N431 Care Plan # 2

Lakeview College of Nursing

Name: Richard Kumpi

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
11/10/21	CM	51	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	Acetaminophen, Cefepime, Honey
Code Status	**Height**	**Weight**	
Full code	177.8 Cm	81.6 Kg	

Medical History (5 Points)

Past Medical History: End stage renal disease (ESRD), Hashimoto's thyroiditis, Heart Failure with reduced ejection fraction, depression, Thrombotic Thrombocytopenic Purpura.

Past Surgical History: Removal of peritoneal dialysis catheter, laparoscopic cholecystectomy

Family History: C.A.D her father.

Social History (tobacco/alcohol/drugs): never smoker, never used drugs or alcohol.

Assistive Devices: none

Living Situation: lives at home with her husband.

Education Level: she has college degree

Admission Assessment

Chief Complaint (2 points): the mother reported that the patient was complaining about abdominal pain and chills. She was depressed before having seizure.

History of present Illness (10 points): On November 10th, 2021, a 51-year-old white female patient with a history of peritonitis was referred from BroMenn medical center to the ICU department of Carle foundation hospital for abdominal abscess (intraabdominal abscess and ileus) related to complications of the peritoneal dialysis catheter and DVTs. The

patient complained about dull abdominal pain. On November 10th patient had a seizure; at arrival to Carle, she was intubated 30 min after. The CT scan imaging demonstrated a large loculated intraperitoneal fluid. Patient is on antibiotic and is tolerating treatment.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Septic shock

Secondary Diagnosis (if applicable):acute respiratory failure with hypoxia, intra-abdominal abscess.

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

Septic shock is a potentially life-threatening complication of sepsis susceptible to including an altered mental state, a dramatic low blood pressure, and organ dysfunction (Capriotti, 2020). Septic shock incorporates a cascade of hemodynamic, metabolic, and clinical changes that result from invasive infections and the release of microbial toxins in the blood (Capriotti, 2020). Septic shock refers to a subset of sepsis in which the underlying circulatory and cellular metabolism abnormalities are intense enough to increase mortality (Hinkle & Cheever, 2018) considerably.

Septic shock is caused by widespread infection or sepsis originating in conditions such as bacteremia in the bloodstream, pneumonia in the lungs, urosepsis in the urinary tract. Other infections include wound infections and intra-abdominal infections (Hinkle & Cheever, 2018). Additional risk factors that lead to incidences of septic shock include invasive procedures, indwelling medical devices, comorbid conditions, undergoing emergent and or multiple surgeries, chronic illness (Hinkle & Cheever, 2018). Gram-negative, gram-positive bacterial infections, fungal infections, and viral infections are

commonly implicated microorganisms in sepsis. At cellular levels, when these microorganisms invade the human body tissues, the body exhibits an immune response, which provokes the activation of biochemical cytokines and mediators related to inflammatory responses and produces a complex cascade of physiologic events leading to decreased venous return, decreased cardiac output, and poor tissue perfusion leading to organ dysfunction (Hinkle & Cheever, 2018).

Symptoms of septic shock include high fever or chills, increased heart rate, shallow blood pressure, warm, flushed skin, severe breathing problem, bounding pulses, elevated respiratory rate, decreased or cessation of urinary output (Hinkle & Cheever, 2018). Septic shock is mainly diagnosed with X-rays, CT scans, and MRI to visualize the body's internal organs (Hinkle & Cheever, 2018). For this particular patient, an X-ray and a CT scan were performed to diagnose the septic shock.

Treatment of septic shock consists of developing and implementing protocols that focus on preventive measures and early detection and management of sepsis. Pharmacologic therapy consists of administering intravenous antibiotics to fight the infection. Vasopressor medications, such as norepinephrine or dopamine, can be initiated to constrict blood vessels and increase blood pressure, insulin for blood sugar stability, and corticosteroids. Packed red blood cells and heparin may be ordered; fluid replacement therapy will be initiated to correct tissue hypoperfusion that resulted from an incompetent vasculature and the inflammatory response (Hinkle & Cheever, 2018). This patient is being treated with medications such as IV hydrocortisone, IV meropenem, vancomycin oral solution, and others.

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *Pathophysiology: Introductory concepts and clinical perspectives*. 2nd edition. F.A. Davis Company.

