N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 02/08/2022	Client Initials SS	Age 65-year-olds	Gender Female
Race/Ethnicity Caucasian	Occupation State of Illinois	Marital Status Widowed	Allergies Skelaxin (Metaxalone): Anaphylaxis Dilaudid Hydromorphone: Hives and Itching Morphine: Hives and Itching Percocet (Oxycodone-Acetaminophen): Nausea
Code Status Full Code	Height 154.9 cm	Weight 123 kg	

Medical History (5 Points)

Past Medical History: Patient has a past medical history of Type two Diabetes, anxiety, asthma, hypertension, hyperlipidemia, depression, colitis, fibromyalgia, diaphragmatic hernia, iron deficiency anemia, S/P EGD with CRE dilation to 20mm, morbid obesity, obstructed sleep apnea, acute respiratory failure, post gastric bypass, abnormal chest radiology, post ex lap with bowel resection for small bowel obstruction, cerebrovascular accident, and multiple falls.

Past Surgical History: Patient has a surgical history of gastric bypass, cholecystectomy, diaphragmatic hernia repair, small intestine surgery, and tracheostomy that was placed on March 1, 2022.

Family History: Patient was not able to identify family history.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient does not have a social history of using tobacco, alcohol, or drugs.

Assistive Devices: Patient did not use any assistive devices at home, but while in the hospital the patient is using a Hoyer lift to get up to a chair and back to bed.

Living Situation: Patient currently lives at home by self in the Champaign area.

Education Level: Patient has an education level of a college diploma.

Admission Assessment

Chief Complaint (2 points): Patient went an outside facility with shortness of breath that has been going on for over a week.

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

A 65-year-old Caucasian female on February 8, 2022, presented to an outside facility with shortness of breath with severe intensity while ambulating that started over the weekend. The patient stated that the shortness of breath decreased with rest. Patient was stating in the 70's. The outside facility sent the female to do a CT scan which made the female become very distressed and had to intubate the female patient. The female was sent to OSF for higher acuity of care.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute Respiratory Failure with hypoxia

Secondary Diagnosis (if applicable): Patient did not present with a second diagnosis

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

Acute respiratory failure (ARF) develops when the lungs cannot exchange oxygen and carbon dioxide adequately (Swearingen & Wright, 2019). The PaO2 is less than 60 mmHg with a patient at rest and breathing room air (Swearingen & Wright, 2019). PaCO2 is 50 mmHg or more or pH less than 7.35, is significant for respiratory acidosis, and is a

common precursor to ARF (Swearingen & Wright, 2019). The four primary mechanisms involved are alveolar hypoventilation, ventilation-perfusion mismatch, diffusion disturbances, and right-to-left shunt (Swearingen & Wright, 2019). The challenge is to predict when a patient will cease independent breathing and incur respiratory failure (Capriotti & Frizzell, 2020). A patient showing signs of respiratory failure appears distressed and may be using accessory muscles and have difficulty maintaining a standard respiratory rate despite oxygen administration (Capriotti & Frizzell, 2020). A patient with respiratory failure or at risk needs intubation equipment ready at the bedside (Capriotti & Frizzell, 2020). After the patient has been intubated, the clinical picture needs to be observed (Capriotti & Frizzell, 2020). Once it is corrected, the underlying cause of the intubation needs to be investigated (Capriotti & Frizzell, 2020).

The symptoms of the patient's reasoning for acute respiratory failure are described in terms of OLDCART – onset, location, duration, characteristics, aggravating or relieving factors, and treatment (Capriotti & Frizzell, 2020). Assess if dyspnea occurs with exertion or in the presence of edema (Capriotti & Frizzell, 2020). If the patient has ankle edema often indicates a cardiac disorder (Capriotti & Frizzell, 2020). Exertional dyspnea commonly occurs with cardiac conditions (Capriotti & Frizzell, 2020). Signs of pulmonary edema of cardiac origin can present similar to pneumonia (Capriotti & Frizzell, 2020). Both conditions cause crackles indicative of fluid in the lungs (Capriotti & Frizzell, 2020). A chronic cough can be associated with asthma, heart failure, TB, lung cancer, or COPD (Capriotti & Frizzell, 2020). Clinical indicators of ARF vary according to the underlying disease process and severity of the failure (Swearingen & Wright, 2019). ARF is one of the most common causes of the impaired level of consciousness (Swearingen & Wright, 2019).

It is also misdiagnosed with heart failure, pneumonia, and stroke (Swearingen & Wright, 2019). Early signs and symptoms of ARF include restlessness, changes in mental status, anxiety, headache, fatigue, cool or dry skin, increased blood pressure, tachycardia, and cardiac dysrhythmias (Swearingen & Wright, 2019). Intermediate signs and symptoms include confusion, increased agitation, and increased oxygen requirements with decreased oxygen saturation (Swearingen & Wright, 2019). Late signs and symptoms include cyanosis, diaphoresis, coma, and respiratory arrest (Swearingen & Wright, 2019). SS presented with symptoms of shortness of breath with severe intensity with ambulation.

Expected findings related to pneumonia include early signs and symptoms of ARF, including restlessness, changes in mental status, anxiety, headache, fatigue, cool or dry skin, increased blood pressure, tachycardia, cardiac dysrhythmias (Swearingen & Wright, 2019). Intermediate signs and symptoms include confusion, increased agitation, and increased oxygen requirements with decreased oxygen saturation (Swearingen & Wright, 2019). Late signs and symptoms include cyanosis, diaphoresis, coma, and respiratory arrest (Swearingen & Wright, 2019). Early signs and symptoms of ARF include restlessness, changes in mental status, anxiety, headache, fatigue, cool or dry skin, increased blood pressure, tachycardia, and cardiac dysrhythmias (Swearingen & Wright, 2019). Intermediate signs and symptoms include confusion, increased agitation, and increased oxygen requirements with decreased oxygen saturation (Swearingen & Wright, 2019). Late signs and symptoms include cyanosis, diaphoresis, coma, and respiratory arrest (Swearingen & Wright, 2019). With ARF, labs are expected to include arterial blood gas analysis, increased white blood cells, and low oxygen saturation (Swearingen & Wright, 2019).

