N441 Care Plan

Lakeview College of Nursing

Rece Doggett

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
01/16/2022	R.J.	57	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Black/African American	None	Divorced	Ampicillin, Tramadol
Code Status	**Height**	**Weight**	
Full code	5’ 6”	86 kg	

Medical History (5 Points)

Past Medical History: R.J. has a past medical history including bipolar disorder, breast cancer, carcinoma, congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus type 2, end stage renal disease, hypertension, and an old myocardial Infarction.

Past Surgical History: The surgeries this client has undergone include a breast lumpectomy, cesarean section, chest tube insertion, dialysis catheter insertion, CB implantable cardioverter defibrillator, and a PleurX drain insertion.

Family History: Family history includes R.J.’s mother who was diagnosed with hypertension and diabetes.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): The only social history mentioned in the chart includes smoking cigarettes. 0.5 packs per day but does not specify how long.

Assistive Devices: The client was intubated during my clinical visit. No information was listed in the chart.

Living Situation: Client lives in a nursing home and is provided partial nursing care.

Education Level: Not specified in chart and unable to assess due to intubation.

Admission Assessment

Chief Complaint (2 points):Worsening Dyspnea X4 days

History of Present Illness – OLD CARTS (10 points):

Four days prior to admission the client had complaints of worsening shortness of breath with a recent visit to the emergency department for fluid retention. This began in the nursing home and continued to take effect at the hospital. The client had not stated if anything made the shortness of breath better or worse, but we can assume the combination of the two problems exacerbated each other. The chart makes no mention of the characteristics of the dyspnea but there was visible edema in relation to the client's fluid retention. Upon the assessment of the client, she presented with 3+ pitting edema. The client is given medications at the nursing home to help with the shortness of breath and fluid retention. The severity of the client's condition resulted in admission to the hospital where she has coded two times during her stay.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Fluid Overload, Respiratory Failure

Secondary Diagnosis (if applicable): End stage renal disease, diabetes mellitus

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

Fluid overload can cause edema throughout the body as well as pulmonary edema. Signs and symptoms may appear acutely or develop over time. Some of these signs and symptoms include dyspnea, a feeling of suffocation, cough with frothy sputum, wheezing or gasping for air, cold/clammy skin, anxiety, bluish lips, or a rapid, irregular heartbeat (Mayo Clinic, 2020). The signs the client displayed were clammy skin, rapid irregular heartbeat, dyspnea, and wheezing. Some lab tests used to diagnose this include serum osmolarity tests, sodium levels, hematocrit

tests, and BUN. Risk factors for this disease include heart arrhythmias, alcohol use, heart diseases such as congenital heart disease, coronary artery disease, heart valve disease, high blood pressure, diabetes, and sleep apnea (Mayo Clinic, 2020).

Diagnostic tests for this disease include chest X-ray, arterial blood gas, B-type natriuretic peptide (BNP) blood test, complete blood count, complete metabolic panel. A few more tests include an electrocardiogram, echocardiogram, and an ultrasound of the lungs (Mayo Clinic, 2020). R.J. had abnormal lab values from blood draws, chest x-rays, EKGs, and a BNP. The treatments for this disease include diuretics, blood pressure medications, and inotropes (Mayo clinic, 2020). Some lifestyle changes that may help with fluid overload include maintaining healthy blood pressure, managing other medical conditions, smoking cessation, eating healthier with less salt, and regular exercise to help maintain weight (Mayo Clinic, 2020). Fluid overload puts stress on the cardiac system and well and the pulmonary system. If left untreated, it may affect the kidneys and pancreas.

Respiratory failure occurs when the respiratory system fails to maintain gas exchange. This disease can relate to various conditions, including issues with the central nervous system, peripheral nervous system disorders, airway obstructions, and abnormalities of the alveoli (NCBI, 2021). These issues can cause a lack of oxygen in the bloodstream resulting in hypoxia. Hypoxia can cause significant issues throughout the body due to the need for oxygen in every body system. Oxygen therapy is applied to manage this condition, but the body can rely on supplemental oxygen. Signs and symptoms of hypoxemia include dyspnea, irritability, confusion, tachycardia, arrhythmias, tachypnea, and cyanosis. With respiratory failure, diagnostic testing will show common abnormalities in arterial blood gas labs, chest x-rays, and

decreased oxygen saturation (NCBI, 2021). Treatment of respiratory failure is to treat the underlying issues causing the issue. Supportive measures for this diagnosis include maintaining a patent airway, adequate ventilation, and the correction of the ABGs (NCBI, 2021).