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of Medical Surgical Nursing*. 14th Wolters Kluwer.

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 10^6 uL	Not drawn	2.92 <	RBCs are low in situation involving a decreased production in the bone marrow, kidney impairment, anemia, certain medication, and hemorrhage. Client has ESRD and septic shock (Hinkle & Cheever, 2018).
Hgb	11.0-16.0g/dl	Not drawn	8.4<	Hgb decreases in case involving anemia, fluid retention, renal failure, chronic diseases, and recent hemorrhage. Client has chronic kidney disease and septic shock (Hinkle & Cheever, 2018)
Hct	34.0-47.0%	Not drawn	26.4 <	Hct decreases in case involving anemia, fluid retention, renal failure, chronic diseases, and recent hemorrhage. Client has chronic disease and septic shock (Hinkle & Cheever, 2018)
Platelets	140-400 10^3 ul	Not drawn	134<	platelets are decreased during anemia, fluid retention, renal failure, chronic diseases, and recent hemorrhage. Client has thrombotic thrombocytopenic Purpura and sepsis. (Hinkle & Cheever, 2018)
WBC	400-11.00	Not	11.98 >	WBC are higher in situation

	10^3 ul	**drawn**		**involving infection, stress, and Leukocytosis. Patient has wound and septic shock. (Hinkle & Cheever, 2018)**
Neutrophils	**1.60-7.70 10^3/ul**	**Not drawn**	**10.72>**	**Neutrophils are elevated during inflammation, infection, leukopenia, stress, and steroid usage. Client has septic shock and inflammation (Hinkle & Cheever, 2018)**
Lymphocytes	**1.00-4.90 10^3/ul**	**Not drawn**	**0.73<**	**Lymphocytes decrease in case of immunosuppression, Infectious diseases, autoimmune disorders and bonne morrow suppression. Client has septic shock (Hinkle & Cheever, 2018).**
Monocytes	**0.00-1.10 10^3**	**Not drawn**	**0.48**	
Eosinophils	**0.0- 0.50 10^3/ul**	**Not drawn**	**0.12**	
Bands	**0.0- 10.0%**	**Not drawn**	**0.9%**	

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 mmol/l**	**Not drawn**	**133<**	**Hyponatremia occurs when the body losses sodium due to CHF, SIADH, kidney impairment, cystic fibrosis, diuretic use, metabolic acidosis, Addison's disease, ascites. Patient has CHF, ESRD (Hinkle & Cheever, 2018).**
K+	**3.5-5.1 mmol/l**	**Not drawn**	**3.5**	
Cl-	**98-107 mmol/l**	**Not drawn**	**100**	
CO2	**22.0-29.0 mmol/l**	**Not drawn**	**19.0<**	**Low CO2 levels can be caused by hyperventilation, tachycardia, kidney disease, aspirin toxicity. This client has tachycardia and ESRD (Hinkle & Cheever, 2018).**

Glucose	**74-100mg/ dl**	**Not drawn**	**98**	
BUN	**10-20mg/dl**	**Not drawn**	**43>**	**BUN levels are increased in renal failure, CHF, kidney disease, shock, dehydration, urinary tract obstruction, DM, GI bleed. This client has CHF, septic shock, and ESRD (Hinkle & Cheever, 2018).**
Creatinine	**0.55-1.02 mg/dl**	**Not drawn**	**2.83>**	**The serum creatinine is elevated in case of impaired kidney function, CHF, renal disease, dehydration, shock, hyperparathyroidism. This client has CHF, septic shock, Hashimoto's thyroiditis, and ESRD (Hinkle & Cheever, 2018).**
Albumin	**3.5-5.0 g/dl**	**Not drawn**	**Not drawn**	
Calcium	**8.9-10.6 mg/dl**	**Not drawn**	**9.7**	
Mag	**1.6-2.6 mg/ dl**	**Not drawn**	**2.4**	
Phosphate	**2.3-4.7 mg/ dl**	**Not drawn**	**4.8>**	**High serum of phosphorus can be caused by impaired kidneys, hypoparathyroidism, metabolic or respiratory acidosis. This patient has ESRD and thyroid diseases (Hinkle & Cheever, 2018).**
Bilirubin	**0.1-1.4mg/ dl**	**Not drawn**	**Not drawn**	
Alk Phos	**40-150 U/l**	**Not drawn**	**Not drawn**	
AST	**5-34 U/l**	**Not drawn**	**Not drawn**	
ALT	**0-55 U/l**	**Not drawn**	**Not drawn**	
Amylase	**30-110 U/L**	**Not drawn**	**Not drawn**	
Lipase	**0-160 U/L**	**Not drawn**	**Not drawn**	
Lactic Acid	**0.5-2.2 mmol/L**	**Not drawn**	**Not drawn**	
Troponin	**I: <0.03mg/**	**Not drawn**	**Not**	

