0	26.0	Low bicarbonate shows that the client is in partially compensated respiratory acidosis (Capriotti, 2020).
SaO2	94-100	85.3	98.0	Client is hypoxic from MI and CHF (Capriotti, 2020).

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	Positive	N/A	*Acinetobacter baumannii*, implying client is suffering from a UTI (Capriotti, 2020).
Blood Culture	Negative	Negative	N/A	N/A
Sputum Culture	Negative	Negative	N/A	N/A
Stool Culture	Negative	Negative	N/A	N/A

Lab Correlations Reference (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest Xray (CXR) performed 10/27, 10/28, 10/29, 10/30, 10/31, 11/1, 11/2

This test noninvasive test utilizes radiation to create imaging of the internal structure and condition of the heart and lungs (Capriotti, 2020). The test was performed due to the client's chief complaint of shortness of breath. This test was repeated daily to assess the continuing condition of her lungs. The CXR was also utilized to confirm the placement of the client's nasogastric (NG) tube, endotracheal (ET) tube, and PICC line placement.

Chest Computed Tomography Scan (CCT) performed 10/27

This noninvasive test creates a detailed image of the internal tissues and structures of the lungs and heart. This test was performed to rule out a pulmonary embolism (PE), which could cause chest pain and shortness of breath (Capriotti, 2020).

Electrocardiogram (ECG) performed 10/27, 10/30

This client received an ECG due to her symptoms of chest pain and shortness of breath. The ECG allows healthcare providers to diagnose cardiac dysrhythmias or myocardial infarction. An ECG analyzes the heart's electrical activity to gain a sort of "snapshot" of its current condition (Capriotti, 2020).

Diagnostic Test Correlation (5 points):

Chest Xray The client's CXRs from 10/27-11/1 show mild heart enlargement, hazy opacities bilaterally noted in her lungs. Mild pulmonary edema noted with no indication of pneumothorax. By 11/2, her CXR reported worsening bilateral alveolar opacities implying a worsening fluid volume overload. The CXRs also confirmed the proper placement of the ET tube (about 2 cm above the carina), the NG tube, and the PICC line. This diagnostic test supports the diagnosis of fluid volume overload related to CHF exacerbation.

Chest Computed Tomography Scan (CCT) The Chest CT indicated that the client did not have a PE.

Electrocardiogram (ECG) On 10/27 at 1545, the client's ECG showed she was in sinus tachycardia. A repeat ECG at 2300 showed the client was in normal sinus rhythm with an ST depression and a prolonged QT segment. ECG performed on 10/30 indicate normal sinus rhythm. The abnormal ECG supports the diagnosis NSTEMI.

Diagnostic Test Reference (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

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

Home Medications (5 required)

Brand/	Klonopin/	Lasix/	Toprol	Exelon/	Kenalog/

Generic	clonazepam	furosemide	XL/ metoprolol succinate	rivastigmine	triamcinolone
Dose	0.25 mg	20 mg	50 mg	4.5 mg	0.1%
Frequency	Daily PRN anxiety	Daily	Daily	Daily	3 times daily as needed
Route	Oral	Oral	Oral	Oral	Topical
Classification	Benzodiazepine	Loop diuretic	Betablocker	Cholinesterase inhibitor	Corticosteroid
Mechanism of Action	Potentiates the effects of GABA which produces an antianxiety and anti-seizure effect.	Inhibits sodium and water reabsorption at the loop of Henle increasing urine formation.	Inhibits beta receptor cites of the heart decreasing cardiac excitability.	Slows the decline of cognitive deterioration in dementia patients by increasing acetylcholine concentration at cholinergic transmission sites.	Inhibits the phospholipase A2 enzyme on the cell hindering lysosomal membranes creating an anti-inflammatory and immunosuppressant effect.
Reason Client Taking	To treat panic/anxiety	To treat HTN and CHF	To manage HTN	To treat mild to moderate dementia.	To treat inflammation caused by eczema.
Contraindications (2)	Acute narrow angle glaucoma, hypersensitivity	Anuria, hypersensitivity.	Acute heart failure, cardiogenic shock, pulse less than 60/min.	Hypersensitivity to rivastigmine or other carbamate derivatives.	Recent liv-virus vaccine therapy, hypersensitivity.
Side Effects/Adverse Reactions (2)	Drowsiness, hallucinations	Hypokalemia, dizziness	Bradycardia, heart block	Aggression, anxiety, seizures, UTI.	Ecchymosis, pruritis
Nursing	Monitor for	Older adult	Use with	Monitor for	Clients with

