N431 Care Plan #1

Lakeview College of Nursing

Chelsea Grubb

Demographics (3 points)

Date of Admission 09/12/22	Client Initials C. H.	Age 21	Gender Male
Race/Ethnicity White	Occupation Unemployed	Marital Status Single	Allergies maxipime (Cefepime)
Code Status Full code	Height 3'11"	Weight 76 lbs	

Medical History (5 Points)

Past Medical History: Meningitis, mixed development disorder, myopia, asthma, autism, cerebral palsy, child maltreatment syndrome, down syndrome, blind bilaterally, deaf bilaterally, type 2 diabetes mellitus, and seasonal allergies.

Past Surgical History: Myringotomy with tubes, bilateral club feet surgery, tonsillectomy and adenoidectomy (unknown dates to all past surgical history).

Family History: Unknown family history due to patient being a ward of the state.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): No current tobacco/alcohol or drug use.

Assistive Devices: Patient has a wheelchair.

Living Situation: Patient lives at Swann in Champaign since the age of 12 years old.

Education Level: Patient has severe mental impairment and developmentally delayed speech.

Admission Assessment

Chief Complaint (2 points): Client was brought in due to difficulty breathing.

History of Present Illness – OLD CARTS (10 points): The patient is unable to provide a H&P due to being intubated and severe mental impairment at a non-verbal baseline. The patient was brought in today with difficulty breathing that started on 9/12/22. Patient is

unable to provide the location, characteristics, associated/aggravating factors. A Swann's caretaker provided details on trying to treatment options by setting the patient up more however this option did not seem to work. The Swann's employee said as soon as they realized the patient was not breathing, they called 911. The breathing was so irregular the severity of this made the Swann's team member immediately dial 911 to dispatch the ambulance.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute respiratory failure with hypoxia.

Secondary Diagnosis (if applicable): There was not a secondary diagnosis for this patient.

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

The illness known as respiratory failure occurs when either one or both of the respiratory system's two gas exchange processes—oxygenation and carbon dioxide elimination—fail. It can be categorized as either hypoxemic or hypercapnic in real life. Respiratory failure is when the lungs do not work well enough to carry out routine duties and support typical activities (Villgran et al., 2022). There are numerous reasons why the lungs cannot efficiently transfer oxygen into circulation and remove carbon dioxide from the blood, making respiratory failure a complex disorder (known as a gas exchange). To improve breathing and quality of life, the cause must be found, and proper therapy or respiratory rehabilitation must be obtained (Villgran et al., 2022). Respiratory failure results when the capillaries, or tiny blood vessels surrounding the air sacs, cannot adequately exchange carbon dioxide for oxygen. Acute or chronic conditions are both possible.

When there is acute respiratory failure, the body does not get enough oxygen, which causes instant symptoms. In most cases, if this failure is not addressed swiftly, it could result in death. The reason, blood oxygen, carbon dioxide levels, and symptoms of respiratory failure all affect how the patient feels. The inability to breathe in enough air and shortness of breath are both signs of low blood oxygen levels. The fingernails, skin, and lips could all be blue in hue. Rapid breathing and confusion can occur when there is a high carbon dioxide level (Capriotti & Frizzell, 2020). Those who experience respiratory failure can lose consciousness or become extremely tired. Arrhythmia may also exist in them (irregular heartbeat). If the brain and heart are not getting enough oxygen, the patient can experience these symptoms.

Various methods, including physical examination and ABGS, may identify respiratory failure. The patient can look for a bluish hue on the skin, lips, and fingernails while listening to the lungs for odd noises. A tiny pulse oximeter sensor determines how much oxygen is in the blood. The sensor can be placed on the ear or the tip of the finger (Capriotti & Frizzell, 2020). An arterial blood gas analysis is a test to determine the blood's levels of carbon dioxide and oxygen. Treatment is different between different patients and the level of severity. Oxygen therapy is a good start when treating this condition. The patient can modify oxygen therapy to reduce respiratory issues and improve the quality of life. The patient can live with respiratory failure through pulmonary rehabilitation, which offers education and counseling (Capriotti & Frizzell, 2020).