	ml T: <0.1mg/ml		**drawn**	
CK-MB	**3-5 % of the total CK**	**Not drawn**	**Not drawn**	
Total CK	**26-174**	**Not drawn**	**Not drawn**	

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 ratio**	**1.6>**	**Not drawn**	**INR is used to test the effectiveness of anticoagulant. The patient has slightly elevated INR meaning that the clotting time is greater than expected (Hinkle & Cheever, 2018).**
PT	**M: 6.6-11.8 sec F: 9.5-11.3 sec**	**Not drawn**	**Not drawn**	
PTT	**22.4-35.9 sec**	**18.9<**	**Not drawn**	**The PTT test is performed to determine if heparin therapy is effective. (Hinkle & Cheever, 2018).**
D-Dimer	**<250mg/mg**	**Not drawn**	**Not drawn**	
BNP	**<100mg/L**	**Not drawn**	**Not drawn**	
HDL	**>60**	**Not drawn**	**Not drawn**	
LDL	**<130 mg/dL**	**Not drawn**	**Not drawn**	
Cholesterol	**<200mg/dL**	**Not drawn**	**Not drawn**	
Triglycerides	**<150 mg/dL**	**Not drawn**	**Not drawn**	
Hgb A1c	**4-5.6 %**	**Not drawn**	**Not drawn**	
TSH	**0.5-5.0 mlU/L**	**Not drawn**	**Not drawn**	

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	Colorless/yellow, clear	Not drawn	Not drawn	
pH	4.5-8	Not drawn	Not drawn	
Specific Gravity	1.005-1.035	Not drawn	Not drawn	
Glucose	none	Not drawn	Not drawn	
Protein	none	Not drawn	Not drawn	
Ketones	none	Not drawn	Not drawn	
WBC	None/ rare	Not drawn	Not drawn	
RBC	None/ rare	Not drawn	Not drawn	
Leukoesterase	None	Not drawn	Not drawn	

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	Not drawn	Not drawn	Not drawn
PaO2	80-100	Not drawn	Not drawn	
PaCO2	35-45	Not drawn	Not	

			drawn	
HCO3	**22-26**	**Not drawn**	**Not drawn**	
SaO2	**92-100%**	**Not drawn**	**Not drawn**	

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	**>100,000ml**	**Not drawn**	**Not drawn**	
Blood Culture	**Negative**	**Not drawn**	**Not available**	
Sputum Culture	**Negative**	**Not drawn**	**Not drawn**	
Stool Culture	**Negative**	**Not drawn**	**Not drawn**	

Lab Correlations Reference (1) (APA):

Labs normal range by the EPIC

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of Medical Surgical Nursing*. 14th Wolters Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

XR chest AP OR PA only: moderate size right pleural effusion. Associated atelectasis in the lower normal limits, pacemaker in place.

CT chest abdomen/ pelvis with contrast: lungs and pleura= small amount of pleural fluid remains on the right side. Some fibrotic changes are noted within basilar lung fields, some areas of opacity and patchy reticular nodular.

Diagnostic Test Correlation (5 points):

Patient presented with septic shock, the provider would likely order a CT scan and an X-ray to investigate the internal view of body organs. A chest X-rays and a CT scan were performed, these tests provided information about the abnormal findings of internal organs. The CT scan demonstrated a large loculated intraperitoneal fluid collection meaning that there is an infiltration.

Diagnostic Test Reference (1) (APA):

Hinkle, J.L., & Cheever, K. H. (2018). ***Brunner & Suddarth's textbook of Medical Surgical Nursing*****. 14th Wolters Kluwer.**

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

Home Medications (5 required)

Brand/Generic	Acetaminophen/ Tylenol (Jones & Bartlett, L, 2020, P. 9-12).	Atorvastatin/ Lipitor (Jones & Bartlett, L, 2020, P. 106-108).	Alprazolam / Xanax (Jones & Bartlett, L, 2020, P. 44-45).	Levothyroxine (Jones & Bartlett, L, 2020, P. 697-699)	Pantoprazole/ protonix (Jones & Bartlett, L, 2020, P. 950-953).