Diagnostic testing includes a chest x-ray, arterial blood gas analysis, CT scan, pulse oximetry, imaging studies, bronchoscopy, pulmonary function tests, and thoracocentesis (Capriotti & Frizzell, 2020).

The patient observed with ARF had arterial blood gas done, showing PaO2 was decreased. A CBC showed an increase in white blood cell count, platelets, carbon dioxide, and bilirubin, decreasing hemoglobin and hematocrit, calcium, albumin, and lymphocytes. The patient also had several chest x-rays performed to show the ET tube placement, tracheostomy, and one chest x-ray showing the right lung hazy with bands of atelectasis and the left lung nearly completely opacified reflects atelectasis and no pneumothorax. The patient had one CT scan of the head and brain without contrast, showing seizure activity.

Treatment for ARF includes a variety of drugs and procedures (Capriotti & Frizzell, 2020). Along with general treatment measures: bronchodilators reduce bronchospasm, and antibiotics treat bacterial respiratory infections (Capriotti & Frizzell, 2020). Decongestant medications cause vasoconstriction, help to reduce the inflammation and edema in the nasal passage, and relieve nasal congestion (Capriotti & Frizzell, 2020). Antihistamine medications block the inflammatory effects of histamine in the airways (Capriotti & Frizzell, 2020). Antitussive medications can control coughs (Capriotti & Frizzell, 2020). Antiviral drugs, such as amantadine are available to lessen the effects of viral infection in the respiratory tract (Capriotti & Frizzell, 2020).

Clinical data that correlates to this patient includes increased white blood cells, increased platelets, neutrophils, lymphocytes, monocytes, eosinophils, increase in carbon dioxide, increase in glucose, increase in bilirubin, decrease in hematocrit and hemoglobin, the neutrophils, lymphocytes, monocytes also decreased in the labs, calcium is decreased,

albumin level decreased, pH was increased, decrease in the PaO2. The patient had chest x-rays performed to show the placement and movement of the ET tube, the tracheostomy placement, and the orogastric tube placement. One chest x-ray showed the right lung hazy with bands of atelectasis; the left lung near completely opacified reflects atelectasis but no pneumothorax. CT scan of the head and brain showed seizure activity. The patient also had two swallow evaluations performed.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. (2020). *Pathophysiology: Introductory concepts and clinical perspectives. F.A. Davis Company*.

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and Psychiatric-Mental Health*. Elsevier.

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	**3.8-5.3**	**4.16**	**3.94**	**N/A**
Hgb	**12-15.8 (Pagana et al., 2019)**	**9.6**	**10.4**	**A decreased hemoglobin can be caused by a nutritional deficiency. (Pagana et al., 2019)**
Hct	**36-47 (Pagana et al., 2019)**	**32.2**	**32.6**	**A decreased hematocrit can be caused by a dietary deficiency. (Pagana et al., 2019)**
Platelets	**140-440 (Pagana et al., 2019)**	**732**	**409**	**A decreased in platelets can be caused by iron deficiency anemia. (Pagana et al., 2019)**
WBC	**4-12 (Pagana et al., 2019)**	**38.3**	**6.7**	**An increase in white blood cell count can be caused by an inflammation. (Pagana et al., 2019)**
Neutrophils	**47-73**	**96.2**	**29.7**	**An increase in neutrophils can be**

	(Pagana et al., 2019)			caused by acute suppurative infection. A decrease in neutrophils can caused by dietary deficiency. (Pagana et al., 2019)
Lymphocytes	18-42 (Pagana et al., 2019)	2.7	52.2	A decrease in lymphocytes can be caused by an infection. An increase in lymphocytes can be caused by an infection. (Pagana et al., 2019)
Monocytes	4-12 (Pagana et al., 2019)	1.0	9.5	A decrease in monocytes can be caused by drug therapy the patient may be on. (Pagana et al., 2019)
Eosinophils	0-5 (Pagana et al., 2019)	0.0	7.0	An increase in eosinophils can be caused by an allergic reaction. (Pagana et al., 2019)
Bands	0.0-10 (Pagana et al., 2019)	4.0	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	133-144 (Pagana et al., 2019)	142	140	N/A
K+	3.5-5.1 (Pagana et al., 2019)	4.1	4.1	N/A
Cl-	98-107 (Pagana et al., 2019)	102	105	N/A
CO2	21-31 (Pagana et al., 2019)	33	24	An increase in carbon dioxide can be caused by the patient being short of breath. (Pagana et al., 2019)
Glucose	70-99 (Pagana et al., 2019)	164	118	An increase in glucose can be caused by the patient being a type 2 diabetic. (Pagana et al., 2019)
BUN	7-25 (Pagana et al., 2019)	11	13	N/A