Pathophysiology References (2) (APA): Capriotti, T. & Frizzell, J.P. (2020).

Pathophysiology: Introductory Concepts and Clinical Perspectives. **(2nd ed.). F.A.**

Davis Company.

Villgran, V. D., Lyons, C., Nasrullah, A., Clarisse Abalos, C., Bihler, E., Alhajhusain, A.

(2022). Acute respiratory failure. *Critical Care Nursing Quarterly,* **45(3), 233-247.**

https://dx.doi.org/10.1097/CNQ.0000000000000408

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	**4.6 m/uL-6.0 m/uL**	**4.7 m/uL**	**N/A**	**Within normal range.**
Hgb	**13.8 g/dL-18 g/uL**	**11.4 g/dL**	**N/A**	**Nutritional deficiency due to low weight causing hemoglobin levels to decline (Kee, 2018).**
Hct	**40%-54%**	**36.0%**	**N/A**	**Decreased hematocrit levels due to dietary deficiency (Kee, 2018).**
Platelets	**150,000 uL-400,000 uL**	**340,000 uL**	**N/A**	**Within normal range.**
WBC	**4.5 uL-10.0 uL**	**7.97 uL**	**N/A**	**Within normal range.**
Neutrophils	**55 uL-70 uL**	**63 uL**	**N/A**	**Within normal range.**
Lymphocytes	**20 uL-40 uL**	**20.8 uL**	**N/A**	**Within normal range.**
Monocytes	**2 uL-8 uL**	**4.2 uL**	**N/A**	**Within normal range.**
Eosinophils	**1 uL-4 uL**	**1 uL**	**N/A**	**Within normal range.**
Bands	**50%-65%**	**N/A**	**N/A**	**Not completed on this admission.**

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135 mEq/L-145 mEq/L	142 mEq/L	N/A	Within normal range.
K+	3.5 mEq/L-5.3 mEq	4.1 mEq/L	N/A	Within normal range.
Cl-	95 mEq/L-105 mEq/L	101 mEq/L	N/A	Within normal range.
CO2	22 mEq/L-30 mEq/L	<mark>21.0 mEq/L</mark>	N/A	<mark>Decreased CO2 levels due to respiratory failure (Kee, 2018).</mark>
Glucose	70 mg/dL-110 mg/dL	244 mg/dL	N/A	Within normal range.
BUN	5 mg/dL-25 mg/dL	17 mg/dL	N/A	Within normal range.
Creatinine	0.5 mg/dL-1.2 mg/dL	0.91 mg/dL	N/A	Within normal range.
Albumin	3.5 g/dL-5.0 g/dL	<mark>3.1 g/dL</mark>	N/A	<mark>Decreased albumin levels due to inadequate nutritional intake (Kee, 2018).</mark>
Calcium	4.5 mEq/L-5.5 mEq/L	5.4 mEq/L	N/A	Within normal range.
Mag	1.5 mEq/L-2.5 mEq/L	1.7 mEq/L	N/A	Within normal range.
Phosphate	1.7 mEq/L-2.6 mEq/L	2.1 mEq/L	N/A	Within normal range.
Bilirubin	0.1 mg/dL-1.2 mg/dL	0.3 mg/dL	N/A	Within normal range.
Alk Phos	40 units/dL-12 units/dL	88 units/dL	N/A	Within normal range.
AST	0-35 units/L	N/A	N/A	Not completed on this admission.
ALT	7-55 units/L	N/A	N/A	Not completed on this admission.
Amylase	60-120 units/L	N/A	N/A	Not completed on this admission.
Lipase	0-160 units/L	6.1 units/L	N/A	Within normal range.

Lactic Acid	5-20 mg/dL	6.9 mg/dL	N/A	Within normal range.
Troponin	< 0.1 ng/mL	N/A	N/A	Not completed on this admission.
CK-MB	< 5.0 ng/mL	N/A	N/A	Not completed on this admission.
Total CK	5-25 IU/L	N/A	N/A	Not completed on this admission.