Dose	**500 mg**	**80 mg**	**0.25 mg**	**200mg**	**40 mg**
Frequency	**Q 4hr prn**	**daily**	**3x a day**	**daily**	**2x daily**
Route	**po**	**po**	**po**	**po**	**po**
Classification	**Antipyretic, nonopioid analgesic**	**HMG-CoA reductase inhibitor & antihyperlipidemic**	**Anxiolytic, antipanic**	**Thyroid hormone**	**Proton pump inhibitor, antiulcer**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.**	**Reduces cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in liver by increasing LDL receptors on liver to enhance LDL uptake and breakdown.**	**Xanax may increase effects of gamma-aminobutyric acid and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of the CNS.**	**This hormone replaces endogenous thyroid hormone, to increase energy expenditure, enhance carbohydrate and protein metabolism, regulates growth, and decrease blood and hepatic cholesterol concentration.**	**Interfere with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphate enzyme system.**
Reason Client Taking	**To relieve pain.**	**To reduce hyperlipidemia and reduce the risk of heart failure exacerbation.**	**The client is taking to treat depression.**	**The client is takin to treat Hashimoto's thyroiditis**	**To prevent erosive esophagitis associated with GERD.**
Contraindicati	**Sever**	**Hepatitis**	**Acute angle-**	**Acute**	**Contra**

ons (2)	**hepatic impairment & active liver disease.**	**disease & thrombocytopenia.**	**closure glaucoma & hypersensitivity to Xanax or other benzodiazepines.**	**heart attack & uncorrected adrenal insufficiency.**	**indicted with concurrent therapy with rilpivirine-containing products &hypersensitivity to pantoprazole.**
Side Effects/Adverse Reactions (2)	**Neutropenia &hemolytic anemia**	**Cognitive impairment & depression**	**Hepatitis & hypotension.**	**Cardiac arrest & heart failure.**	**Anxiety & chest pain**
Nursing Considerations (2)	**Long-term use monitor liver enzyme (AST, ALT), and renal function.**	**Monitor diabetes patient because atorvastatin can affect blood glucose control. Monitor lipid level during treatment.**	**Taper the dose down when discontinued & Avoid opioid with Xanax.**	**Monitor glucose and PT**	**Flush IV line with D5W normal saline solution & Giving the IV over two minutes reconstitute with 10 ml of normal saline.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Monitored liver and real impairment**	**Monitor liver function test before treatment.**	**Monitor respiratory depression & decease in level of consciousness.**	**Monitor thyroid function.**	**Monitor hypomagnesemia before and during treatment.**
Client Teaching needs (2)	**Instruct client to report liver toxicity signs such as bleeding, easy bruising, and malaise & report skin reaction.**	**Take the drug at the same time each day & instruct the patient to report muscle pain, tenderness, or weakness.**	**Teach the patient to not stop the drug abruptly & avoid driving during therapy.**	**Teach client that this drug is a life long treatment & Take the morning dose before breakfast and**	**Tell the client to swallow the tablet as whole & expect symptoms relieved within 2 weeks.**

				evening dose may cause insomnia.	

Hospital Medications (5 required)

Brand/ Generic	**Hydrocortisone / solucortef (Jones & Bartlett, L, 2020, P. 588-591).**	**Meropenem / Merrem (Jones & Bartlett, L, 2020, P. 760-762).**	**Micafungin / mycamine (Jones & Bartlett, L, 2020, P. 801-802).**	**Vancomycin hydrochloride/ Vancocin (Jones & Bartlett, L, 2020, P. 1289-1291).**	**Venlafaxine/ effexor (Jones & Bartlett, L, 2020, P. 1298-1301).**
Dose	**50 mg**	**500 mg**	**100 mg**	**125 mg**	**37.5 mg**
Frequency	**Q 6hrs**	**Q 24 h**	**Q 24h**	**BID**	**2x a day**
Route	**IV**	**IV push**	**IV PB**	**Oral solution given by G-tube**	**Gastric tube**
Classification	**glucocorticoids**	**Antibiotic**	**Antifungal antibiotic**	**Antibiotic**	**Antidepressant (SSIR)**
Mechanism of Action	**Hydrocortisone binds to intracellular glucocorticoid receptors and suppresses inflammatory and immune response by inhibiting**	**Meropenem penetrates cell walls of most gram-negative and gram-positive bacteria, inactivating penicillin-**	**Micafungin inhibits synthesis of 1,3-beta-D-glucan, which is an essential component of the candida fungal cell wall. Without**	**Vancomycin inhibits bacterial RNA and cell wall synthesis; alters permeability of bacterial membranes, causing cell wall lysis and cell**	**Effexor inhibits neuronal reuptake of norepinephrine and serotonin, along with its active metabolite, 0-desmethylvenlafaxine. These actions raise**