The intention of ventilating a client is to correct hypoxemia, correct acute respiratory acidosis, and rest the ventilation muscles. Respiratory failure will more likely present with issues relating to cardiac, neurological, renal, and gastrointestinal systems, nutritional disturbances, infections, and pulmonary issues. R.J. presented with cardiac issues, renal complications, and infection. Her labs were abnormal—the "Laboratory Data" section will show this; the most critical data in the ABGs. The client underwent intubation to help correct lab values and keep client stable. There was also sedation given to R.J. to help keep her relaxed during this time of distress.

End-stage renal disease, also known as kidney failure, is a chronic kidney disease where the kidneys struggle to maintain the body's needs or may not work at all. The kidneys filter the blood in the body, help the body excrete waste, and work closely with the gastro-urinary system to maintain a healthy body. If the kidneys are failing, there are a couple of options to help keep an individual at baseline health: dialysis or a kidney transplant. The blood is run through a machine, filtered, and then put back into the individual's body during dialysis. Symptoms of kidney failure include nausea, vomiting, loss of appetite, fatigue, and weakness, changes in urination, chest pain, shortness of breath, swelling of the feet and ankles, hypertension, headaches, difficulty sleeping, muscle cramping, and persistent itching (Mayo Clinic, 2019). Some causes of kidney failure include diabetes, glomerulonephritis, other kidney diseases, and recurring kidney infections. Risk factors that can progress kidney disease include poor glucose

control, hypertension, tobacco use, race, old age, and medication use that may damage the kidneys (Mayo Clinic, 2019). Some expected findings with this disease include abnormal lab values such as waste products in the blood, urine tests to check protein albumin present, C.T. imaging to assess abnormalities in the kidney's appearance, and a kidney tissue biopsy to look for damage in the kidneys (Mayo Clinic, 2019).

These diagnostic tests may not always show positive results if the client follows their dialysis schedule as prescribed. As mentioned earlier, the treatments for end-stage kidney disease include kidney transplants, dialysis, and supportive care (Mayo Clinic, 2019). Each type of treatment has its benefits and complications, but the benefits still outweigh the possible problems. R.J. presented severe edema resulting from the fluid overload that the end-stage kidney disease had very likely influenced. The combination of these two diseases is likely what caused the respiratory failure and dyspnea the client was experiencing. The client was experiencing anuria, chest discomfort, shortness of breath, and edema prior to intubation, which are signs and symptoms of end-stage kidney disease.

Pathophysiology References (2) (APA):

Pulmonary edema - Symptoms and causes. (2020, October 20). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/pulmonary-edema/symptoms-causes/syc-20377009

End-stage renal disease - Diagnosis and treatment - Mayo Clinic. (2019, August 17). Mayo Clinic - Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/diagnosis-treatment/drc-20354538

Respiratory failure - StatPearls - NCBI bookshelf. (2021, April 9). National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books/NBK526127/