Considerations (2)	suicidal ideation during the drug therapy, be aware of paradoxical psychiatric reactions when using this drug in elderly.	clients are more susceptible to hypotensive or electrolyte imbalances from this medication. When giving medication I.V. give over 2 minutes to prevent ototoxicity.	extreme caution in clients with **CHF** as it can reduce cardiac contractility worsening heart failure. May interfere with insulin or oral antidiabetic medications.	adequate urine output due to drugs anticholinergic effects. Medication should not be abruptly discontinued do potential increasing behavioral disturbances.	active or inactive TB should not receive triamcinolone. Caution use in clients with diabetes as it may make them more susceptible to fungal infections of the integumentary.
Key Nursing Assessment(s) Prior to Administration	Monitor clients CBC and LFTs during long term medication therapy.	Monitor electrolytes, daily weights, LFTs, and BUN.	ECG for signs of AV-heart block, blood glucose. Measure apical pulse for 1 minute prior to admin.	Urine output, respiratory status.	Assess for worsening irritation of the skin.
Client Teaching needs (2)	Warn client not to perform any activity that requires concentration with this medication due to drowsiness effects. Notify Dr of any OTC or herbal medications	Medication is best taken in the morning to prevent nocturia. Change positions slowly after taking this medication to prevent orthostatic	Do not crush or chew extended-release tablets. Diabetics should assess blood glucose more	Explain to family that this medication cannot cure dementia, only slow the mental decline of the patient. Medication should be	Use gloves when administering or make sure to thoroughly wash hands after administration. Do not use for longer than

	while using this medication due to high chance of medication interaction.	hypotension.	regularly when taking this medicatio n.	taken with food to decrease adverse GI effects.	2 weeks at a time.

Hospital Medications (5 required)

Brand/Generic	MS Contin/ morphine	Lovenox/ enoxaparin	Pacerone/ amiodarone	Diprivan/ propofol	Duragesic/ fentanyl
Dose	1 mg	40 mg	16.7mL/hr at 1.8mg per mL	15.8mL/hr at 1000 mg in 100 mL	25 mc/hr titrate up/down to maintain pain <3. Max dose 400mcg/hr
Frequency	Q4H PRN pain	Daily	Continuous	Continuous	Q2H PRN pain
Route	I.V.	Subcutaneously	I.V.	I.V.	I.V.
Classification	Opioid analgesic	Low-molecular weight heparin, anticoagulant	Benzofuran antiarrhythm ic	Seditive-hypnotic	Opioid analgesic
Mechanism of Action	Binds with and activates opioid receptors in the brain and spine producing an analgesic effect	Potentiates the action of antithrombin III, a coagulation inhibitor. Without thrombin, fibrinogen cannot convert to fibrin and clots cannot form.	Prolongs the repolarizatio n and refractory period of cardiac cells. This relaxes cardiac smooth muscle and improves myocardial blood flow.	Decreases cerebral blood flow, metabolic oxygen consumption, and increases cerebrovascul ar resistance.	Binds with opioid receptors in the brain and spinal cord altering perceptual and emotional response to pain.

Reason Client Taking	To manage moderate to severe pain	Prophylaxis to prevent DVT during hospitalization.	To prevent further cardiac dysrhythmias.	To provide sedation during critical illness.	To manage breakthrough pain
Contraindications (2)	Acute bronchial asthma, paralytic ileus.	Active major bleeding, History of heparin-induced thrombocytopenia (HIT) in the past 100 days.	Cardiogenic shock, bradycardia.	Hypersensitive to drug, or allergy to egg or soy products.	Hypersensitivity, severe respiratory depression.
Side Effects/Adverse Reactions (2)	Seizures, increased intracranial pressure, toxic megacolon.	Hematemesis, melena, HIT.	Arrythmias including heart blocks, hypotension, acute renal injury.	Bradycardia, hypotension.	Hypotension, laryngospasm.
Nursing Considerations (2)	Caution with clients with conditions that may lead to hypercapnia or hypoxia as it reduces respiratory drive. Give over 4 to 5 minutes I.V. to prevent adverse effects	Use severe caution in clients experiencing any type of GI bleed (such as diverticulitis). Monitor serum potassium labs especially in clients with renal failure.	Use central venous catheter when possible as this medication causes peripheral vein phlebitis. Assess apical pulse for 1 minute and hold if pulse is below 60.	May aggravate peripheral vascular disease, heart disease, or increased intracranial pressure. Expect client to recover from sedation 8 minutes from discontinuation.	Caution titrating doses in elderly clients as they are more susceptible to adverse effects. Expect clients to have some withdrawal symptoms after long term therapy.
Key Nursing Assessment(s) Prior to Administration	Assess respirations, monitor appropriate level of sedation.	Monitor for signs of bleeding. Monitor CBC for anemia. Monitor electrolytes for hyperkalemia.	Check ECG for worsening dysrhythmias, monitor Renal labs, monitor for electrolyte	Monitor respiratory function of clients with long term therapy.	Assess/ monitor respiratory and cardiac function before and during this drug therapy.