	monocyte and neutrophil accumulation at inflammation site and suppressing their bactericidal and phagocytic activity.	**binding proteins. This action inhibits bacterial cell wall synthesis and causes cell death.**	**1,3-beta-D-glucan, the fungal cells die.**	**death.**	**norepinephrine and serotonin levels at nerve synapses, elevating mood and reducing depression.**
Reason Client Taking	**The client is taking to treat septic shock**	**The client taking to treat septic shock resulted from peritoneal dialysis catheter.**	**The client is taking to treat candidemia, disseminated candidiasis, and candida peritonitis.**	**The client is taking to treat bacterial septicemia.**	**The client was given as sedative regimen for septic shock during mechanical ventilation.**
Contraindications (2)	**Idiopathic thrombocytopenic purpura & systemic fungal infection.**	**Hypersensitivity to meropenem, its products or carbapenem.**	**Hypersensitivity to micafungin, or its products or other echinocandins.**	**Hypersensitivity to corn & vancomycin or its products.**	**Concomitant use with MAO inhibitor within 14 days. Hypersensitivity to desvenlafaxine.**
Side Effects/Adverse Reactions (2)	**Hypertension & heart failure**	**Shock & seizure**	**Bradycardia & cardiac arrest and hypotension.**	**Clostridium difficile associated diarrhea & acute kidney injury, and thrombocytopenia.**	**Heart failure & suicidal ideation.**
Nursing Considerations (2)	**Administer oral dose with food & monitor weight.**	**Take seizure precaution & Monitor patient**	**Monitored patient closely for anaphylactic shock & angioedem**	**Rapid delivery can result in red men syndrome and**	**This medicine can worsen heart failure & monitor hyponatremia.**

		with creatine clearance.	**a. Stop the infusion immediately and notify the provider.**	**hypotension.**	
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Monitor blood pressure, electrolytes, blood glucose before and during therapy.**	**Obtain body fluid and tissue samples, as ordered, for culture and sensitivity testing. Expect to review result before administering first dose.**	**Monitor renal and hematologic status before and during treatment.**	**Monitor CBC, BUN and serum creatinine for renal impairment.**	**Monitor electrolytes, especially for patient taking diuretic.**
Client Teaching needs (2)	**Instruct client to not stop abruptly & take the daily dose at 9 am**	**Instruct the patient to report difficult breathing immediately & report diarrhea.**	**Instruct patient to report any infusion-site discomfort immediately & report any unusual or persistent signs and symptoms to provider.**	**Encourage client to complete the full course of treatment & report diarrhea.**	**Instruct the client about not stop the drug abruptly & avoid alcohol during treatment.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). ***2020 Nurse's drug handbook*** **(19th ed.). Burlington, MA.**

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Well developed, appears unamused, speaks difficulty with low tone and voice.** **Patient is alert and oriented x4** **Patient appears distressed** **well groomed**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type: Jackson Pratt**	 **Pink** **Moisture, skin damaged** **Warm to touch** **Slow** **No rashes noted** **Patient has some bruises at the abdomen** **Wound at the abdomen and left forearm** **15**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 **Head and neck symmetrical, normal cephalic.** **Ears are symmetrical and free of discharge, no hearing deficiencies, no hearing aids.** **Eyes are symmetrical, wears eyeglasses.** **Nose septum midline, no drainage or bleeding.** **Patient has natural teeth, no dentures.**
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:**	 **Normal S1 and S2 with murmur/ sinus tachycardia** **Peripheral pulses are 1+, more diminished through bilateral** **Weak, 1+** **Edema inspected and palpated in both lower extremities.**
RESPIRATORY (2 points):	

