N431 Care Plan # 2

Lakeview College of Nursing

Kade Thomas

Demographics (3 points)

Date of Admission 11/15/21	Patient Initials T.G	Age 44	Gender Female
Race/Ethnicity White/Non-Hispanic	Occupation Unemployed	Marital Status Married	Allergies No known allergies
Code Status Full Code	Height 5'9" (175.3cm)	Weight 278lbs (126.1kg)	

Medical History (5 Points)

Past Medical History: Alcohol abuse, morbid obesity, tobacco abuse, acute respiratory failure, acute kidney injury, metabolic acidosis, end stage renal failure

Past Surgical History: Unable to review, history was not completed

Family History: Mother has Alzheimer's disease and history of stroke, maternal grandfather has diabetes, no family history for her father or paternal side

Social History (tobacco/alcohol/drugs): Current tobacco user 0.5 packs per day, alcohol abuser (daily beer and vodka use) 3-20 cans of beer per week

Assistive Devices: NA

Living Situation: Lives with her husband at home

Education Level: Unable to assess

Admission Assessment

Chief Complaint (2 points): Chest pain

History of present Illness (10 points): The client is 44-year-old women who has end stage renal failure. She initially came into the hospital for a urology consultation; however, she developed chest pains and was sent to the emergency room. She suffered a myocardial infarction and had to be resuscitated, she was unable to describe an OLDCART because she didn't wake up. The client is currently in a sedated state with limited brain activity.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Renal Failure

Secondary Diagnosis (if applicable): Cardiac arrest

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

Renal Failure

Renal failure occurs when the client has sustained enough kidney damage to require renal replacement therapy (dialysis) (Belleza, 2021). Renal failure results in a gradual/progressive loss of kidney function. This can increase the risk of infections, vascular diseases, and many other harmful effects on various organ systems. There are several stages to renal failure. The client is currently in end-stage renal failure, demonstrated by 15-20% GFR (Belleza, 2021). Once eliminated by the kidneys, substances now accumulate in the body fluid, affecting metabolic and electrolyte and acid-base function (Belleza, 2021). Factors that increase the risk of renal failure are diabetes, age 60 or older, family history, Lupus erythematosus, and bladder obstructions (Belleza, 2021). Lifestyle risk factors are overexposure to toxins, sedentary lifestyle (Belleza, 2021). Diagnosis and assessment for renal failure include GFR tests and creatinine clearance, sodium/water retention, acidosis, CBC and CMP, ABG's, and chemistry panels (Belleza, 2021). These tests ensure kidney function and will instruct the physician on the client's severity and treatment options (Belleza, 2021). Treatment for renal failure; pharmacologic therapy like calcium and phosphorus binders to manage hypertension (Capriotti, 2020), erythropoietin to treat anemia, nutritional therapy, and eventually dialysis to filter blood and waste products (Capriotti, 2020). The client has several comorbidities that increase her risk of developing renal failure. She

suffered from alcoholism and a severe sedentary lifestyle. She is morbidly obese, which strains her body further (Capriotti, 2020).

Pathophysiology References (2) (APA):

Belleza, R. M. N. (2021, February 20). *Chronic renal failure*. Nurseslabs. Retrieved November 19, 2021, from https://nurseslabs.com/chronic-renal-failure/

Capriotti, T. (2020). *Davis Advantage for Pathophysiology* (2nd ed.). F. A. Davis Company.

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	**3.50-5.20**	**1.79**	**2.21**	**The client's kidneys no longer function, therefore, erythropoietin will not be adequately secreted** (PhD Rn et al., 2020).
Hgb	**11.0-16.0**	**7.0**	**8.6**	**Because there are fewer red blood cells, the protein hemoglobin will be decreased as well** (PhD Rn et al., 2020).
Hct	**34-47%**	**21.5**	**25.0**	**Hct and Hgb are related, if hemoglobin is decreased hematocrit will also be decreased** (PhD Rn et al., 2020).
Platelets	**140,000-400,000**	**150,000**	**151,000**	
WBC	**4-11**	**10.53**	**10.68**	
Neutrophils	**55-70**	**57**	**60**	
Lymphocytes	**20-40**	**22**	**20**	
Monocytes	**2-8**	**7.9**	**3.5**	
Eosinophils	**1-4**	**1.3**	**1.8**	