			imbalances.		
Client Teaching needs (2)	Take medication exactly as directed to prevent risk of overdose. Demonstrate proper use of morphine antidote naloxone.	Advise against NSAID or aspirin medications as it increases chances of GI bleeds. Teach client to report signs of potential bleeding such as unusual bruising or petechiae.	Report any cough, dark urine, dyspnea, or fainting while using this medication. Report any OTC or herbal medications due to high risk of interactions.	Encourage patient/family to express concerns before beginning therapy. Reassure client that they will be closely monitored during sedation. This medication will suppress mental alertness for some time after given, and client should avoid driving.	Avoid alcohol or any other CNS depressant while using this medication. Avoid hazardous activities such as operating a vehicle while using this medication due to its CNS depressing effects.

Medications Reference (APA):

Jones & Bartlett Learning. (2020). *2020 nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client responds to some painful stimuli. Client is unresponsive to all non-painful stimuli. Frequent grimacing and tearing of the eyes. Though the client is unresponsive she shows signs of mild discomfort, especially when performing interventions.

INTEGUMENTARY (2 points):	
Skin color:	Appropriate for ethnicity and age.
Character:	Dry and intact.
Temperature:	Warm.
Turgor:	Elastic <= 3 seconds.
Rashes:	Pink/scaly rashes bilaterally on the anterior lower legs. Blanchable erythema forming on client's coccyx, indicating a stage 1 pressure ulcer. Mepilex placed over site.
Bruises:	N/A
Wounds:	N/A
Braden Score:	10 (High risk)
Drains present: None **Type:** N/A	
HEENT (1 point):	
Head:	Normocephalic with symmetrical facial features.
Neck:	Trachea centered, 3 + carotid pulse bilaterally.
Ears:	Tympanic membrane gray bilaterally. No drainage
Eyes:	Pupils equal round reactive to light and accommodation. Sclera white.
Nose:	Nares patent bilaterally. Absent of any discharge or drainage. NG tube placed in left nostril.
Teeth:	Teeth intact and yellow. Pink and moist oral mucosa. 6.5 ET tube 24 cm at the lip.
CARDIOVASCULAR (2 points):	
Heart sounds:	Heart sounds audible. No murmur or gallop.
S1, S2, S3, S4, murmur etc.	S1, S2 present.
Cardiac rhythm (if applicable):	Normal Sinus Rhythm
Peripheral Pulses:	3+ radial and carotid bilaterally. 1+ (doppler) pedal pulse bilaterally.
Capillary refill:	<3seconds.
Neck Vein Distention:	None
Edema	Pitting edema
Location of Edema:	+2 Right forearm/hand, +1 left forearm/ hand +2 bilateral lower legs/feet.
RESPIRATORY (2 points):	
Accessory muscle use:	None
Breath Sounds: Location, character	Coarse/diminished breath sounds auscultated anterior and posterior in all 5 lobes.
ET Tube:	Yes
Size of tube:	6.0
Placement (cm to lip):	24 cm
Respiration rate:	20
FiO2:	25%
Total volume (TV):	350