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	4.4 – 5.8	**3.4**	**3.55**	**Decreased hemoglobin may result in reduced RBC volume from increased extracellular water. (NCBI, 2015.)**
Hgb	13 – 16.5	**9.4**	**9.9**	**Overhydration/fluid retention is an independent prediction of low hemoglobin concentrations. (NCBI, 2021)**
Hct	38 – 50	**30.9**	**31.5**	**Insufficient healthy red blood cell production will result in a lower-than-normal hematocrit level (Mayo Clinic, 2019).**
Platelets	140 – 446	**59**	**62**	**Platelet count is low due to the medication Heparin currently being given.**
WBC	4 – 12	**3.6**	**8.9**	**The client is currently recovering from COVID-19. She is out of quarantine, but is in a critical condition causing abnormal WBC values.**
Neutrophils	**47 – 73 %**	**92**	**N/A**	**The client is currently recovering from COVID-19. She is out of quarantine, but is in a critical condition causing abnormal WBC values.**
Lymphocytes	**18 – 42 %**	**4.3**	**N/A**	**The client is currently recovering from COVID-19. She is out of quarantine, but is in a critical condition causing abnormal WBC values.**
Monocytes	**4 – 12 %**	**2.8**	**N/A**	**The client is currently recovering from COVID-19. She is out of quarantine, but is in a critical condition causing abnormal WBC values.**
Eosinophils	**0.0 – 5.0 %**	**0.6**	**N/A**	
Bands	**0.0 – 1.0 %**	**0.3**	**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-	133 – 144	**129**	**133**	**Client's abnormal sodium value resulted from fluid overload pulling the sodium from the bloodstream causing the edema visible to the patient (NCBI, 2021).**
K+	3.5 – 5.1	**4.8**	**3.5**	
Cl-	98 – 107	**92**	**96**	**Hypochloremia is likely occurring due to the extra fluid inside the body.**
CO2	22 – 32	**31**	**24**	
Glucose	70 – 99	**180**	**178**	**Abnormal glucose levels come from clients diagnosis of Diabetes. Her body is unable to produce its own insulin.**
BUN	**6 – 20**	**13**	**14**	
Creatinine	**0.5 – 1.00**	**2.83**	**2.00**	**Kidney failure results in waste staying in the bloodstream raising creatinine levels (Mayo Clinic, 2019).**
Albumin	**3.5 – 5.7**	**2.9**		**Fluid overload will likely lower albumin levels due to systematic inflammatory response (NCBI, 2021).**
Calcium	**8.6 – 10.3**	**8.7**		
Mag	**1.6 – 2.6**	**1.7**		
Phosphate	**N/A**			
Bilirubin	**0.2 – 0.8**	**0.8**		

Alk Phos	**34 – 104**	**136**		**Increased alkaline phosphate levels are typically seen with liver damage or certain types of blood disorders (Medline Plus, 2020).**
AST	**13 – 39**	**19**		
ALT	**7 – 52**	**9**		
Amylase	**N/A**			
Lipase	**N/A**			
Lactic Acid	**0.5 – 2.0**	**0.7**		
Troponin	**0.05 or less**	**0.117**		**Troponin is a test indicator to detect heart damage. This result shows damage to the heart (Mayo Clinic, 2019).**
CK-MB	**N/A**			
Total CK	**30 - 223**	**65**		

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**0.8 – 1.1**	**1.2**		**INR result high due to the medication Heparin currently being given.**
PT	**10.1 – 13.1**	**13.6**		**PT result high due to the medication Heparin currently being given.**
PTT	**25 - 36**	**25**		
D-Dimer	**N/A**			
BNP	**N/A**			
HDL	**N/A**			
LDL	**N/A**			

Cholesterol	**N/A**			
Triglycerides	**<150**	**62**		
Hgb A1c	**N/A**			
TSH	**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	**No UA on file**			
pH	**No UA on file**			
Specific Gravity	**No UA on file**			
Glucose	**No UA on file**			
Protein	**No UA on file**			
Ketones	**No UA on file**			
WBC	**No UA on file**			
RBC	**No UA on file**			
Leukoesterase	**No UA on file**			

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**	**7.3**	**In Progress**	
PaO2	**80 – 100**	**67**	**In Progress**	**Due to client's rapid breathing ABGs were altered. She did show signs of improvement the next day.**
PaCO2	**35 – 45**	**67**	**In Progress**	
HCO3	**22 – 26**	**32.6**	**In Progress**	
SaO2	**94 - 100%**	**94%**	**100%**	

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	**In Progress**			
Blood Culture	**No Growth**	**--**	**No growth**	
Sputum Culture	**N/A**			
Stool Culture	**No growth**	**--**	**In process**	

Lab Correlations Reference (1) (APA):

Normal lab values were taken from OSF Epic system.