Bands	**0-10%**	**0**	**0**	

*****PER CARLE EPIC**

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**	**136**	**137**	
K+	**3.5-5.1**	**4.1**	**4.0**	
Cl-	**98-107**	**110**	**104**	**Increased Cl- is often seen in clients with poor renal function** (PhD Rn et al., 2020).
CO2	**22-29**	**11.0**	**17.0**	
Glucose	**74-100**	**96**	**91**	
BUN	**7-19**	**18**	**26**	**Elevated BUN is a sign of renal dysfunction** (PhD Rn et al., 2020).
Creatinine	**0.55-1.02**	**5.10**	**4.81**	**Like BUN, Creatinine is also elevated during renal dysfunction** (PhD Rn et al., 2020).
Albumin	**3.5-5.0**	**1.6**	**1.7**	**Albumin is decreased in relation to the clients poor kidney's** (PhD Rn et al., 2020).
Calcium	**8.9-10.6**	**5.9**	**7.8**	**Calcium is lowered in renal failure** (PhD Rn et al., 2020).
Mag	**1.6-2.6**	**NA**	**NA**	
Phosphate	**3.4-4.5**	**NA**	**NA**	
Bilirubin	**0.2-1.2**	**3.2**	**3.6**	**The client is an alcoholic, her liver is decreasing in effectiveness** (PhD Rn et al., 2020).
Alk Phos	**40-150**	**165**	**198**	**Because the client is an alcoholic, her hepatic system is also impaired** (PhD Rn et al., 2020).
AST	**5-34**	**100**	**114**	**Damage to the liver like cirrhosis elevates AST** (PhD Rn et al., 2020).
ALT	**0-55**	**48**	**53**	

Amylase	**30-220**	**NA**	**NA**	
Lipase	**0-160**	**NA**	**NA**	
Lactic Acid	**5-20**	**NA**	**NA**	
Troponin	**<0.1**	**NA**	**NA**	
CK-MB	**3-5%**	**NA**	**NA**	
Total CK	**22-198**	**NA**	**NA**	

*****PER CARLE EPIC**

LABS labeled NA, were not completed yet, I saw that there were orders in the chart for many of these.

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	**0.9-1.1**	**1.1**	**NA**	
PT	**11-13.5sec**	**NA**	**NA**	
PTT	**22.4-35.9s**	**31.2**	**NA**	
D-Dimer	**<0.50**	**NA**	**NA**	
BNP	**<100pg/ml**	**NA**	**NA**	
HDL	**40mg/dl**	**NA**	**NA**	
LDL	**<100mg/dL**	**NA**	**NA**	
Cholesterol	**<200mg/dL**	**NA**	**NA**	
Triglycerides	**<150mg/Dl**	**NA**	**NA**	
Hgb A1c	**<5.7%**	**NA**	**NA**	
TSH	**0.350-4.940**	**NA**	**NA**	

*****PER CARLE EPIC**

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	**Straw yellow/ clear**	**Amber/Cloudy**	**Amber/Cloudy**	**The client has end stage renal disease, therefore her kidneys do not function** (PhD Rn et al., 2020)**.**
pH	**4.5-8.0**	**NA**	**NA**	
Specific Gravity	**1.005-1.030**	**NA**	**NA**	
Glucose	**NEG**	**NA**	**NA**	
Protein	**NEG**	**NA**	**NA**	
Ketones	**NEG**	**NA**	**NA**	
WBC	**NEG**	**NA**	**NA**	
RBC	**NEG**	**NA**	**NA**	
Leukoesterase	**NEG**	**NA**	**NA**	

*****PER CARLE EPIC**

There was not a urinalysis done or not performed yet.

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	**7.350-7.450**	**7.054**	**7.275**	**Renal failure can impact arterial blood gasses** (PhD Rn et al., 2020).
PaO2	**80-100**	**77.8**	**135.2**	**Because the client is in renal failure arterial blood gases are affected** (PhD Rn et al., 2020).

PaCO2	**35-45**	**45.3**	**38.1**	**Arterial blood gases are negatively impacted by renal failure, it can lead to metabolic acidosis or alkalosis** (PhD Rn et al., 2020).
HCO3	**22-26**	**12.4**	**17.3**	**Bicarbonate is decreased along with the PH, with renal failure this is metabolic acidosis** (PhD Rn et al., 2020).
SaO2	**90-100**	**92.3**	**98.5**	**O2 saturation is affected by ABG's when the ABG's are impacted O2 saturation will decrease** (PhD Rn et al., 2020).