Other Tests <mark>Highlight All Abnormal Labs</mark>—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	< 1.1	N/A	N/A	Not completed on this admission.
PT	11-13.5	N/A	N/A	Not completed on this admission.
PTT	25 seconds-35 seconds	N/A	N/A	Not completed on this admission.
D-Dimer	< 0.50 ng/mL	N/A	N/A	Not completed on this admission.
BNP	6-20 mg/dL	N/A	N/A	Not completed on this admission.
HDL	< 40 ng/dL	N/A	N/A	Not completed on this admission.
LDL	< 100 mg/dL	N/A	N/A	Not completed on this admission.
Cholesterol	< 200 mg/dL	N/A	N/A	Not completed on this admission.
Triglycerides	< 150 mg/dL	N/A	N/A	Not completed on this admission.
Hgb A1c	< 5.7%	N/A	N/A	Not completed on this admission.
TSH	0.5-5.0 mIU/L	N/A	N/A	Not completed on this admission.

Urinalysis <mark>Highlight All Abnormal Labs</mark>—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	Light straw-dark amber	N/A	N/A	Not completed on this admission.

pH	4.5-8.0	N/A	N/A	Not completed on this admission.
Specific Gravity	1.005-1.030	N/A	N/A	Not completed on this admission.
Glucose	Negative	N/A	N/A	Not completed on this admission.
Protein	2 mg/dL-8 mg/dL	N/A	N/A	Not completed on this admission.
Ketones	Negative	N/A	N/A	Not completed on this admission.
WBC	Negative	N/A	N/A	Not completed on this admission.
RBC	Negative	N/A	N/A	Not completed on this admission.
Leukoesterase	Negative	N/A	N/A	Not completed on this admission.

Arterial Blood Gas <mark>Highlight All Abnormal Labs</mark>—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	<mark>7.28</mark>	N/A	<mark>Decreased pH levels due to respiratory depression (Kee, 2018).</mark>
PaO2	75-100 mmHg	43	N/A	Within normal range.
PaCO2	35-45 mmHg	45.9	N/A	Within normal range.
HCO3	22-26 mEq/L	<mark>21.3</mark>	N/A	<mark>Decreased HCO3 levels due to hyperventilation (Kee, 2018).</mark>
SaO2	95%-100%	95%	N/A	Within normal range.

Cultures <mark>Highlight All Abnormal Labs</mark>—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	N/A	N/A	
Blood Culture	Negative	N/A	N/A	Not completed on this admission.
Sputum Culture	Normal URT	N/A	N/A	Not completed on this admission.
Stool Culture	Normal intestinal flora	N/A	N/A	Not completed on this admission.

Lab Correlations Reference (1) (APA): Kee, J. L. F. (2018). *Pearson Handbook of*

Laboratory & Diagnostic Tests with Nursing Implications **(8ᵗʰ Ed.). Pearson.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Patient got a chest x-ray. Patient has never gotten a

chest x-ray for this condition before. The patient received a chest x-ray to determine where

on the lungs is the disease and possibly why.

Diagnostic Test Correlation (5 points): A chest x-ray allows the provider more detail of the

lungs if there is fluid or any nodules on the lungs or chest cavity. The impression of the

chest x-ray was significant showing patchy airway disease on both lobes. The right lobe has

small nodules.

Diagnostic Test Reference (1) (APA): Pagana, K.D., & Pagana, T. J., Pagana, T. N. (2018).