Association of fluid retention with anemia and clinical outcomes among patients with chronic kidney disease. (n.d.). PubMed Central (PMC). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4330071/

Hematocrit test. (2019, February 12). Mayo Clinic - Mayo Clinic. https://www.mayoclinic.org/tests-procedures/hematocrit/about/pac-20384728#:~:text=A%20lower%20than%20normal%20hematocrit,Vitamin%20or%20mineral%20deficiencies

Do you know which blood tests can point to heart disease? (2019, December 17). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/heart-disease/in-depth/heart-disease/art-20049357

Alkaline Phosphatase: MedlinePlus medical test. (2020, July 30). MedlinePlus - Health Information from the National Library of Medicine. https://medlineplus.gov/lab-tests/alkaline-phosphatase/#

Pulmonary edema - Symptoms and causes. (2020, October 20). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/pulmonary-edema/symptoms-causes/syc-20377009

End-stage renal disease - Diagnosis and treatment - Mayo Clinic. (2019, August 17). Mayo Clinic - Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/end-stage-renal-disease/diagnosis-treatment/drc-20354538

Respiratory failure - StatPearls - NCBI bookshelf. (2021, April 9). National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books/NBK526127/

Diagnostic Imaging

All Other Diagnostic Tests (5 points): EKG on 1/18/2022 Chest X-ray X3 on 1/16,18,19/2022, and C-reactive protein. These tests were taken to evaluate the severity of the client's admitting diagnoses as well as to monitor the clients ventricular tachycardia. These tests can help us visualize the consolidation inside of the lungs and the function of the cardiac system.

Diagnostic Test Correlation (5 points): The chest X-ray on all three days show bibasilar infiltration with visible cardiomegaly according to the Radiologist. The first EKG showed A-fib with rapid ventricular response, the second EKG showed Ventricular tachycardia. The EKG shows the client has little perfusion due to the abnormally high pulse rate and arrhythmias (NCBI, 2021).

Diagnostic Test Reference (1) (APA):

Respiratory failure - StatPearls - NCBI bookshelf. (2021, April 9). National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books/NBK526127/

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

Home Medications (5 required)

Brand/Generic	**Furosemide Lasix**	**Aminocaproic acid Amicar**	**Fluphenazine decanoate Poloxin**	**Metoprolol succinate Toprol-XL**	**Pravastatin Pravachol**
Dose	**40mg tablet**	**500 mg tablet**	**25 mg tablet**	**25mg/ml**	**40mg tablet**
Frequency	**BID**	**Q6**	**Daily**	**Daily**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Diuretic**	**Antihemorrhagic**	**Antipsychotic**	**Antihypertensive**	**Antihyperlipidemic**
Mechanism of Action	**Inhibits sodium and water reabsorption**	**Inhibits breakdown of blood clots**	**May block postsynaptic dopamine receptor sites**	**Inhibits stimulation of beta1-receptor sites,**	**Inhibits cholesterol synthesis**
Reason Client Taking	**Fluid Retention**	**Prevent blood clots**	**Bipolar disorder**	**Prevent heart**	**Maintain proper liver**

		due to being bed bound		**damage cause by hypertension**	**function**
Contraindications (2)	**Anuria unresponsive to furosemide, hypersensitivity to furosemide**	**Active intravascular clotting, upper urinary tract bleeding.**	**CNS depressants, coma, cerebral arteriosclerosis**	**Acute heart failure, cardiogenic shock**	**Active hepatic disease, persistent elevated liver enzymes**
Side Effects/Adverse Reactions (2)	**Hyperglycemia, Arrhythmias**	**Stroke, hypotension**	**Tachycardia, hyperglycemia**	**Anxiety, arrhythmias, shortness of breath, dyspnea**	**Dyspnea, confusion, chest pain**
Nursing Considerations (2)	**Know clients allergic to sulfonamides may also be allergic to this med, Give in the morning so the client will not need to use the bathroom at night**	**Avoid rapid I.V. delivery d/t increased risk of hypotension, monitor neurologic status for drug induced changes**	**This med should not be used to treat dementia induced psychosis, use cautiously in patients with hx of glaucoma or renal impairment**	**Use cautiously in clients with angina, before starting therapy for heart failure, expect to give an ACE inhibitor such as digoxin and a diuretic to help keep client stable**	**Use cautiously in clients with hepatic or renal impairment, give drug 1 hour before or 4 hours after giving cholestyramine or colestipol**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Obtain clients weight before taking, Measure output for client and if oliguria occurs then stop giving medication**	**Assess blood pressure and heart rate before and after administration, Check blood clotting factors such as PT, aPTT, and**	**Assess neurovascular status, obtain blood pressure and pulse. Check kidney function.**	**Monitor for dyspnea and monitor client closely if they have previous experienced bronchospasms, Obtain ECG if client is at**	**Monitor liver enzymes before giving, monitor patient's BUN and serum creatinine levels periodically**