*****PER CARLE EPIC**

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	**NEG**	**NA**	**NA**	
Blood Culture	**NEG**	**NA**	**NA**	
Sputum Culture	**NEG**	**NEG**	**NEG**	
Stool Culture	**NEG**	**NA**	**NA**	

*****PER CARLE EPIC**

Lab Correlations Reference (1) (APA):

PhD Rn, P. K. D., Facs, M. T. P. J., & Faaem, P. T. M. N. (2020). *Mosby's® Diagnostic and Laboratory Test Reference* (15th ed., Vol. 489). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): X-ray to confirm positioning for endotracheal tube placement

Diagnostic Test Correlation (5 points): The X- ray was used to visualize the clients airway to ensure patency of the endotracheal tube placement.

Diagnostic Test Reference (1) (APA):

PhD Rn, P. K. D., Facs, M. T. P. J., & Faaem, P. T. M. N. (2020). *Mosby's® Diagnostic and Laboratory Test Reference* (15th ed., Vol. 489). Mosby.

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

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

Home Medications (5 required)

Brand/Generic	**Tylenol Acetaminophen**	**Moi-Stir Artificial saliva**	**Dulcolax Bisacodyl**	**NovoLOG Insulin aspart**	**Protonix Pantoprazole**
Dose	**500mg tab**	**1 spray**	**10mg**	**Sliding scale**	**40mg**
Frequency	**Q4H PRN**	**PRN**	**Daily**	**Q4H**	**BID**
Route	**Oral**	**Oral**	**Rectal**	**Sub-Q**	**Gastric Tube**
Classification	**Antipyretic/analgesic**	**Electrolyte maintenance**	**Laxative/stool softener**	**Insulin**	**Proton-pump-inhibitor**
Mechanism of Action	**Stimulates the release of prostaglandins**	**OTC medication that lubricates the oral mucosa to improve oral dryness**	**Increases peristalsis and increases water absorption in the small intestine**	**Acts to facilitate the breakdown of sugar molecules in the blood**	**Covalent bond that inhibits gastric secretions**
Reason Client Taking	**Fever/mild pain**	**Oral mucosa dryness**	**Promote soft bowel movements**	**For high blood sugar**	**Acid reflux**
Contraindications (2)	**Bleeding disorders, hepatic dysfunction**	**Fructose intolerance, hypersensitivity**	**Diarrhea, Diverticulitis**	**Hypoglycemia Hypokalemia**	**Diarrhea with C-Diff, systemic lupus**
Side Effects/Adverse Reactions (2)	**Nausea/vomiting Decreased clotting time**	**Mild-Allergic reaction Anaphylaxis**	**Diarrhea, GI discomfort, nausea-vomiting**	**Hypoglycemia Hypersensitivity**	**GI upset, Nausea and vomiting**
Nursing	**Monitor for signs of**	**Monitor for**	**Assess the**	**Monitor signs**	**Ensure**

Considerations (2)	**hypersensitivity and adverse effects, use caution when treating the client to decrease bleeding risk.**	**aspiration Use cautiously when giving to an unconscious client**	**clients abdomen for tenderness, discomfort or distention**	**of hypoglycemia, administer medication according to the sliding scale directions.**	**adequate hydration, monitor for signs of hypersensitivity**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Hepatic function and GI R.O.S**	**Assess the clients airway and swallowing ability**	**Assess bowel sounds and GI system prior to administering**	**Assess the clients blood glucose prior to administering**	**Assess for distention or discomfort in the abdomen**
Client Teaching needs (2)	**NA-client is medically unconscious**	**NA-client is medically unconscious**	**NA-client is medically unconscious**	**NA-client is medically unconscious**	**NA-client is medically unconscious**

Hospital Medications (5 required)