Creatinine	**0.5-1.2 (Pagana et al., 2019)**	**0.73**	**0.61**	**N/A**
Albumin	**3.5-5.7 (Pagana et al., 2019)**	**2.5**	**3.1**	**A decrease in albumin can be caused by an acute infection. (Pagana et al., 2019)**
Calcium	**8.6-10.3 (Pagana et al., 2019)**	**8.1**	**9.5**	**A decrease in calcium can be caused by malabsorption. (Pagana et al., 2019)**
Mag	**1.3-2.1 (Pagana et al., 2019)**	**N/A**	**N/A**	**N/A**
Phosphate	**3.0-4.5 (Pagana et al., 2019)**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.2-0.8 (Pagana et al., 2019)**	**0.9**	**0.9**	**An increase in bilirubin can be caused by anemia. (Pagana et al., 2019)**
Alk Phos	**34-104 (Pagana et al., 2019)**	**53**	**53**	**N/A**
AST	**13-39 (Pagana et al., 2019)**	**13**	**18**	**N/A**
ALT	**7-52 (Pagana et al., 2019)**	**10**	**14**	**N/A**
Amylase	**60-120 (Pagana et al., 2019)**	**N/A**	**N/A**	**N/A**
Lipase	**0-160 (Pagana et al., 2019)**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.5-2.0 (Pagana et al., 2019)**	**1.0**	**N/A**	**N/A**
Troponin	**0-0.3 (Pagana et al., 2019)**	**N/A**	**N/A**	**N/A**
CK-MB	**0.6-6.3 (Pagana et al., 2019)**	**N/A**	**N/A**	**N/A**
Total CK	**30-223 (Pagana et**	**N/A**	**N/A**	**N/A**

	al., 2019)			

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	11-12.5 (Pagana et al., 2019)	N/A	N/A	N/A
PT	11-12.5 (Pagana et al., 2019)	N/A	N/A	N/A
PTT	30-40 (Pagana et al., 2019)	N/A	N/A	N/A
D-Dimer	0-0.62 (Pagana et al., 2019)	N/A	N/A	N/A
BNP	0-100 (Pagana et al., 2019)	N/A	N/A	N/A
HDL	23-92 (Pagana et al., 2019)	N/A	N/A	N/A
LDL	<100 (Pagana et al., 2019)	N/A	N/A	N/A
Cholesterol	<199 (Pagana et al., 2019)	N/A	N/A	N/A
Triglycerides	0-149 (Pagana et al., 2019)	N/A	N/A	N/A
Hgb A1c	4-6 (Pagana et al., 2019)	5.9	N/A	N/A
TSH	0.45-5.33 (Pagana et al., 2019)	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Clear/ Yellow (Pagana et al., 2019)	N/A	N/A	No lab was performed for this patient
pH	5-8 (Pagana et al., 2019)	N/A	N/A	N/A
Specific Gravity	1.005-1.034 (Pagana et al., 2019)	N/A	N/A	N/A
Glucose	Normal (Pagana et al., 2019)	N/A	N/A	N/A
Protein	Negative (Pagana et al., 2019)	N/A	N/A	N/A
Ketones	Negative (Pagana et al., 2019)	N/A	N/A	N/A
WBC	<5 (Pagana et al., 2019)	N/A	N/A	N/A
RBC	Negative (Pagana et al., 2019)	N/A	N/A	N/A
Leukoesterase	Negative (Pagana et al., 2019)	N/A	N/A	N/A

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7 .35-7.45	7.53	N/A	An increase in pH can be caused

	(Pagana et al., 2019)			by gastric suctioning. (Pagana et al., 2019)
PaO2	85—105 (Pagana et al., 2019)	71	N/A	A decrease in PaO2 can be caused by acute respiratory failure. (Pagana et al., 2019)
PaCO2	35-45 (Pagana et al., 2019)	36	N/A	N/A
HCO3	22-26 (Pagana et al., 2019)	N/A	N/A	N/A
SaO2	95-98 (Pagana et al., 2019)	96	N/A	N/A

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative (Pagana et al., 2019)	N/A	N/A	No labs were performed on this patient
Blood Culture	Negative (Pagana et al., 2019)	N/A	N/A	N/A
Sputum Culture	Negative (Pagana et al., 2019)	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

	(Pagana et al., 2019)			

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference*. Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

2/12/22

CT Head Brain without contrast: Showed seizure activity.

Chest X-rays were performed every day during the time that the patient was intubated. To confirm proper placement of the tube.

Patient had a swallow evaluation done on 2/18/22. Showed concerns of dysphagia and swallowing delayed.

On 2/21/22, the ET tube was removed. A chest x-ray was performed. Showed right lung was hazy with bands of atelectasis and the left lung was near completely opacified, reflects atelectasis. No pneumothorax or pleural effusion visual.

On 2/21/22, a new ET tube and OG tube have been placed.

On 2/23/22-3/1/22, chest x-ray performed to check placement of the ET tube and OG tube.

On 3/1/22, the ET tube extubated, and a tracheostomy was placed.

On 3/1/22-3/14/22, chest x-ray was performed to confirm placement of tracheostomy.

On 3/25/22, a swallow evaluation was performed.

Diagnostic Test Correlation (5 points):

The patient with a chest x-ray aids in assessing the perfusion scan, it visualizes the heart, lungs, and bones (Pagana et al., 2019). A chest x-ray can diagnose pneumonia, pleural fluid, and many other diseases involved in heart and lungs (Pagana et al., 2019). The patient had a chest x-ray performed due to her diagnosis of acute respiratory failure, and they also did a chest x-ray to monitor placement of the ET tube, the placement of the OG tube, and tracheostomy (Pagana et al., 2019).

The patient had a CT scan takes images of the body from different angles; it can help visualize more into the images than a normal x-ray can (Pagana et al., 2019). The patient had a CT scan performed that showed seizure activity in the brain.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference*. Mosby.