		INR		**risk for AV block**	
Client Teaching needs (2)	**Instruct patient to take hours before bedtime, caution to client on drinking alcoholic beverages and standing in hot weather due to increased hance of hypotensive effect (Jones & Bartlett, 2018).**	**Tell client they will be closely monitored during I.V. therapy and will receive blood draws to check and maintain proper lab values, advise patients to report adverse reactions (Jones & Bartlett, 2018).**	**Advise patient not to mix oral solution with beverages containing caffeine, teach patient how to prevent heatstroke, orthostatic hypotension, and photosensitivity (Jones & Bartlett, 2018).**	**Tell client to take at the same time each day, Advise patient to notify provider if the pulse rate drops below 60 beats per minute (Jones & Bartlett, 2018).**	**Advise patient to notify prescriber at one about muscle pain, tenderness, weakness, and other evidence of myopathy, advise women not to breastfeed while on pravastatin (Jones & Bartlett, 2018).**

Hospital Medications (5 required)

Brand/Generic	**Diprivan Propofol**	**Magnesium sulfate in 5% dextrose**	**Fentanyl**	**Amiodarone**	**Heparin**
Dose	**25mcg**	**1g**	**25 mcg**	**360mg/ 200mL**	**5000 Units**
Frequency	**Continuous c intubation**	**Once**	**Continuous c intubation**	**33.3mL/ hour**	**Q8**
Route	**IV**	**IV**	**IV**	**IV**	**Sub Q**
Classification	**Sedative-**	**Electrolyte**	**Opioid**	**Antiarrhyt**	**Anticoagulan**

	hypnotic			**hmic**	**t**
Mechanism of Action	**Decreases cerebral blood flow, cerebral metabolic oxygen consumption, and intracranial pressure and increases cerebrovascular resistance.**	**Assists all enzymes involved in phosphate transfer reactions**	**Blocks pain receptors in the brain**	**Prolongs repolarization and the refractory period**	**Inhibits production of fibrin which prevents clots from forming**
Reason Client Taking	**Intubation/ sedation**	**Low magnesium**	**Pain**	**Ventricular tachycardia**	**Prevent clotting**
Contraindications (2)	**Hypersensitivity to drug, egg allergy**	**Hypersensitivity to magnesium salts, heart disease**	Acute asthma, increase intracranial pressure	**Bradycardia, cardiogenic shock**	**Breastfeeding, history of heparin-induced thrombocytopenia**
Side Effects/Adverse Reactions (2)	**Bradycardia, hypotension, apnea**	**Arrhythmias, hypotension, dyspnea**	Adrenal insufficiency, hypertension	**Disorientation, arrhythmias**	**Chills, chest pain, vomiting**
Nursing Considerations (2)	**Repeated use of sedation drugs during procedures or surgeries should be avoided, shake container ell before using**	**Drug isn't metabolized if in GI tract for 30 minutes it can cause watery stools, avoid giving with antacid in 2-hour window**	Use caution with elderly patients especially when initiating and titrating therapy, as they are at increased risk for adverse effects, especially	**Check patient's implanted cardiac device at start and during administration, monitor IV infusion closely**	**Drug should be preserved with benzyl alcohol, use cautiously with alcoholics**