Brand/Generic	**Keppra Levetiracetam**	**Unasyn Ampicillin-Sulbactam**	**Chlorhexidine Gluconate Mouthwash**	**Heparin**	**White petrolatum-mineral oil (opthalm)**
Dose	**500mg**	**3g @ 200ml/ hr**	**15ml**	**1000u/ml**	**1 ribbon to each eye**
Frequency	**BID Q12**	**Daily at bedtime**	**BID Q12**	**Daily**	**Q4H**
Route	**G-Tube**	**IVPB**	**Oral swish and spit**	**Venous catheter dwell**	**Ophthalmic**
Classification	**Anticonvulsant**	**Penicillin antibiotics**	**Dental aids**	**Anticoagulants**	**Eye preparations OTC**
Mechanism of Action	**Binds to the synaptic vesicle protein SV2A in the brain to decrease seizure activity**	**Binds to bacteria to prevent cell wall formation**	**Antiseptic mouth rise that kills bacteria in the mouth**	**Acts to decrease clotting factors in the blood to prevent blood clots from forming**	**Acts as a lubricant and protectant to the eye for those who are unconscious**
Reason Client Taking	**Limit seizure/ muscle contraction activity**	**Prophylactic prevention of sepsis or other infection**	**Clean the mouth and prevent bacteria build up**	**Prevention of blood clots**	**To maintain moisture on the eyes for sedated clients**
Contraindications (2)	**Anemia, thrombocytope**	**Penicillin allergy**	**Only one contraindicat**	**Thrombocytopenia**	**Hypersensitivity Eye infections**

	nia	**Viral infections**	**ion for this medicine and it is hypersensitivity**	**Uncontrolled hypertension**	
Side Effects/Adverse Reactions (2)	**Decreased appetite, generalized weakness**	**Hypersensitivity General GI upset**	**Only one, Anaphylaxis/ allergic reaction**	**Heparin induced thrombocytopenia, Anaphylaxis**	**Redness or irritation of the eye Blindness**
Nursing Considerations (2)	**Monitor for appetite changes, and monitor for weakness which can increase fall risk**	**Monitor for hypersensitivity Give with food if upset stomach occurs**	**Rinse mouth as prescribed Instruct the client the proper way to swish and spit the medication**	**Monitor platelets Assess client for hypertension and controlling methods**	**Use only as prescribed and monitor hypersensitivity which may cause blindness**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Assess the clients gait and bilateral strength prior to giving. Assess platelet counts**	**Assess the clients allergy, and confirm ID before administering**	**Assess the clients gag reflex and airway patency**	**Assess the clients blood pressure and platelet count prior to adminstering**	**Assess the eyes prior to administering for signs of inflammation or redness**
Client Teaching needs (2)	**NA-client is medically unconscious**	**NA-client is medically unconscious**	**NA-client is medically unconscious**	**NA-client is medically unconscious**	**NA-client is medically unconscious**

Medications Reference (1) (APA):

EdD Rn, F. G., & PhD Rn, P. S. S. (2020). *Abrams' Clinical Drug Therapy: Rationales for Nursing Practice* (Twelfth, North American ed.). LWW.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Client is sedated, she is non alert or oriented** **Appears appropriate per situation** **No apparent distress**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 **Skin is warm and dry** **Skin color is normal per ethnicity** **Normal skin turgor** **No rashes or bruises or wounds however, there are indications that skin breakdown is occurring** **Braden score is 1**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck are symmetrical and midline, no deviation of the trachea** **Ears are symmetric without redness or rash** **Eyes are closed and mineral oil is placed to keep them moist** **Nose is midline, no deviation of the septum** **Teeth show poor dentition**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**Clear S1, S2 without audible murmur, rubs or gallops** **Cardiac rhythm shows normal sinus rhythm** **Peripheral pulses are 2+ carotid, brachial and radial,** **Cap refill is sub 3 seconds** **NA**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**She is on a mechanical vent, lungs sounds are heard in all locations, no stridor, wheezes, or crackles are heard.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:**	**Unable to assess home diet** **She is on gastrostomy feedings** **5'9"** **278lbs** **Bowel sounds are audible in all four quadrants**