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

Home Medications (5 required)

Brand/ Generic	**Seroquel/ Quetiapine fumarate**	**Clonidine/ Catapres**	**Eliquis/ Apixaban**	**Furosemide/ Lasix**	**Meloxicam/ MOBIC**
Dose	**200 mg**	**0.2 mg**	**5 mg**	**20 mg**	**15 mg**
Frequency	**Daily**	**Daily**	**BID**	**BID**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Dibenzothiazepine derivative,**	**Centrally acting alpha agonist,**	**Factor Xa inhibitor, anticoagulan**	**Loop diuretic, antihypertensive, diuretic**	**NSAID, Analgesic (2020**

	antipsychotic (2020 Nurse's Drug Handbook, 2020)	**analgesic (2020 Nurse's Drug Handbook, 2020)**	**t (2020 Nurse's Drug Handbook, 2020)**	**(2020 Nurse's Drug Handbook, 2020)**	**Nurse's Drug Handbook , 2020)**
Mechanism of Action	**May produce antipsychotic effects by interfering with dopamine binding to dopamine type 2-receptor sites in the brain and by antagonizing serotonin 5-HT dopamine type 1, histamine H, and adrenergic alpha and alpha receptors (2020 Nurse's Drug Handbook, 2020)**	**Stimulates peripheral alpha-adrenergic receptors in the CNS to produce transient vasoconstriction and then stimulates central alpha-adrenergic receptors in the brain stem to reduce heart rate, peripheral vascular resistance, heart rate, and systolic and diastolic blood pressure (2020 Nurse's Drug Handbook, 2020)**	**Inhibits free and clot-bound factor Xa and prothrombinase activity. Although apixaban has no direct effect on platelet aggregation, it does indirectly inhibit platelet aggregation, it does indirectly inhibit platelet aggregation induced by thrombin (2020 Nurse's Drug Handbook, 2020)**	**Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation. As the body's plasma volume decreases, aldosterone production increases, which promotes sodium reabsorption and the loss of potassium and hydrogen ions (2020 Nurse's Drug Handbook, 2020)**	**Blocks cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate the inflammatory response and cause local pain, swelling, and vasodilation. (2020 Nurse's Drug Handbook , 2020)**
Reason Client Taking	**Patient is taking medication as an adjunct therapy with antidepressants.**	**Patient is taking medication to treat hypertension.**	**Patient is taking medication reduce risk of a stroke.**	**Patient is taking medication to manage hypertension.**	**Patient is taking medication for fibromyalgia.**
Contraindi	**1. Hyper**	**1. Antico**	**1. Activ**	**1. Anuria**	**1. His**

cations (2)	**sensitivity to quetiapine or its components** **2. Possibly increased risk of prolonged QT interval** **(2020 Nurse's Drug Handbook, 2020)**	**agulant therapy** **2. Hypersensitivity to clonidine or its components** **(2020 Nurse's Drug Handbook, 2020)**	**e pathological bleeding** **2. Severe hypersensitivity to apixaban or its components** **(2020 Nurse's Drug Handbook, 2020)**	**2. Hypersensitivity to furosemide or its components** **(2020 Nurse's Drug Handbook, 2020)**	**tory of angioedema** **2. Asthma** **(2020 Nurse's Drug Handbook, 2020)**
Side Effects/Adverse Reactions (2)	**1. Hypothermia** **2. Cardiomyopathy** **(2020 Nurse's Drug Handbook, 2020)**	**1. Thrombocytopenia** **2. Angioedema** **(2020 Nurse's Drug Handbook, 2020)**	**1. Hemorrhagic stroke** **2. Anaphylaxis** **(2020 Nurse's Drug Handbook, 2020)**	**1. Arrhythmias** **2. Thromboembolism** **(2020 Nurse's Drug Handbook, 2020)**	**1. CVA** **2. Hemolytic anemia** **(2020 Nurse's Drug Handbook, 2020)**
Nursing Considerations (2)	**1. Know that quetiapine should not be**	**1. Use clonidine cautiously in elderly patient**	**1. Know that apixaban should not**	**1. Be aware that patients who are allergic**	**1. Be aware that NSAI**

	given to patient's who have a history of cardiac arrhythmias. **2. Monitor patients closely for suicidal tendencies, especially when therapy starts or dosage changes, because depression may worsen temporarily during these**	**s, who may be more sensitive to its hypotensive effect.** **2. Be aware that extended-release tablets are not interchangeable with immediate-release tablets.** **(2020 Nurse's Drug Handbook, 2020)**	**be given to patients with severe hepatic dysfunction.** **2. Crush tablet and mix with applesauce and administer immediately for patient unable to swallow whole tablets.** **(2020 Nurse's Drug Handbook, 2020)**	**to sulfonamides may also be allergic to furosemide. Monitor patient closely.** **2. Prepare drug for infusion with normal saline solution, lactated Ringer's solution, or D5W.** **(2020 Nurse's Drug Handbook, 2020)**	**Ds like meloxicam should avoided in patients with a recent MI because risk of reinfarction increases with NSAID therapy. Know that the risk of heart failure increases**

	times (2020 Nurse's Drug Handbook, 2020)				**with NSAID use (2020 Nurse's Drug Handbook, 2020)** **2.**
Key Nursing Assessment (s)/Lab(s) Prior to Administration	**Monitor patient for orthostatic hypotension, prolonged abnormal muscle contractions, blood glucose and lipid level. Assess patient for hypothyroidism. (2020 Nurse's Drug Handbook, 2020)**	**Monitor patient with AV block and sinus node dysfunction closely. Monitor blood pressure and heart rate often during clonidine therapy. (2020 Nurse's Drug Handbook, 2020)**	**Monitor patient closely for bleeding, as apixaban may cause life-threatening bleeding. (2020 Nurse's Drug Handbook, 2020)**	**Monitor patient for hypokalemia which may occur with brisk diuresis, inadequate oral electrolyte intake, or when cirrhosis is present. (2020 Nurse's Drug Handbook, 2020)**	**Monitor liver enzymes because, rarely, elevations may progress to severe hepatic reactions. (2020 Nurse's Drug Handbook, 2020)**
Client Teaching needs (2)	**1. Instruct patient to take quetiapine with food to reduce stomach upset.** **2. Advise patient not to**	**1. Inform patient who wears contact lenses that clonidine may cause dry eyes.** **2. Instruct patient to consult prescriber if dry**	**1. Emphasize the importance of taking apixaban exactly as prescribed.** **2. Tell patient to alert all**	**1. Instruct patient to take furosemide at the same time each day to maintain therapeutic effects.** **2. Instruct patient to take**	**1. Instruct patient to take meloxicam with food or after me**