			resp. depression. Should not be given to pregnant women		
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Monitor for propofol infusion syndrome, assess respiratory status and do not mix drug with other drugs.**	**Monitor all electrolytes especially magnesium, take EKG prior to administration.**	**Monitor vitals such as BP and respirations, Monitor neurological status after administration**	**Check heart rate and rhythms, watch pulmonary effort due to ability to worsen pulmonary disorders**	**Monitor aPTT before and during treatment, assess for bleeding before administering**
Client Teaching needs (2)	**Urge patient and family to voice concerns and ask questions before administration, reassure patient they will be monitored closely during administration.**	**If a chewable tablet instruct patient to thoroughly chew tablet, instruct patient to refrigerate magnesium citrate solution at home**	**Instruct client that they may feel lightheaded or dizzy after administration, do not take more than prescribed, do not stop taking unless instructed due to withdrawal.**	**Explain the client will need frequent monitoring and lab tests during treatment, advise patient to report cough, dark urine, dyspnea, fainting, and fatigue**	**Explain it can not be taken orally, inform about increased risk for bleeding, advise patient to avoid drug-drug interactions**

Medications Reference (1) (APA):

Learning, J. & B. (2018). *2019 nurse's drug handbook*. Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Client presented in hospital gown and overall had a view of discomfort.** **The client was intubated and sedated and was unable to follow commands or questions.**
INTEGUMENTARY: **Skin color: Brown** **Character: Hard, swollen/retaining fluid** **Temperature: warm** **Turgor: not rapid, but not slow ~ 1.5 seconds** **Rashes: see right** **Bruises: None** **Wounds: see right** **Braden Score:** **Drains present: Y☒ N ☐** **Type: PleurX drain**	**There is visible scarring and dry skin throughout the entire body. The swelling of the skin and immobility was causing skin breakdown** **The PleurX drain was located on the clients left side.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Clients neck and face were retaining fluid. The eyes were closed and when opened the pupils were pinpoint and minimally reactive to light. The clients nose appears with no abnormalities. The client's teeth were white with few missing.**
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 2+ see right for abnormalities** **Capillary refill: see right** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema: Whole body**	**Client had audible S3 sounds with a cardiac rhythm of tachycardia.** **Client had a slower capillary refill at ~ 5 seconds. Pedal pulses were not palpable or audible with doppler.**

RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube: 28** **Placement (cm to lip):25** **Respiration rate:20** **FiO2: 35%** **Total volume (TV):585** **PEEP:5 - 6** **VAP prevention measures: See right.**	**Client had audible rhonchi and wheezing through ET tube.** **It was difficult to decipher breath sounds over the vent.** **VAP precautions needed for this client include changing the suction tubing, providing oral care, and cleaning the tubes with normal saline where able to. None were performed during my clinical time.**
GASTROINTESTINAL: **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:**	**There is no mention of the client's diet in the chart. After intubation the client had not received any food or tube feedings. On the third day of the client's intubation (the day we were present at the clinical site) the APN had spoken with the nurse about starting it.** **The client's abdomen was visibly distended and there was a single scar. There were no incisions or current wounds. The clients bowels were hypoactive during auscultation. R.J. did not react to the palpation of the abdomen. The last bowel movement was recorded on the evening of 01/19/2022.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	**Client did not produce urine during our clinical stay. The client did not have a foley catheter inserted. This section of the assessment is unable to be assessed.**
MUSCULOSKELETAL:	**The client was sedated during our clinical**

Neurovascular status: **ROM: limited** **Supportive devices:** **Strength: Weak.** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: Hight risk** **Activity/Mobility Status: Bed bound.** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**visit. The client had restricted ROM but with assistance the limbs are moveable. There is no mention of any supported devices.** **The client is unable to be assessed due to intubation.**
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☐ N☒** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Client unable to follow or understand commands due to sedation.**
PSYCHOSOCIAL/CULTURAL: **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 due to circumstances of clients condition.** **Client's POA was mother who was in Georgia and had shown up the day after our clinical stay. The chart did say the client was a Christian.**

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0845	186	97/43	20	98.9	100%
1015	130	81/67	20	98.8	100%