Last BM: **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☒ N ☐** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☒ N ☐** **Type:**	**11/15/21** **Unable to assess pain, no masses or abnormal abdominal events noted** **No distention** **No incisions** **No scars, drains or wounds** **She has a gastrostomy feeding tube in place**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: Foley** **Size: 16F**	**Urine is straw yellow, it is clear, the amount of urine in the catheter bag is oliguric** **She is receiving dialysis for end stage renal failure** **Genitals are clean and free of lesions**
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 ☐**	**The client is sedated, and on a mechanical vent, her neurovascular status is maintained, blood flow is going to all extremities as evidence by sub 3 second capillary refill** **Strength is unable to be assessed, she needs complete ADL assistance, she is not a fall risk because she cannot move** **Fall score 0** **Immobile and non-active** **NO** **NA** **NA**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☐ N☒** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:**	**The client is in a sedated state, she is not alert or oriented and unable to follow commands or independently function. She cannot move her extremities, currently unconscious and unable to assess mental status, speech or sensory function**

LOC:	
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 this portion since the client is on a vent and heavily unconscious**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	**114**	**139/70**	**28**	**98.4F axillary**	**93% on mechanical vent**
1500	**109**	**134/61**	**19**	**98.5F axillary**	**98% on mechanical vent**

Vital Sign Trends: Vital signs are stable and are trending in a neutral position, the client is currently stable without indications of crashing.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1300	**CPOT**	**0**	**0**	**0**	**0**
1500	**CPOT**	**0**	**0**	**0**	**0**

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:**	18G Left forearm AC 11/16/21 No signs of infiltration, flushes without resistance, no erythema or drainage Dressing is dry and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
0	**NA**

She is currently not receiving any fluid intake today; she has oliguria therefore the output is not able to be assessed

Nursing Care

Summary of Care (2 points)

Overview of care: Dr. White, Samina RN, Kade Thomas RN-BSN student

Procedures/testing done: Chem labs, hematology, respiratory therapy, xray confirmation, IJ non-tunneled line placement, foley catheter placement, 18G IV in the right AC

Complaints/Issues: unable to assess

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: NA

Physician notifications: NA

Future plans for patient: NA -uncertainty on the client's condition

Discharge Planning (2 points)

Discharge location: NA

Home health needs (if applicable):NA

Equipment needs (if applicable):NA

Follow up plan: NA

Education needs: unable to assess

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

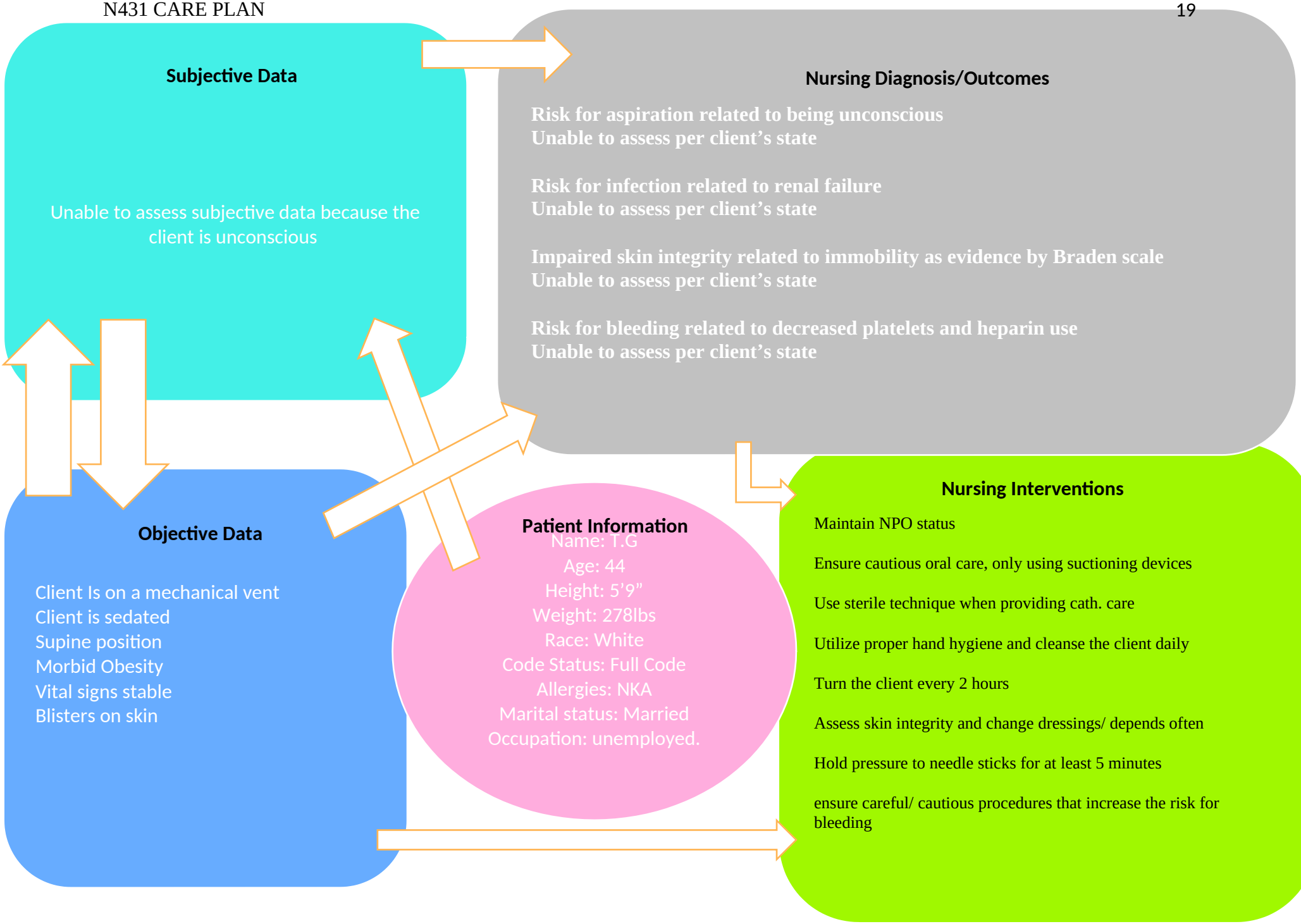
Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with	• Explain why the nursing		• How did the patient/family