	stop taking quetiapine suddenly because doing so may exacerbate his symptoms or produce with-drawl symptoms. (2020 Nurse's Drug Handbook, 2020)	**mouth or drowsiness becomes a problem during oral clonidine therapy. (2020 Nurse's Drug Handbook, 2020)**	**prescribers to use of apixaban therapy before any invasive procedure, including dental work, is scheduled. (2020 Nurse's Drug Handbook, 2020)**	**the last dose of furosemide several hours before bedtime to avoid sleep interruption from diuresis. (2020 Nurse's Drug Handbook, 2020)**	**als if she has stomach upset. Alert patient to rare but serious skin reactions. Urge her to seek ummediate medical attention for blister, fever, itching, rash, or other indications of hypersensitivity. (2020 Nurse's Drug Handbook, 2020) 2.**

Hospital Medications (5 required)

Brand/ Generic	**Cardizem/ Diltiazem**	**Lovenox/ Enoxaparin**	**Guaifenesin/ Mucinex**	**Keppra/ Levetiracetam**	**Sertraline Hydrochlorid**

					e/ Zoloft
Dose	**30 mg**	**40 mg**	**600 mg**	**500 mg**	**1000 mg**
Frequency	**QID**	**Q12 hours**	**BID**	**Q12 hours**	**Daily**
Route	**Oral**	**Subq Injection**	**Oral**	**Oral**	**Oral**
Classification	**Calcium Channel Blocker, Antianginal (2020 Nurse's Drug Handbook, 2020)**	**Low-molecular-weight heparin, Anticoagulant (2020 Nurse's Drug Handbook, 2020)**	**Glyceryl guaiacolate, expectorant (2020 Nurse's Drug Handbook, 2020)**	**Beta2 agonist, bronchodilator (2020 Nurse's Drug Handbook, 2020)**	**Selective serotonin reuptake inhibitor (SSRI), antianxiety, antidepressant, antiobsessant, antipanic, antiposttraumatic stress, antipremenstrual dysphoric (2020 Nurse's Drug Handbook, 2020)**
Mechanism of Action	**Diltiazem inhibits calcium movement into coronary and vascular smooth-muscle cells by clocking slow calcium channels in cell membrane (2020 Nurse's Drug**	**Potentiates the action of antithrombin III, a coagulation inhibitor (2020 Nurse's Drug Handbook, 2020)**	**Increases fluid and mucus removal from the upper respiratory tract by increasing the volume of secretions and reducing their adhesiveness and surface tension (2020 Nurse's Drug Handbook, 2020)**	**Attaches to beta2 receptors on bronchial cell membrane, which stimulates the intracellular enzyme adenyl cyclase to convert adenosine triphosphate to cAMP. Increased intracellular cAMP level relaxes bronchial smooth**	**Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in nerve synapses. An elevated serotonin level may result in elevated mood and reduced depression**

	Handbook, 2020)			**muscle and inhibits histamine release from mast cells (2020 Nurse's Drug Handbook, 2020)**	**(2020 Nurse's Drug Handbook, 2020)**
Reason Client Taking	**Patient is taking the medication to control hypertension.**	**Patient is taking medication to prevent DVT.**	**Patient is taking medication to promote productive cough.**	**Patient is taking medication to treat the acute respiratory failure.**	**Patient is taking medication to treat anxiety disorder.**
Contraindications (2)	**1. Pulmonary edema 2. Systolic blood pressure below 90 mm Hg (2020 Nurse's Drug Handbook, 2020)**	**1. Active major bleeding 2. Pork products or their components (2020 Nurse's Drug Handbook, 2020)**	**1. Hypersensitivity to guaifenesin or its components 2. Significant uncontrolled high blood pressure (2020 Nurse's Drug Handbook, 2020)**	**1. Hypersensitivity to levalbuterol 2. Other sympathomimetic amines (2020 Nurse's Drug Handbook, 2020)**	**1. Concurrent use of disulfiram or pimozide 2. Hypersensitivity to sertraline or its components (2020 Nurse's Drug Handbook, 2020)**
Side Effects/Adverse	**1. AV block**	**1. Congestive**	**1. Dizziness 2. Nause**	**1. Arrhythmias 2. Asthm**	**1. Cerebrovascular**

Reactions (2)	**2. Heart failure (2020 Nurse's Drug Handbook, 2020)**	**Heart Failure 2. Hyperkalemia (2020 Nurse's Drug Handbook, 2020)**	**a and vomiting (2020 Nurse's Drug Handbook, 2020)**	**a exacerbation (2020 Nurse's Drug Handbook, 2020)**	**spasm 2. Neuroleptic malignant syndrome-like reaction (2020 Nurse's Drug Handbook, 2020)**
Nursing Considerations (2)	**1. Use diltiazem cautiously in patients with impaired hepatic or renal function. 2. Assess patient for sig**	**1. Don't give drug by I.M. injection. 2. Expect to give drug with aspirin to patient with unstable angina, STEMI, and non-Q-wave MI. (2020 Nurse's Drug Handbook,**	**1. Give liquid forms of guaifenesin to children, as prescribed and as appropriate 2. Watch for evidence of more serious condition, such as cough that lasts longer than 1 week, fever,**	**1. Use levalbuterol cautiously in patients with arrhythmias, diabetes mellitus, hypertension, hyperthyroidism, or a history of seizures. 2. Give oral solution form only by nebulizer. (2020 Nurse's Drug**	**1. Be aware that sertraline should not be given to patient with bradycardia, congenital long QT syndrome, hypokalemia or hypomagnesemia, recent acute myocardial infarction, or uncom**