Mosby's Manual of Diagnostic and Laboratory Test Reference **(14ᵗʰ Ed.). Mosby.**

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

Home Medications (5 required)

Brand/Generic	Tylenol (acetaminophen)	ProAir albuterol HFA (albuterol sulfate)	Benadryl (diphenhydramine hydrochloride)	Singulair (montelukast)	Enoxaparin sodium (Lovenox)
Dose	325 mg	90 mcg	25 mg	5 mg	20 mg
Frequency	Every 4 hours or PRN	Every 4 hours or PRN	PRN	Once daily	Every 24 hours
Route	PO	PO (inhalant)	PO	PO	Subcutaneous
Classification	Pharmacological class: non salicylate, para-aminophenol derivative Therapeutic class: antipyretic, nonopioid analgesic	Pharmacological class: adrenergic Therapeutic class: bronchodilator	Pharmacological class: antihistamine Therapeutic class: antianaphylaxis adjunct	Pharmacological class: leukotriene receptor antagonist Therapeutic class: antiallergen	Pharmacologic class: Low-molecular-weight heparin Therapeutic class: Anticoagulant
Mechanism of Action	Blocks the formation of prostaglandins and interferes with the peripheral nervous system's ability to produce pain impulses by inhibiting the enzyme cyclooxygen	The intracellular enzyme adenylate cyclase is stimulated when albuterol binds to beta2 receptors on bronchial cell membranes, turning adenosine triphosphate into cyclic adenosine	Binds to the central and peripheral H1 receptors, displacing histamine from the areas where it acts by competing for these receptors (Jones & Bartlett Learning, 2020).	Inhibits the production of cysteine leukotrienes, which are released by eosinophils, mast cells, and other cells as a result of the metabolism of arachidonic acid (Jones & Bartlett Learning,	By interacting with antithrombin III, enoxaparin potentiates the effect of antithrombin III, a coagulation inhibitor. Enoxaparin rapidly binds to and

	ase (Jones & Bartlett Learning, 2020).	monophospha te (Jones & Bartlett Learning, 2020).		2020).	inactivates clotting factors (primary factor Xa and thrombin). Fibrinogen cannot convert to fibrin without thrombin, and clots cannot form without it (Jones & Bartlett Learning, 2020).
Reason Client Taking	**Pain**	**Shortness of breath**	**Seasonal allergies**	**Asthma**	**To prevent DVT**
Contraindicati ons (2)	**The two contraindic ations are hepatic toxicity and hypersensiti vity to this drug (Jones & Bartlett Learning, 2020).**	**Hypersensitiv ity to albuterol or adverse bronchoconst riction (Jones & Bartlett Learning, 2020).**	**Hypersensiti vity to diphenhydra mine and adverse reactions may occur (Jones & Bartlett Learning, 2020).**	**Hypersensit ivity to montelukas t and decreased peripheral circulation (Jones & Bartlett Learning, 2020).**	**Active major bleeding, and hypersensi tivity to benzyl alcohol (Jones & Bartlett Learning, 2020).**
Side Effects/Advers e Reactions (2)	**Agitation and dyspnea (Jones & Bartlett Learning, 2020).**	**Respiratory arrest or bronchoconst riction (Jones & Bartlett Learning, 2020).**	**Dizziness and tachycardia (Jones & Bartlett Learning, 2020).**	**Cough and tachycardia (Jones & Bartlett Learning, 2020).**	**Bloody stools, and dyspnea (Jones & Bartlett Learning, 2020).**
Nursing	**Ensure the**	**Monitor**	**Never take**	**Monitor**	**Use**

Considerations (2)	patient is getting an adequate dosing based on his low weight and assessing vitals one hour after giving medication (Jones & Bartlett Learning, 2020).	serum potassium levels and drug tolerance may occur (Jones & Bartlett Learning, 2020).	another form of antihistamine with his medication and educate caretaker on the withdraw effect if taken for a long period of time (Jones & Bartlett Learning, 2020).	the patient for adverse effects and assess before giving the medication (Jones & Bartlett Learning, 2020).	caution in patients that are a high fall risk and have bleeding precautions (Jones & Bartlett Learning, 2020).
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	The nurse should obtain an AST and ALT level. Assess the patients pain and vitals (Jones & Bartlett Learning, 2020).	Assessing patients breathing habits and response to the inhalant (Jones & Bartlett Learning, 2020).	Assess the patient's vitals and response to this drug (Jones & Bartlett Learning, 2020).	Assess the patients vitals and skin (Jones & Bartlett Learning, 2020).	Assessing the patient's injection sites and assessing patient's vitals (Jones & Bartlett Learning, 2020).
Client Teaching Needs (2)	Teach the caretaker to only have the client take medication as prescribed by provider and never to exceed maximum dosage (Jones & Bartlett	Advise the caretaker to shake the canister before administering, and there is no priming required before administering (Jones & Bartlett Learning, 2020).	Advise the caretaker to take with food and put sunscreen on the patient if taking the patient outside due to photosensitivity (Jones & Bartlett Learning, 2020).	Advise the caretaker to watch closely for abnormal behaviors and take with food (Jones & Bartlett Learning, 2020).	The nurse will always rotate sites, and that it might sting while being injected (Jones & Bartlett Learning, 2020).