PEEP:	8
VAP prevention measures:	Oral care every 2 hours, head of bed between 30-45 degrees, good hand hygiene. ET tube was removed at 1207 on 11/2 and switched to NC at 2 L. Client tolerated change well.
GASTROINTESTINAL (2 points):	
Diet at home:	Normal diet.
Current Diet:	NPO, NG tube feeding discontinued morning of 11/2
Height:	157 cm
Weight:	78.7 kg
Auscultation Bowel sounds:	Active in all 4 quadrants.
Last BM:	Large soft stool morning of 11/2.
Palpation: Pain, Mass etc.:	Supple, nontender, no masses.
Inspection:	No signs of bruising of swelling.
Distention:	None
Incisions:	None
Scars:	None
Drains:	None
Wounds:	None
Ostomy: None **Nasogastric:** Yes **Size:** 14 FR **Feeding tubes/PEG tube:** None **Type:** N/A	
GENITOURINARY (2 Points): Color:	Yellow
Character:	Clear
Quantity of urine:	250 mL
Pain with urination:	N/A
Dialysis:	N/A
Inspection of genitals:	No sign of discharge/irritation/infection.
Catheter: Yes **Type:** Indwelling **Size:** 12 FR	
CAUTI prevention measures:	Frequent assessment that urine is draining. Collection container below the level of the bladder. Peri-care every 4 hours. Propper hand hygiene and glove usage.
MUSCULOSKELETAL (2 points):	
Neurovascular status:	Pink nail beds, cap refill <3 seconds.
ROM:	Passive ROM in all 4 extremities.
Supportive devices:	None while in the CCU
Strength:	None
ADL Assistance:	Yes

Fall Risk:	Yes
Fall Score:	50
Activity/Mobility Status:	Bedrest
Independent (up ad lib):	No
Needs assistance with equipment	Yes
Needs support to stand and walk	Yes
NEUROLOGICAL (2 points): MAEW:	No
PERLA:	Yes
Strength Equal:	N/A
Orientation:	N/A
Mental Status:	N/A
Speech:	N/A
Sensory:	N/A
LOC:	Sedation induced coma.
PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s):	Family and faith.
Developmental level:	High school graduate. Client does not currently have capacity to make decisions.
Religion & what it means to pt.:	Client is an active member in her Pentecostal Congregation.
Personal/Family Data (Think about home environment, family structure, and available family support):	Lives home with husband. Husband is supportive and loving and appears to accommodate client's dementia well.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	65	136/86	20 (BiPAP)	36.3 C	100%
1100	66	120/66	16 (CPAP)	36.1 C	100 %

Vital Sign Trends/Correlation: Vital signs trend stable throughout this clinical time.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	FLACC	N/A	2/10	Frequent grimacing/tearing of eyes	Turned client
1100	FLACC	N/A	2/10	Frequent	Turned client

				grimacing/ tearing of eyes	

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV:	18 Gauge Midline
Location of IV:	Upper right arm
Date on IV:	10/27
Patency of IV:	Flushes easily, saline locked.
Signs of erythema, drainage, etc.:	No signs of erythema. Dry and intact.
IV dressing assessment:	Transparent
Other Lines (PICC, Port, central line, etc.)	PICC
Type:	PICC line
Size:	18 gauge
Location:	Left AC
Date of insertion:	10/28
Patency:	Patent, Amiodarone in D5W at 16.7 mL/hr Propofol at 15.8 mL/hr discontinued at 1030 when vent was switched from BiPAP to CPAP mode.
Signs of erythema, drainage, etc.:	None
Dressing assessment:	Dry and intact.
Date on dressing:	10/28
CUROS caps in place:	Yes.
CLABSI prevention measures:	Use of CUROS caps, aseptic technique when handling central line, proper hand hygiene, change dressings every 7 days.

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**
Amiodarone in D5W 16.7ml/hr*5.5hr = 92 mL Propofol 15.8mL/hr*3.5hr = 55 mL	250 mL emptied from indwelling catheter

Nursing Care

Summary of Care (2 points)

Overview of care: Client is intubated on BiPAP setting. Client is on continuous amiodarone and propofol.

Procedures/testing done: Terminal extubation performed on 11/2 at 1207.

Complaints/Issues: None

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Client appears to tolerate care well.

Physician notifications: Provider authorized the continuation of supportive care after extubating the client. Client is DNR and DNI after extubating ET tube.

Future plans for patient: Continue to offer supportive care until the client is stable enough to transfer to medical surgical floor. Provider may speak with husband about switching the client to palliative care in the future pending the client's condition.

Discharge Planning (2 points)

Discharge location: If client can return to a stable condition she will be discharged to home with husband. Client may need transferred to skilled nursing facility due to her complex health condition in tandem with dementia.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Follow up with regular care provider.