	ns and symptoms of heart failure (2020 Nurse's Drug Handbook, 2020)	**2020)**	**persistent headache, and rash. (2020 Nurse's Drug Handbook, 2020)**	**Handbook, 2020)**	**pensated heart failure because of increasing risk of prolonged QT interval and torsades de pointes** **2. Monitor liver enzyme and BUN and serum creatinine levels (2020 Nurse's Drug Handbook, 2020)**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor liver and renal function, as appropriate. (2020 Nurse's Drug Handbook, 2020)**	**Watch closely for bleeding Check serum potassium for elevation. Test stool for occult blood. (2020 Nurse's Drug Handbook, 2020)**	**Watch for prolonged cough that lasts longer than a week, fever, rash, and persistent headache. (2020 Nurse's Drug Handbook, 2020)**	**Observe dyspnea, increased coughing and wheezing. Monitor blood pressure and pule rate before and after nebulizer treatment. (2020 Nurse's Drug Handbook, 2020)**	**Monitor liver enzymes and BUN and serum creatinine levels, as appropriate, in patients with hepatic or renal dysfunction (2020 Nurse's Drug Handbook, 2020)**

Client Teaching needs (2)	**1. Explain that capsules and ER tablets must be swallowed whole. 2. Urge patient to report chest pain, difficulty breathing, dizziness, fainti**	**1. Emphasize the importance of complying with follow-up visits with prescriber. 2. Caution patient not to rub the site after giving the injection to minimize bruising. (2020 Nurse's Drug Handbook, 2020)**	**1. Instruct patient to take each dose with a full glass of water. 2. Tell patient to increase fluid intake to help thin secretions. (2020 Nurse's Drug Handbook, 2020)**	**1. Teach patient how to use levalbuterol nebulizer and to measure correct dose. 2. Show patient how to clean nebulizer or inhaler, and explain the need to do so at least once weekly. (2020 Nurse's Drug Handbook, 2020)**	**1. Advise patient with a latex sensitivity to use an alternate dispenser because the supplied dropper dispenser contains dry natural rubber 2. Tell patient to take dose immediately after mixing it. (2020 Nurse's Drug Handbook, 2020)**

	ng, irregular heartbeat, rash, or swollen ankles. (2020 Nurse's Drug Handbook, 2020)				

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurse's Drug Handbook.*

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient was alert and oriented to person, place, time, and situation. Patient was not showing signs of distress and was clean and appropriate for the situation.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:**	**The patient's skin color was normal for ethnicity, Caucasian. Her skin was warm, dry, and intact. Patient's skin was elastic, and less than 3 seconds for tenting. The patient had generalized bruising on the arms. Patient had a pressure injury on the right posterior thigh. Patient had no signs of rashes. Braden score**

Wounds: . **Braden Score:** **Drains present: Y☐ N ☒** **Type: N/A**	**for the patient was 14, which places her at a high risk for pressure ulcers.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Patient's head and neck were symmetrical and no deviation. The trachea was midline. The patient's eyes were PERRLA. There was no deviated septum, equal turbinates, bilateral. The oral mucosa was pink, moist, and intact, with no teeth showing signs of decay.**
CARDIOVASCULAR: **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:**	**S1 and S2 were heard with normal sinus rhythm. No presence of S3 or S4. No murmur was present. Patient's radial pulses were +2 bilaterally. Patient's pedal pulses were +2 bilaterally. Cap refill was less than 3 seconds bilaterally in both radial and pedal pulses. Patient presented with edema located in the hands, feet, and lower extremities, bilaterally, which was +2. Patient had no neck vein distention.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	**Patient's breath sounds were regular, clear, and diminished were heard anterior and posterior all lobes bilaterally. Patient had no accessory muscle usage. Patient did not have an ET tube placed. The patient had a tracheostomy placed at the time of care. The tracheostomy was a size 6. The respiratory rate was set to 16 breaths per minute. FiO2 was set to 30%. Total volume was set to 450. The tracheostomy was on 3 liters of oxygen. VAP prevention measure include provide excellent oral care every 2 hours or as needed, suctioning the tracheostomy as needed or every 2 hours, and maintain optimal positioning.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:**	**Patient's diet at home was a regular diet. The current diet is also regular during stay at the hospital. Patient's height was 154.9 cm and weight is 123 kg. Patient had hyperactive bowel sounds in all four quadrants. Patient's last bowl movement was 3/28/22 during clinical. Upon palpating the patient's abdomen there was no masses, distention, drains, or pain. Patient has a past surgical history of gastric bypass, cholecystectomy,**

Incisions: **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size: N/A** **Feeding tubes/PEG tube Y ☐ N ☒** **Type: N/A**	**diaphragmatic hernia repair, small intestine surgery, and tracheostomy. Patient has scars present from previous surgeries. The patient did not present with an ostomy, nasogastric, or feeding tube/ PEG tube.**
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:**	**Patient's urine was clear and yellow. Patient had voided 1500 mL during clinical shift. Patient did not show signs of pain with urination. Patient is not on dialysis. Patient's genitals were normal for ethnicity. Patient had a catheter in place. The catheter size was one size and it was an external catheter. CAUTI prevention measures includes handwashing, barrier precautions such as sterile gloves, drape, sponges, antiseptic solution, and ingle use lubricant, proper care of catheters, and remove any unnecessary catheters.**
MUSCULOSKELETAL: **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☐**	**Patient has a history of multiple falls. Patient had difficulty being able to move the lower extremities, bilaterally. Patient was able to perform range of motion with the upper extremities, bilaterally. Patient was weak overall. Patient has been using a Hoyer lift to move between the bed and chair. Patient is considered a high fall risk due to having a history of falls and being weak overall. Patient's fall risk score was 70. Patient is not up ad lib. Patient needs full assistance with equipment and ADLs. Patient is not able to stand or walk.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**SS speaks English as a primary language and responds appropriately for age. MAEW was present. PERLA was present. SS strength is equal bilaterally in all extremities. SS mental status is appropriate for age. SS sensory and level of consciousness are present. Orientation is A/O x4.**
PSYCHOSOCIAL/CULTURAL:	**SS was calm and cooperative during time of**