Accessory muscle use: Y☐ N ☒ **Breath Sounds: Location, character**	**Fine crackling, crunching sounds noted in the lung at the end of inspiration. No accessory muscle use, patient is on 2L oxygen therapy.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Cardiac diet** **NPO** **177.8 cm** **81.6 kg** **Bowel sounds are hypoactive in all 4 quadrants** **Earlier today in the morning** **Patient complains pain and tenderness.** **Abdominal rigidity and distended** **No incisions or scars noticed.** **Patient has a Jackson Pratt** **Wound at the abdomen and left forearm**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Not available** **Not available** **Not available, patient voided in the toilet**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 20** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐**	**Edema on both lower extremities.** **active ROM upper and lower extremities** **No supportive devices** **equal strength both upper and lower bilateral.** **Patient is at fall risk due to the medications and is under supervision with need of support to stand or walk.** **Patient doesn't need assistive devices for gait at hospital or at home.**

Needs support to stand and walk☐	
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Patient is oriented x4, awake in bed, fatigued, and distressed. Patient speaks difficultly and looks. No signs of altered mental status.**
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):**	**Patient is unamused and has a poor coping method because she has a history of depression, but now she is cooperative and calm. Patient never smoke or use drugs.** **Patient has a college degree** **Patient states she is a catholic and has faith in Jesus Christ. Patient lives at home, she has a good support from her husband and mother who take care of her.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1315	104	115/51	20	99.6	91% 2L canula
1547	102	108/56	18	99.8	91% 2L canula

Vital Sign Trends: patient's pulse and blood pressure are abnormal, they are elevated. Her respiration was at upper limit before going to fluoroscopy for swallowing test.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1547	**Numeric Scale** **0/10**	**Abdomen**	**4/10**	**Dull, throbbing**	**No interventions implemented because patient had to go for fluoroscopy and should not be under effect of opioid.**
0450	**Numeric Scale** **0/10**	**Patient denies pain**	**Patient denies pain**	**Patient denies pain**	**No interventions implemented**

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:**	18 Anterior, lower right forearm (11/14/21), Arterial line at right femoral (11/ o6/ 21), PIVS, HD catheter tunneled double at left subclavian (10/15/21). No sign of erythema, saline lock. IV dressing clean.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
320 mL	**210 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: patient is tolerating care.

Procedures/testing done: Fluoroscopy

Complaints/Issues: patient complains about mild headache.

Vital signs (stable/unstable): vital signs (pulses and BP) unstable.

Tolerating diet, activity, etc.: patient is still NPO, failed speech therapy.

Physician notifications: keep patient on NPO

Future plans for patient: patient will need to resume intermittent CRRT today.

Discharge Planning (2 points)

Discharge location: patient will go home.

Home health needs (if applicable): n/a

Equipment needs (if applicable): n/a

Follow up plan: patient will need to follow up with the speech therapy

Education needs: educate patient to practice safe sterile practice.

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. Risk for impaired gas exchange related to altered oxygen supply caused by endotoxins in the cells and capillaries and altered blood	**This diagnosis is pertinent because sepsis causes acute respiratory distress and client will mechanical ventilation.**	**1.Administer supplemental oxygen via appropriate route (nasal canula, mask, or high-flow rebreathing mask). Rational: Supplemental oxygen is very**	**The patient displays ABGs and respiratory rate within the normal range, with breath sound clear and the chest X-ray improving. The client experiences no dyspnea or cyanosis.**

flow as evidenced by patient being on 2 L oxygen.		**important for correction of hypoxemia in patient with failing respiratory effort. 2.Reposition client frequently, encourage coughing and deep-breathing exercise, and suctioning. Rational: Good pulmonary toilet is important for minimizing ventilation, perfusion imbalance, and mobilizing secretion to maximize gas exchange.**	
2. Risk for deficient fluid volume related to capillary permeability with fluid leaks into the interstitial space as evidenced by pleural effusion by chest X-ray.	**This diagnosis was chosen because the chest X-ray and CT scan indicate that the patient has pleural effusion of the right side of the lung, giving rise to signs of dehydration.**	**1.Measure and record urinary output and specific gravity. Rational: Decreasing urinary output with a high specific gravity suggests relative hypovolemia associated with vasodilation. 2. Monitor blood pressure and heart rate. Assess for dry mucous membranes, poor skin turgor, and thirst. Rational: Reduction in circulating fluid**	**The patient maintains adequate circulatory volume as evidenced by vital signs within the patient's normal range, appropriate urinary output and palpable peripheral pulses of good quality.**