Education needs: Educate husband on how to care for client's condition, what signs and symptoms of MI or CHF exacerbation to recognize and to seek medical assistance should they occur.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired gas exchange related to acute respiratory failure as evidenced by decreased SaO2.	Acute respiratory failure is a life-threatening condition that makes airway and breathing a priority to maintain in this client.	**1.** Assess for the correct ET tube placement. **2.** Assess ventilator settings and alarm systems hourly.	ET tube was measured 24 cm at the lip upon placement and confirmation with Xray. ET tube remains at this measurement. All settings and alarms remain operational. Client SaO2 consistently remains at 100%.
2. Ineffective airway clearance related to ET intubation as evidenced by presence of airway secretions.	Presence of excessive secretions and intubation put the client at risk for aspiration and therefore ventilator associate pneumonia.	**1.** Observe color, consistency, and quantity of secretions while performing vent care. **2.** Auscultate lung sounds for presence of adventitious breath sounds.	Scant, thin, clear secretions noted. Coarse lung sounds noted in all 5 lobes of the lungs.
3. Imbalanced fluid volume related to CHF as evidenced by pulmonary edema.	CHF causes imbalances in fluid volume and electrolytes, as well as fluid on the lungs.	**1.** Obtain daily weights from client. **2.** Assess for pitting edema.	Sudden weight gain indicates worsening FVO, clients weight remains consistent. Client shows mild to moderate pitting edema in her hands and lower extremities.
4. Risk for infection related to ET tube insertion as evidenced by continuous mechanical ventilation.	Ventilator-associated pneumonia is a dangerous hospital acquired infection, that is easily acquired if improper care is	**1.** Performed oral care every 2 hours. **2.** Assess labs for increase in WBC count.	Patient tolerates oral care well. WBCs are down significantly from the date of admission.

	given.		
5. Impaired skin integrity related to bedridden status as evidenced by pressure injury beginning to form on the client's coccyx.	With heavy sedation the client is completely bedridden and unable to move voluntarily. She it at high risk for skin breakdown which may lead to further complications.	**1.** Performed turns every 2 hours. **2.** Applied mepilex dressing to prevent further skin breakdown.	Patient tolerates turns well. Additional barrier to client's coccyx tolerated well.

Other References (APA): N/A

Concept Map (20 Points):

Subjective Data

Shortness of breath and chest pain that's worsened with exertion. Limited subjective data available due to sedation/coma and dementia.

Nursing Diagnosis/Outcomes

1.Impaired gas exchange related to acute respiratory failure as evidenced by decreased SaO2.
Client maintains SPO2 above 92%.
2.Ineffective airway clearance related to ET intubation as evidenced by presence of airway secretions.
Client's airway will become free of secretions.
3.Imbalanced fluid volume related to CHF as evidenced by pulmonary edema.
Client will maintain consistent weight and cease to have pitting edema.
4.Risk for infection related to ET tube insertion as evidenced by continuous mechanical ventilation.
Client will remain free of ventilator-acquired-pneumonia.
5.Impaired skin integrity related to bedridden status as evidenced by pressure injury beginning to form on the client's coccyx.
Client will remain free of any new or worsening pressure injuries.

Objective Data

Abnormal labs: RBC: 340 Hgb:10.1, 9.2 Hct:31.1, 27.6 WBC:23.1 Neutrophils: 89.0 Lymphocytes :5.7 Eosinophils: 8.1 Cl: 110 Glucose: 260, 253 Troponin: 17.981 CK-MB:83.70 Total CK: 611 BNP: 370 UA-WBC: 6 **ABGs** pH: 7.29, 7.52 PaO2: 55.3, 68.6 PaCO2: 52.5, 30.4 HCO3: 19.0 SaO2: 85.3 Urine culture: positive *A. baumani*. **Assessment findings:** Coarse/diminished breath sounds auscultated, scant thin secretions suctioned from vent. Stage one pressure injury on coccyx. +1 pedal pulses. Pitting edema in hands and lower extremities. **Diagnostics:** CXR: Pulmonary edema and opacities, ECG: Sinus tach with prolong QT and ST depression.

Patient Information

79-yr-old Caucasian female with Lewy body dementia, DM type 2, HTN, CHF, and CKD 3 brought to E.D. with shortness of breath and chest pain.

Nursing Interventions

1. Assess for the correct ET tube placement.
2. Assess ventilator settings and alarm systems hourly.
3. Observe color, consistency, and quantity of secretions while performing vent care.
4. Auscultate lung sounds for presence of adventitious breath sounds.
5. Obtain daily weights from client.
6. Assess for pitting edema.
7. Performed oral care every 2 hours.
8. Assess labs for increase in WBC count.
9. Performed turns every 2 hours.
10. Applied mepilex dressing to prevent further skin breakdown.