Coping method(s): **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**assessment. SS stated that her religion was Catholic. The patient stated that she goes to church to be closer to the lord. SS stated that she lives in the Champaign area by herself. She has two sons, one lives in Florida and the other one lives right around the block from her. The son that lives around the block from her is her biggest support system.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0922	82 beats per minute	124/58 mmHg	26 breathes per minute	36.5 degrees C (97.7 degrees F)	97% O2 on 3 Liters via tracheostomy
1022	76 beats per minute	120/59 mmHg	25 breathes per minute	36.6 degrees C (97.9 degrees F)	95% O2 on 3 Liters via tracheostomy

Vital Sign Trends/Correlation:

Patient's vital signs remained stable throughout the clinical. Patient's blood pressure was within normal limits on the systolic, but the diastolic was low with the numbers being in the upper fifties. The pulse rate and temperature were within normal limits. Oxygen level is within normal limits with the patient having a tracheostomy on 3 liters of oxygen. The patient's respirations were 25 and 26 breaths per minute, the settings for the tracheostomy were set to 16 breaths per minute.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0922	**Flacc**	**N/A**	**0 out of 10**	**N/A**	**N/A**
1022	**Flacc**	**N/A**	**0 out of 10**	**N/A**	**N/A**

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:**	Patient did not have any peripheral IVs.
Other Lines (PICC, Port, central line, etc.)	PICC Line (Saline Lock)
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☒ N ☐** **CLABSI prevention measures:**	Triple Lumen Central Line 5 French Right Occipitoanterior Position (ROA) 3/09/2022 PICC line is patent, flushed easily, and blood return was assessed from PICC. Patient showed no signs of erythema, drainage, or pain at sight of PICC line. Patient dressing is clean, dry, and intact. 3/24/2022 CLABSI prevention measures include, perform hand hygiene, apply appropriate skin antiseptic, use all five maximal sterile barrier precautions: sterile gloves, sterile gown, cap, and mask, ensure the skin prep agent has completely drived before inserting the central line, and CUROS caps.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Fluid Intake: 720 mL	**Urine: 1500 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: During the shift, the patient stayed in bed. The patient had a tracheostomy placed on 3/1/2022. The patient had a PICC line triple lumen in the right upper arm, the PICC was saline locked. The PICC line was patent, flushed easily, and showed no signs of erythema or drainage from the line. A CUROS cap placed back over the central line for CLABSI prevention measures. The patient was given morning medications orally in applesauce. The patient is still being weaned off the ventilator settings. The plan for discharge was still being processed for the patient.

Procedures/testing done: No procedures or tests performed.

Complaints/Issues: Patient did not state any complaints or issues during time of care.

Vital signs (stable/unstable): Patient's vital signs were stable for the shift. The patient's heart rate was 82 and 76 during the shift. Respirations remained high, but stable with being 26 and 25 breathes per minute. Patient's temperature remained stable the shift of being 36.5 and 36.7 degrees Celsius. The patient's oxygen saturation remained at 97% and 95% for both times the vitals were taken. The patient's blood pressure was 124/58 mmHg during the first set of vitals and 120/59 mmHg for the second set of vitals, the blood pressure was stable with the diastolic being on the low side.

Tolerating diet, activity, etc.: Patient is tolerating the regular diet and bedrest with period of using the Hoyer lift to get up in the chair.

Physician notifications: The physician last discussed about getting the patient into long term care or rehabilitation to regain strength and be able to go back home.

Future plans for client: Future plans have not yet been discussed yet for the patient, other than either longer term care or rehabilitation.

Discharge Planning (2 points)

Discharge location: The hospital is looking for placement for the patient at the moment. The patient has been denied long term care from several facilities. The hospital is looking into rehabilitation for the patient as well.

Home health needs (if applicable): Not yet known for this patient.

Equipment needs (if applicable): Not yet know for this patient.

Follow up plan: The patient will remain in the CCU until placement has been found, so that the patient can be monitored. The patient will continue to be weaned from the ventilator settings.

Education needs: When the patient is ready for discharge the patient will be educated on trach care, equipment needs if needed, and appointments needed by primary care provider or specialist if needed.

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. **Ineffective airway clearance related to the patient having acute respiratory failure as evidence by the patient having a tracheostomy (Gulanick & Myers, 2017).**	**The nursing diagnosis was chosen because the patient is at risk for ineffective airway clearance due to the patient having a tracheostomy.**	**1.Maintain humidified oxygen as prescribed.** **2.Assess respiratory rate, rhythm, and depth. (Gulanick & Myers, 2017)**	**1. The patient's airway will remain patent. (Gulanick & Myers, 2017)**	**The nurse will perform tracheostomy care every 2 hours or PRN, and suctioning if needed. (Gulanick & Myers, 2017)**
2. **Ineffective breathing pattern related to respiratory muscle fatigue as evidenced by the patient stating they were short of breath when going to an outside facility for assistance (Gulanick & Myers, 2017).**	**The nursing diagnosis was chosen because the patient has ineffective breathing patterns due to having a tracheostomy.**	**1. Assess respiratory rate, rhythm, and depth.** **2.Assess for use of accessory muscles. (Gulanick & Myers, 2017)**	**1. The patient's respiratory rate will stay within reasonable range. (Gulanick & Myers, 2017)**	**The nurse monitored the patient's respiratory status as needed or per facility protocol. (Gulanick & Myers, 2017)**
3. **Impaired gas exchange related to patient being short of breath as evidenced by the patient's oxygen saturation being the 70s (Gulanick &**	**The nursing diagnosis was chosen because the patient had a decrease in oxygen level and increase in carbon dioxide.**	**1.Assess for restlessness and changes in level of consciousness.** **2. Monitor for changes in BP and HR. (Gulanick & Myers, 2017)**	**1. The patient's oxygen level will stay above 92%. (Gulanick & Myers, 2017)**	**The nurse monitored the patient's oxygen level status as needed or per facility protocol. (Gulanick & Myers, 2017)**