		volume reduces blood pressure, increase heart rate to compensate cardiac output. Skin signs give rise to signs of dehydration.	
3. Hyperthermia related to dehydration, increased metabolic rate, and direct effect of circulation endotoxins on the hypothalamus, altering temperature regulation as evidenced by tachycardia and increased respiratory rate.	**This diagnosis was chosen because the patient exhibits signs of infection…**	**1. Monitor the client temperature degree and pattern. Note shaking chills or profuse diaphoresis. Rational: Temperature of 102 to 106 F suggest acute infection disease process.** 3.Administer antipyretic as ordered such as acetaminophen **Rational: Antipyretic reduces fever by its central action on the hypothalamus.**	**Patient experiences no associated complications and demonstrates vital signs within normal ranges, a temperature within normal range and free of chills.**
4. Deficit Knowledge related to cognitive limitation as evidenced by inaccurate follow of instructions, developing of preventable complication.	**This diagnosis was chosen because the client developed sepsis chock, which is preventable complication during peritoneal dialysis.**	**1.Review disease process and future expectation. Rational: Discussing the disease and clinical expectations provides a knowledge base from which client can make informed choices. 2. Review individual risk**	**The client will verbalize understanding of the disease process, prognosis, and potential complications. Understanding of the therapeutic needs, treatment regiment, and necessary lifestyle changes.**

		factors, mode of transmission, and portal of entry of infection. Review personal hygiene and environmental cleanliness. Rational: Personal hygiene and awareness can prevent exposure to pathogens.	

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

Patient complained about pain, headache. Before admission, the mother of the client reported that the client had abdominal pain, she was depressed.

Nursing Diagnosis/Outcomes

Risk for impaired gas exchange related to altered oxygen supply caused by endotoxins in the cells and capillaries and altered blood flow as evidenced by patient being on 2 L oxygen
Risk for deficient fluid volume related to capillary permeability with fluid leaks into the interstitial space as evidenced by pleural effusion by chest X-ray.
Hyperthermia related to dehydration, increased metabolic rate, and direct effect of circulation endotoxins on the hypothalamus, altering temperature regulation as evidenced by tachycardia and increased respiratory rate.
The patient displays ABGs and respiratory rate within the normal range, with breath sound clear and the chest X-ray improving. The client experiences no dyspnea or cyanosis
Patient experiences no associated complications and demonstrates vital signs within normal ranges, a temperature within normal range and free of chills
The client will verbalize understanding of the disease process, prognosis, and potential complications.
Understanding of the therapeutic needs, treatment regiment, and necessary lifestyle changes.

Objective Data

XR chest AP OR PA only: moderate size right pleural effusion. Associated atelectasis in the lower normal limits, pacemaker in place.

CT chest abdomen/ pelvis with contrast: lungs and pleura= small amount of pleural fluid remains on the right side. Some fibrotic changes are noted within basilar lung fields, some areas of opacity and patchy reticular nodular.

Hypoactive bowel sounds

Pulse: 104, BP: 115/51

Patient Information

On November 10th, 2021, a 51-year-old white female patient with a history of peritonitis was referred from BroMenn medical center to the ICU department of Carle foundation hospital for abdominal abscess (intraabdominal abscess and ileus) related to complications of the peritoneal dialysis catheter and DVTs. On November 10th patient had a seizure; at arrival to Carle, she was intubated 30 min after. The CT scan imaging demonstrated a large loculated intraperitoneal fluid. Patient is on antibiotic and is tolerating treatment.

Nursing Interventions

1. Monitor respiratory rate and depth. Note use of accessory muscle or work of breathing.
2.Reposition client frequently.
3.Monitor the client temperature degree and pattern. Note shaking chills or profuse diaphoresis.
4.Review individual risk factors, mode of transmission, and portal of entry of infection. Review personal hygiene and environmental cleanliness, proper cooking techniques, and food storage.