Vital Sign Trends/Correlation: Vitals were mostly stable during this clinical visit, but were much better the following day. There was one point in time where the client was having issues with her cardiac rhythm, but it eventually worked itself out.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	**Critical care pain observation tool**	**N/A**	**None**	**None**	**None**
0900	**Critical care pain observation tool**	**N/A**	**None**	**None**	**None**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:22g, **Location of IV:L hand, R subclavian port** **Date on IV:01/18/2022** **Patency of IV: Flushes** **Signs of erythema, drainage, etc.: None** **IV dressing assessment: Clean and intact**	Many medication being infused located in medication section
Other Lines (PICC, Port, central line, etc.)	
Type: hemodialysis catheter double lumen **Size: N/A** **Location: Subclavian** **Date of insertion: 10/29/2021** **Patency: Fully functional** **Signs of erythema, drainage, etc.: None** **Dressing assessment: Clean and intact** **Date on dressing: 01/17/2022** **CUROS caps in place: Y ☐ N ☒** **CLABSI prevention measures: Currently in use, but caps are available.**	Both lumens currently in use for medications.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1390	3940

I/O rates are from chart and is total measurement since client had been admitted.

Nursing Care

Summary of Care (2 points)

Overview of care: Client is still undergoing care and will need to be re-evaluated by the provider. Client will still need to be monitored from a cardiac and pulmonary standpoint.

Procedures/testing done: EKG, X-ray, Blood work, and Intubation were the procedures performed this clinical day.

Complaints/Issues: Client unresponsive to verbal commands, but responsive to painful stimuli.

Vital signs (stable/unstable): One episode of instability, but overall stable for the client's condition.

Tolerating diet, activity, etc.: Client is planning to start enteral feedings if she stays on the vent.

Physician notifications: The nurse spoke with the physician about starting tube feedings. We started Amiodarone after contacting physician about high pulse rate.

Future plans for client: Client will undergo a breathing test to see if she will be able to come off intubation.

Discharge Planning (2 points)

Discharge location: There are not current discharge plans.

Home health needs (if applicable): Client is in a nursing home and will continue to need that care.

Equipment needs (if applicable):

Follow up plan: N/A

Education needs: Diet and fluid balancing.

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

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes,

				modifications to plan.
1. Impaired gas exchange related to (r/t) respiratory distress as evidenced by client needing to be intubated and being on ~30% oxygen.	**The patient is not breathing on her own and is being ventilated.**	**1.Monitor respiratory rate and depth as well as ventilation settings.** **2.Reposition the client frequently and assess oxygen saturation frequently**	**1. Client will improve with ABGs, the ability to lower concentration of O2, and removal in ET tube.**	**Client maintained a good O2 saturation. After speaking with the provider, they recommended a breathing test to see if the client can come off the vent.**
2. Decreased cardiac output r/t history of MI, heart failure, and arrhythmias as evidenced by ventricular tachycardia and unstable vital signs.	**The heart is what keep the body going. Improving the cardiac output may help the fluid overload which will lead to better breathing resulting in better blood flow.**	**1. Limit fluids and sodium and closely monitor fluid intake and restriction orders.** **2.Administer oxygen therapy as prescribed, ensure bedrest to prevent strain.**	**1. The outcome is for the client to have a more stable blood pressure and pulse rate/rhythm with decreased dyspnea and an absence of pulmonary crackles/wheezing.**	**During the clinical stay the client vital slowly improved but were still very unstable. The following day the client had improved greatly from the day before with much more stable vitals and more reactive to stimuli.**
3. Unstable glucose r/t diabetes as evidenced by unstable glucose reading taken during clinical stay.	**Diabetes is a very serious and deadly disease. It is a contributing factor**	**1.Assist the client to identify and record eating patterns that can be modified** **2. Administer insulin as ordered and**	**1. The outcomes for the client include managing and monitoring blood glucose to hopefully manage the**	**The client is on multiple medications that may cause hyperglycemia which was causing her to have high**