Myers, 2017)				
4. Risk for aspiration related to patient having a tracheostomy evidenced by swallow evaluation showing concerns of dysphagia (Gulanick & Myers, 2017)	The nursing diagnosis was chosen because the patient has a tracheostomy and is at risk for aspirating.	1.Monitor level of consciousness. 2. In the patients with tracheostomies, observe for food particles in tracheal secretions. (Gulanick & Myers, 2017)	1. The patient's tracheostomy will remain free of food particles in the secretions. (Gulanick & Myers, 2017)	The nurse will observe the tracheostomy tube to ensure no food particles in the tube before the patient eats. (Gulanick & Myers, 2017)
5. Deficient knowledge related to the patient having a tracheostomy as evidence by the patient not knowing how to care for a tracheostomy. (Gulanick & Myers, 2017)	The nursing diagnosis was chosen because the patient has a decrease knowledge in how to take care of her condition.	1.Instruct the patient in preventive measures as appropriate. 2.Explain the necessity of oxygen therapy, including its limitations. (Gulanick & Myers, 2017)	1. The patient will verbalize understanding of the disease process, procedures, and treatments. (Gulanick & Myers, 2017)	The nurse is educating the patient on their condition, medications being received in the hospital, and the labs that are performed. (Gulanick & Myers, 2017)

Other References (APA):

Gulanick, M., & Myers, J. L. (2017). *Nursing Care Plans*. Elsevier Gezondheidszorg.

Concept Map (20 Points):

Subjective Data

Patient on February 8, 2022, presented to an outside facility with shortness of breath severe intensity while ambulating that only decreased with rest that started over the weekend. Patient had a decrease oxygen level that was stating in the 70s.

Nursing Diagnosis/Outcomes

1. Ineffective airway clearance related to the patient having acute respiratory failure as evidence by the patient having a tracheostomy (Gulanick & Myers, 2017).

The patient's airway will remain patent. (Gulanick & Myers, 2017)
The nurse will perform tracheostomy care every 2 hours or PRN and suctioning if needed. (Gulanick & Myers, 2017)

2. Ineffective breathing pattern related to respiratory muscle fatigue as evidenced by the patient stating they were short of breath when going to an outside facility for assistance (Gulanick & Myers, 2017).

The patient's respiratory rate will stay within reasonable range. (Gulanick & Myers, 2017)
The nurse monitored the patient's respiratory status as needed or per facility protocol. (Gulanick & Myers, 2017)

3. Impaired gas exchange related to patient being short of breath as evidenced by the patient's oxygen saturation being the 70s (Gulanick & Myers, 2017)

The patient's oxygen level will stay above 92%. (Gulanick & Myers, 2017)
The nurse monitored the patient's oxygen level status as needed or per facility protocol. (Gulanick & Myers, 2017)

4. Risk for aspiration related to patient having a tracheostomy evidenced by swallow evaluation showing concerns of dysphagia . (Gulanick & Myers, 2017)

The patient's tracheostomy will remain free of food particles in the secretions. (Gulanick & Myers, 2017)
The nurse will observe the tracheostomy tube to ensure no food particles in the tube before the patient eats. (Gulanick & Myers, 2017)

5. Deficient knowledge related to the patient having a tracheostomy as evidence by the patient not knowing how to care for a tracheostomy. (Gulanick & Myers, 2017)

The patient will verbalize understanding of the disease process, procedures, and treatments. (Gulanick & Myers, 2017)
The nurse is educating the patient on their condition, medications being received in the hospital, and the labs that are performed. (Gulanick & Myers, 2017)

Objective Data

Patient's vitals were B/P: 124/58 mmHg, 120/57 mmHg. Pulse was 82 beats per minute and 76 beats per minute. Temperature was 36.5 C and 36.6 C. Respirations 25 and 26 breaths per minute. Oxygen was 97% and 95% through a tracheostomy on 3 liters of oxygen. Patient had labs drawn: Hgb, Hct, Platelets, WBC, neutrophils, lymphocytes, monocytes, eosinophils, CO2, glucose, albumin, calcium, bilirubin, pH, PaO2. Patient diagnostics, chest x-ray and CT scan.

Client Information

A 65 year old Caucasian widowed female, who presented to an outside facility with shortness of breath with severe intensity while ambulating that started a week prior. Patient has an allergy to Cholaxin, diuretics, morphine, and Percocet. Patient denies use of alcohol, drugs, and tobacco. Patient has a medical history of acute respiratory failure with tracheostomy.

Nursing Interventions

1. Maintain humidified oxygen as prescribed.
2. Assess respiratory rate, rhythm, and depth.

(Gulanick & Myers, 2017)

3. Assess respiratory rate, rhythm, and depth.
4. Assess for use of accessory muscles.

(Gulanick & Myers, 2017)

5. Assess for restlessness and changes in level of consciousness.
6. Monitor for changes in BP and HR.

(Gulanick & Myers, 2017)

7. Monitor level of consciousness.
8. In the patients with tracheostomy, assess for and treat excessive tracheal secretions. (Gulanick & Myers, 2017)
9. Instruct the patient in preventive measures as appropriate.
10. Explain the necessity of oxygen therapy, including its limitations.

(Gulanick & Myers, 2017)