	Learning, 2020).				

Hospital Medications (5 required)

Brand/Generic	Motrin (ibuprofen)	Dulcolax (bisacodyl)	NovoLog (insulin aspart)	Humulin R (human insulin)	Versed (midazolam hydrochloride)
Dose	650 mg	10 mg	Sliding scale	Sliding scale	5 mg
Frequency	Every 4 hours	PRN	Every 4 hours	PRN	PRN
Route	Rectally	Rectally	Subcutaneous	IV	IV push
Classification	Pharmacologic class: NSAID Therapeutic class: analgesic	Pharmacologic class: stimulant laxative Therapeutic class: laxative	Pharmacologic class: human insulin Therapeutic class: antidiabetic	Pharmacologic class: human insulin Therapeutic class: antidiabetic	Pharmacologic class: benzodiazepine Therapeutic class: sedative-hypnotic
Mechanism of Action	Blocks the activity of cyclooxygenase, an enzyme required for the synthesis of prostaglandins, the mediators of inflammatory response that result	As a result of bisacodyl's stimulation of adenylate cyclase and subsequent rise in cyclic AMP, chloride and bicarbonate are actively transported outside of	The heterotetrametric protein insulin receptor (IR), which has two extracellular alpha units and two transmembrane beta units, binds to insulin aspart.	Humulin reduces blood sugar via decreasing hepatic glucose synthesis and promoting peripheral glucose absorption by skeletal muscle and	Gamma-aminobutyric acid (GABA), one of the main inhibitory neurotransmitters in the central nervous system, is the mechanism by which benzodiazepines, such as

	in localized inflammation, discomfort, edema, and vasodilation (Jones & Bartlett Learning, 2020).	cells. While sodium and chloride ions cannot be reabsorbed, water, potassium, and salt ions passively leave the cell (Jones & Bartlett Learning, 2020).	Tyrosine kinase activity that is inherent to the beta subunit of the receptor is stimulated by the binding of insulin to the alpha subunit of IR (Jones & Bartlett Learning, 2020).	fat. Insulins promote protein synthesis while inhibiting lipolysis and proteolysis (Jones & Bartlett Learning, 2020).	midazolam, exert their effects. The sedative effects of benzodiazepines include the relaxation of skeletal muscles, induction of sleep, anesthesia, and forgetfulness, as well as an increase in GABA activity. When benzodiazepines bind to the benzodiazepine site on GABA-A receptors, the frequency of chloride channel opening increases, potentiating the effects of GABA (Jones & Bartlett Learning, 2020).
Reason Client Taking	**Elevated temperature and pain**	**Constipation**	**Hyperglycemia**	**Hyperglycemia**	**Agitation**
Contraindications (2)	**Asthma and bronchospa**	**Hypersensitivity and rectal**	**Hypoglycemia and adverse**	**Hypoglycemia and adverse**	**Hypersensitivity to this medication**

