

Fluid Overload

NextGen SKINNY Reasoning



Anthony Robinson, 67 years old

Primary Concept			
Perfusion/Gas Exchange			
Interrelated Concepts (In order of emphasis)			
<ul style="list-style-type: none"> Clinical judgment 			
NCLEX Client Need Categories	Covered in Case Study	NCSBN Clinical Judgment Model	Covered in Case Study
Safe and Effective Care Environment		Step 1: Recognize Cues	✓
<ul style="list-style-type: none"> Management of Care 	✓	Step 2: Analyze Cues	✓
<ul style="list-style-type: none"> Safety and Infection Control 		Step 3: Prioritize Hypotheses	✓
Health Promotion and Maintenance		Step 4: Generate Solutions	✓
Psychosocial Integrity		Step 5: Take Action	✓
Physiological Integrity		Step 6: Evaluate Outcomes	✓
<ul style="list-style-type: none"> Basic Care and Comfort 			
<ul style="list-style-type: none"> Pharmacological and Parenteral Therapies 			
<ul style="list-style-type: none"> Reduction of Risk Potential 	✓		
<ul style="list-style-type: none"> Physiological Adaptation 			

Present Problem:

You are the nurse caring for Anthony Robinson, a 67-year-old African American male patient with a history of heart failure and iron deficiency anemia who was admitted to the medical floor from the emergency department earlier this morning for low hemoglobin. Mr. Robinson's initial hemoglobin was 6.2 and the primary care provider ordered 2 units of packed red blood cells (PRBC). He received the first unit in the emergency department (ED) over 90 minutes and tolerated well with no change in status.

Current Labs (ED):

Complete Blood Count (CBC)							
WBC		HGB		Hct		PLTs	
7.5		6.2		34		154	
Basic Metabolic Panel (BMP) + Mg							
Na	K	Cl	CO2	BUN	Creat.	Gluc	Mg
143	3.5	110	26	16	1.1	132	1.8

The second unit was started after he arrived on the floor and is nearly 2/3 finished. You are rounding on your other patients when Mr. Robinson presses his call light and states "I feel like I can't catch my breath." When you enter the room, you see Mr. Robinson in bed breathing rapidly and he appears anxious.

1. *What data from the present problem is RELEVANT and must be NOTICED as clinically significant by the nurse?*
(NCSBN: Step 1 Recognize cues/NCLEX: Reduction of Risk Potential)

RELEVANT Data from Present Problem:	Clinical Significance:

Recognizing a potential problem, you stop the blood, allowing saline to infuse TKO, and promptly collect a full set of VS before contacting the primary care provider:

Current VS:	P-Q-R-S-T Pain Assessment:	
T: 98.2 F/36.8 C (oral)	Provoking/Palliative:	
P: 102 (regular)	Quality:	Denies
R: 28 (regular)	Region/Radiation:	
BP: 138/89	Severity:	
O2 sat: 87% RA	Timing:	

2. What VS data is **RELEVANT** and must be **NOTICED** as clinically significant by the nurse? (NCSBN: Step 1 Recognize cues/NCLEX: Reduction of Risk Potential)

RELEVANT Data from Present Problem:	Clinical Significance:

Additional Information:

- You put Mr. Robinson on supplemental oxygen via nasal cannula at 3 LPM. His O₂ saturation improves to 92% and his respiratory rate is 24 breaths/minute. You listen to his lungs and note that they are clear in the upper fields with fine crackles bilaterally in the bases. His skin is cool, and moist.
- A quick scan of the medical record shows a medical history of congestive heart failure. His home medications include metoprolol, lisinopril, furosemide, aspirin, and potassium chloride. You recall that Mr. Robinson told you earlier that he did not take his morning medications before coming to the emergency room.
- The charted intake for the patient is 900 mL (300 PO fluids, 600 mL PRBC – 350 ml from the first unit, plus approximately 250 mL from currently infusing unit), the charted output is 200 mL clear yellow urine.
- When he first arrived on the floor, he was breathing comfortably, RR 16, breath sounds clear throughout, and oxygen saturation 94% on room air.

You quickly review the electronic health record and note the following:

Pre-Transfusion VS:	15” After Transfusion:
T: 98.4 F/36.8 C (oral)	T: 98.2 F/36.8 C (oral)
P: 98 (regular)	P: 96 (regular)
R: 18 (regular)	R: 20 (regular)
BP: 130/80	BP: 128/82
O2 sat: 94% RA	O2 sat: 93% RA

3. What data from the additional information is **RELEVANT** and must be **NOTICED** as clinically significant by the nurse? (NCSBN: Step 1 Recognize cues/NCLEX: Reduction of Risk Potential)

RELEVANT Data from Additional Info:	Clinical Significance:

4. Interpreting clinical data collected, what problems are possible? Which problem is priority? Why?

(NCSBN: Step 2: Analyze cues/Step 3: Prioritize hypotheses/NCLEX: Management of Care)

Problems:	Priority Problem:	Rationale:

5. What nursing priority will guide how the nurse *RESPONDS* to formulate a plan of care?

(NCSBN: Step 4 Generate solutions/Step 5: Take action/NCLEX: Management of Care)

Nursing PRIORITY:	
Nursing Interventions:	Expected Outcome:

Use SBAR to communicate your concern to the primary care provider:

S ituation:
Name/age: BRIEF summary of primary problem:
B ackground:
Primary problem/diagnosis: RELEVANT past medical history: RELEVANT background data:

Assessment:**Vital signs:****RELEVANT body system nursing assessment data:****RELEVANT lab values:****How have you advanced the plan of care? Patient response?****INTERPRETATION of current clinical status (stable/unstable/worsening):****Recommendation:****Suggestions to advance plan of care:**

The primary care provider agrees with your recommendation and orders furosemide 40 mg IV push and discontinue the transfusion of PRBCs. You continue to closely assess Mr. Robinson and after one hour you collect the following assessment data:

6. *After implementing the plan of care, EVALUATE your patient by INTERPRETING relevant clinical data to determine if patient status is improving, declining, or reflects no change.*

(NCSBN: Step 6 Evaluate outcomes/NCLEX: Management of Care)

Assessment Finding:	Improving:	Declining:	No Change:
Urine output: 750 mL			
HR: 92/minute			
RR: 20/minute non-labored			
BP: 120/74			
O2 sat: 95% room air			
Crackles persist in bases but not as pronounced			
Resting comfortably-appears less anxious			