	to the fluid overload and strain on the body.	**teach signs of hyper/hypoglycemia**	**disease better. The goal is to have a glucose reading less than 140 and an A1C reading less than 7%.**	**glucose readings. She did not display signs of hyperglycemia.**
4. Excessive fluid volume related to end stage kidney disease/ kidney failure as evidenced by fluid retention and edema throughout the entire body.	**This is a contributing factor as to the client's current condition and will need to be managed better if the client is to improve.**	**1. Give diuretics as prescribed and monitor fluid I/O** **2. Elevate extremities presenting with edema**	**1. The client's outcome for this nursing diagnosis include reducing the edema and having a balanced I/O**	**Client did not have any output that was noted during our clinical stay. The client's edema did not improve but the vitals began to become more stable during our stay.**
5. Impaired tissue/skin integrity r/t lack of physical movement/activity as evidenced by client being intubated and under sedation.	**Patient is unable to move while sedated which can increase risk for pressure sores and infection**	**1. Provide wound care as needed and assess skin as needed.** **2. Encourage the use of pillows and turn client Q2**	**1. The outcomes for this diagnosis include visible tissue recovery and ensure there is not altered sense of pain or discomfort on bony prominences.**	**The client skin did not improve during our clinical stay and the client was only turned one time. The client had no verbal responses to any intervention for all diagnoses due to being sedated.**

Other References (APA):

Decreased cardiac output – Nursing diagnosis & care plan. (2019, January 29).

Nurseslabs. https://nurseslabs.com/decreased-cardiac-output/

Impaired gas exchange – Nursing diagnosis & care plan. (2017, September 23). Nurseslabs. https://nurseslabs.com/impaired-gas-exchange/

Excess fluid volume – Nursing diagnosis & care plan. (2020, September 8). Nurseslabs. https://nurseslabs.com/excess-fluid-volume/

Impaired tissue (Skin) integrity – Nursing diagnosis & care plan. (2019, March 20). Nurseslabs. https://nurseslabs.com/impaired-tissue-integrity/

Risk for unstable blood glucose level – Nursing diagnosis & care plan. (2017, September 23). Nurseslabs. https://nurseslabs.com/risk-unstable-blood-glucose-level/

Concept Map (20 Points):

Subjective Data

Client came into ED with c/o worsening dyspnea that was ongoing for 4 days that began at the nursing home and continued during her visit in the emergency department.

Nursing Diagnosis/Outcomes

Impaired gas exchange – Client maintained 100% O2 readings throughout entire clinical stay and may come off of the intubation vent soon.
Decreased cardiac output – Client vitals started off extremely unstable but improved by the end of shift.
Unstable glucose levels – client had high glucose readings even after insulin was administered. She did not show any signs of hyperglycemia due to sedation.

Excessive fluid volume – Client did not have any noted output during our clinical visit. The clients edema did not improve throughout out clinical day either. She will need more time and medication before improvement will show.
Impaired skin/tissue integrity – Client skin did not improve during our time at clinical and it did not get worse either. Client will need to recover from the fluid excess before they will improve with skin integrity.

Objective Data

Client vitals as follows: Pulse 130, BP 81/67, RR 20, Temp 98.8, and O2 sat of 100%.
Client was intubated during clinical visit. PleurX drain was present on LUQ of abdomen.
Client has a hx of end stage kidney disease, diabetes, COPD, CHF, and breast cancer.

Client Information

Client initials are R.J. who is a 57 YO black female. She weighs 86kg and is a full code. She is divorced and live in a nursing home.

Nursing Interventions

Impaired gas exchange - **1.Monitor respiratory rate and depth as well as ventilation settings. 2.Reposition the client frequently and assess oxygen saturation frequently**

Decreased Cardiac output –**. Limit fluids and sodium and closely monitor fluid intake and restriction orders. 2. Administer oxygen therapy as prescribed, ensure bedrest to prevent strain.**

Unstable glucose levels –**1.Assist the client to identify and record eating patterns that can be modified. 2. Administer insulin as ordered and teach signs of hyper/hypoglycemia**

Excessive fluid volume – **1. Give diuretics as prescribed and monitor fluid I/O 2. Elevate extremities presenting with edema**

Impaired skin/tissue integrity - **1. Provide wound care as needed and assess skin as needed. 2. Encourage the use of pillows and turn client Q2**