	sm (Jones & Bartlett Learning, 2020).	bleeding (Jones & Bartlett Learning, 2020).	reaction to medication (Jones & Bartlett Learning, 2020).	reaction to medication (Jones & Bartlett Learning, 2020).	and increased agitation (Jones & Bartlett Learning, 2020).
Side Effects/Adverse Reactions (2)	**Dyspnea and wheezing (Jones & Bartlett Learning, 2020).**	**Abdominal discomfort and muscle weakness (Jones & Bartlett Learning, 2020).**	**Hypoglycemia and hypokalemia Hypoglycemia and adverse reaction to medication (Jones & Bartlett Learning, 2020).**	**Hypoglycemia and hypokalemia Hypoglycemia and adverse reaction to medication (Jones & Bartlett Learning, 2020).**	**Trouble breathing and vomiting (Jones & Bartlett Learning, 2020).**
Nursing Considerations (2)	**The two nursing considerations are monitoring patients' hepatic levels and monitoring the patient electrolyte, and renal levels (Jones & Bartlett Learning, 2020).**	**May lead to hypokalemia and may cause abdominal pain and cramps (Jones & Bartlett Learning, 2020).**	**Monitor body weight over time or may cause decreased inorganic phosphates, potassium, and magnesium (Jones & Bartlett Learning, 2020).**	**Determine the level of activity, including the quantity and intensity of exercise that can affect serum glucose levels, the requirement for these medications, and assess vital signs (Jones & Bartlett Learning, 2020).**	**Have flumazenil on hand for the antidote in case of accidental overdose and assess vitals (Jones & Bartlett Learning, 2020).**
Key Nursing Assessment(s)/	**Assessing the patients**	**Monitor fluid and**	**Assess for symptoms**	**Assess for the**	**Monitor patients**

Lab(s) Prior to Administration	pain rating and assessing vitals (Jones & Bartlett Learning, 2020).	electrolyte levels, assess or abdominal distention (Jones & Bartlett Learning, 2020).	related to hypoglycemia (Jones & Bartlett Learning, 2020).	common symptoms of hypoglycemia (Jones & Bartlett Learning, 2020).	vitals and assess level of sedation 2-6 hours after administration (Jones & Bartlett Learning, 2020).
Client Teaching Needs (2)	Teach the client to take with meals to limit stomach discomfort and taking only the advised dosage (Jones & Bartlett Learning, 2020).	Teach the caretaker to only take as directed and not to use one hour prior to taking this medication (Jones & Bartlett Learning, 2020).	Monitor blood sugars three times daily and if the patient experiences hypoglycemia to check blood sugar levels (Jones & Bartlett Learning, 2020).	Monitor blood sugar levels when needed and take with food (Jones & Bartlett Learning, 2020).	Advise the caretaker to watch for slow breathing and adverse reactions (Jones & Bartlett Learning, 2020).

Medications Reference (1) (APA): Jones & Bartlett Learning. (2020). *2021 Nurse's Drug*

   Handbook **(19ᵗʰ Ed.). Jones & Bartlett Learning.**

Assessment

Physical Exam (18 points) – <mark>HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS</mark>

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	<mark>The patient is young and frail, intubated and sedated. Patient is in current respiratory failure.</mark> <mark>Not aware of surroundings and not alert at this time.</mark>
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:**	The patient has pale, dry and warm to touch skin. This patient's skin turgor is normal. There are no rashes, bruises, or wounds upon inspecting. This patients Braden score is an 11. This patient has a 12fr foley catheter, 18 G left lower in the forearm, 20 G in the right upper forearm, 22 G in the left lower forearm, and a triple lumen in the right upper arm. <mark>The patient is also intubated.</mark>
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head, and neck symmetrical, no tracheal deviation, non-palpable thyroid, non-palpable lymph nodes. The patient has normal cephalic, trachea is midline and portioned. There are no wounds or drainage from ears. <mark>The patient is deaf. The patient is blind and left pupil is cloudy and has some slight drainage.</mark> Septum is midline, turbinates are moist and pink bilaterally and there are no visible bleeding or polyps present. Bilateral frontal sinuses are nontender to palpate. Oral cavity is pink and moist. <mark>The patient has several missing teeth, overall dentition is poor.</mark>
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:**	Clear S1 and S2 without murmurs, gallops, or rubs. S3 and S4 were not present. <mark>Tachycardia sinus rhythm present.</mark> Peripheral pulses were a +2. Capillary refills were less than 3. No neck vein distention or edema noted.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒**	<mark>Crackles are present in the right and left lobe, patient is tachypneic.</mark> The patient is not using

Breath Sounds: Location, character	their accessory muscles.