"related to" and "as evidenced by" components	diagnosis was chosen		respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for aspiration related to being unconscious	**The client is comatose and cannot effectively swallow fluid or food, therefore airway is at risk if fluid enters the oral cavity** (Dnp Rn, 2020)	**1.Maintain NPO status** **2.Ensure cautious oral care, only using suctioning devices**	**Unable to assess due to the clients state**
2. Risk for infection related to renal failure	**The client is unconscious, suffers from renal failure and is immobile** (Dnp Rn, 2020)	**1. Use sterile technique when providing cath. care** **2.Utilize proper hand hygiene and cleanse the client daily**	**Unable to assess per client's state**
3. Impaired skin integrity related to immobility as evidence by braden scale	**The client scores very high on the braden scale which predicts likelihood of a pressure injury** (Dnp Rn, 2020).	**1. Turn the client every 2 hours** **2 Assess skin integrity and change dressings/ depends often**	**Unable to assess per client's state**
4. Risk for bleeding related to decreased platelets and heparin use	**The client has low platelets and is on a blood thinner which increases the risk for bleeding Unable to assess per client's state**	**1.Hold pressure to needle sticks for at least 5 minutes** **2. ensure careful/ cautious procedures that increase the risk for bleeding**	**Unable to assess per client's state**

Other References (APA):

Dnp Rn, P. L. (2020). *Sparks & Taylor's Nursing Diagnosis Reference Manual* (11th ed.). LWW.

Concept Map (20 Points):


Subjective Data
Unable to assess subjective data because the client is unconscious
Nursing Diagnosis/Outcomes
Risk for aspiration related to being unconscious
Unable to assess per client's state
Risk for infection related to renal failure
Unable to assess per client's state
Impaired skin integrity related to immobility as evidence by Braden scale
Unable to assess per client's state
Risk for bleeding related to decreased platelets and heparin use
Unable to assess per client's state
Objective Data
Client Is on a mechanical vent
Client is sedated
Supine position
Morbid Obesity
Vital signs stable
Blisters on skin
Patient Information
Name: T.G
Age: 44
Height: 5'9"
Weight: 278lbs
Race: White
Code Status: Full Code
Allergies: NKA
Marital status: Married
Occupation: unemployed.
Nursing Interventions
Maintain NPO status
Ensure cautious oral care, only using suctioning devices
Use sterile technique when providing cath. care
Utilize proper hand hygiene and cleanse the client daily
Turn the client every 2 hours
Assess skin integrity and change dressings/ depends often
Hold pressure to needle sticks for at least 5 minutes
ensure careful/ cautious procedures that increase the risk for bleeding