GASTROINTESTINAL:
Diet at home:
Current Diet
Height:
Weight:
Auscultation Bowel sounds:
Last BM:
Palpation: Pain, Mass etc.:
Inspection:
    Distention: No
    Incisions: No
    Scars: No
    Drains: Yes
    Wounds: No
Ostomy: Y ☐   N ☒
Nasogastric: Y ☐   N ☒
    Size:
Feeding tubes/PEG tube   Y ☐   N ☒
    Type:
	==The patient lives at Swanns and is on a liquid diet only there at Swanns.== ==Current diet is NPO.== ==The patient is 3'11" and weights 76 lbs.== During auscultation of bowel sounds were nondistended and present to be normoactive in all 4 quadrants, and ==patients last bowel movement was unknown.== No pain upon palpations or masses noted. No distention, incisions, scars, or wounds present. This patient has a 12fr foley catheter, 18 G left lower in the forearm, 20 G in the right upper forearm, 22 G in the left lower forearm, and a triple lumen in the right upper arm. Patient does not have an ostomy or nasogastric tube. The patient does not have a feeding/PEG tube present.

GENITOURINARY:
Color:
Character:
Quantity of urine:
Pain with urination: Y ☐   N ☐
Dialysis: Y ☐   N ☒
Inspection of genitals:
Catheter: Y ☒   N ☐
    Type:
    Size:
	Color of urine is straw. Character of urine is odorless and clear. ==Unable to assess pain during urination due to patient being intubated and severe mental impairment.== Patient is not on dialysis. Inspection of patients genitals is WDL. ==The patient does have a 12fr foley catheter present.==

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☒**	No observed joint swelling, or joint tenderness. ==Patient does have smaller long bones, uncoordinated movements of upper extremities, and weakness of all four limbs. Patient does use a wheelchair as their supportive devices. Patient is a fall risk and has a fall score of 33.== ==Patient is dependent and needs assistance with equipment. Patient cannot stand or walk.==
NEUROLOGICAL:	==Patient has severe mental impairment. Unable==

MAEW: Y ☐ N☒ **PERLA: Y ☐ N☒** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	==**to assess PERLA, speech and sensory due to patient being intubated. Patient does have equal strength in both arms and legs but has significant weakness. Mental status is severely impaired. LOC noncoherent state.**==
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):**	**Per a Swanns caretaker, the patients coping method is self-soothing.** ==**Patients developmental level shows severe mental impairment.**== **Patient has no religion marked down in their chart.** ==**The patient is a ward of the state and has no family history.**==

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	==**106**==	**120/77**	==**28**==	**99.1** **(rectally)**	**97%**
1000	==**103**==	**115/63**	==**35**==	==**100.9**== ==**(rectally)**==	**97%**

Vital Sign Trends: The patients vital signs are stable. The patients vitals may fluctuate due to his condition. Plan to continue to do vital signs every 2 hours due to patients status.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	**CPOT 0**	**N/A**	**N/A**	**N/A**	**N/A**
1000	**CPOT 0**	**N/A**	**N/A**	**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 has a 20 G in the right upper arm, 22 G in the left lower forearm, 18 G in the left lower proximal forearm, and triple lumen in the right brachial that was placed on 9/12/22, patency is open and normal no signs of drainage, or erythema. NS 500 mL running at 75 mL/hr, NS 250 mL with phenylephrine 50 mg running at 150 mL/hr, and NS 265 mL with vancomycin 750 mg running at 10 mL/hr. None of the listed IVs are infiltrated.**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
NS 500 mL, NS 250 mL phenylephrine 50 mg, and 265 mL NS vancomycin 750 mg.	**200 mL emesis and 700 mL of urine. No bowel incontinence charted.**

Nursing Care

Summary of Care (2 points)

      Overview of care: Patient is intubated and sedated upon arrival. The client remained on bedrest and did not leave his room throughout the day for any procedures. The patient was does not speak due to mental impairment and sedation. The patient's vital signs remain stable with slight tachypneic. No one was notified of the change in vitals however the RN was at bedside. The patient is tolerating NPO. No known discharge date at this time. Patient will remain in the hospital until greater health.

Procedures/testing done: Patient had a chest x-ray that was completed at 0045 on 9/12.

Complaints/Issues: No complaints due to intubated patient.

Vital signs (stable/unstable): Patients vital signs remained stable.

Tolerating diet, activity, etc.: Patient is tolerating NPO well.

Physician notifications: Patient was notified of crackles in both lungs.

Future plans for client: No future plans for this client at this time, plan to revisit on 9/13.

Discharge Planning (2 points)

Discharge location: Swanns

Home health needs (if applicable): None

Equipment needs (if applicable): Wheelchair

Follow up plan: The patient will follow up with his primary provider 5 days after discharge.

Education needs: Educate the caretaker to watch for any decline in vitals or status of patients health.

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 altered oxygen supply as evidence by respiratory failure.**	**Patient is at increased risk for impaired gas exchange due to inadequate respiratory rate.**	**1.Assess the patients vitals and watch for coloring of the skin and nails.** **2.Monitor ABG levels.**	**1. The patients respiratory rate will remain stable and ABGS will be within normal limits.**	**The patient responded well to these interventions. The caretaker will update if any changes are seen in the patient.**
2. **Ineffective airway clearance related to intubation as evidence by dyspnea.**	**Patient is at an increased risk for ineffective airway clearance due to ineffective respiratory rate.**	**1. Turn the patient every 2 hours.** **2. In-line suctioning used on patient.**	**1. The patient was able to tolerate suctioning and being turned every 2 hours.**	**The patient responded well to the interventions. The caretaker understand that they should be moving the client in a timely fashion.**
3. **Impaired spontaneous ventilation related to respiratory muscle fatigue as evidence by pH ABG levels.**	**Patient is at an increased risk for ventilation due to weakness in breathing patterns.**	**1. Auscultate lung sounds.** **2Monitor oxygen saturation.**	**1. The clients lung sounds improved and no longer had crackles.**	**Patient responded well to the interventions; no modifications needed.**
4. **Impaired verbal communication related to delayed language skills as evidence by severe mental impairment.**	**Patient has delayed verbal communication due to his developmental level.**	**1.Allow patient to communicate with gestures or in their own way.** **2. Allow time for patient to respond to instructions.**	**1. The patient can respond to instructions.**	**The caretaker helped the patient learn further language skills and no modifications were needed at this time plan to revisit.**

Other References (APA): Phelps, L. L. (2020). *Sparks & Taylor's Nursing diagnosis*

reference manual **(11th ed.). Wolters Kluwer**

Concept Map (20 Points):

Subjective Data

Patient has no subjective data due to being intubated and sedated.

Nursing Diagnosis/Outcomes

Impaired gas exchange related to altered oxygen supply as evidence by respiratory failure. The patients respiratory rate will remain stable and ABGS will be within normal limits.

Ineffective airway clearance related to intubation as evidence by dyspnea. The patient was able to tolerate suctioning and being turned every 2 hours.

Impaired spontaneous ventilation related to respiratory muscle fatigue as evidence by pH ABG levels. The clients lung sounds improved and no longer had crackles.

Impaired verbal communication related to delayed language skills as evidence by severe mental impairment. The patient can respond to instructions.

Objective Data

BP: 115/63
P: 103
RR: 35
T: 100.9 (rectally)
O2: 97%

Client Information

C.H.
21
Male
Single

Nursing Interventions

Assess the patients vitals and watch for coloring of the skin and nails. Monitor ABG levels.

Turn the patient every 2 hours. In-line suctioning used on patient.

Auscultate lung sounds. Monitor oxygen saturation.

Allow patient to communicate with gestures or in their own way. Allow time for patient to respond to instructions.