N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 09/11/2022	**Client Initials** BL	**Age** 28	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Unemployed	**Marital Status** Single	**Allergies** Sulfa Drugs- Rash
Code Status Full	**Height** 5'10" (177.8 cm)	**Weight** 163 lb. 2.3 oz (74 kg)	

Medical History (5 Points)

Past Medical History: Alcohol abuse, anxiety

Past Surgical History: This patient has no past surgical history.

Family History: Patient reported in the emergency department that both of his parents have hypertension.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): This patient reported in the emergency department that he smokes marijuana and half a pack of cigarettes daily (0.5 ppd). His mother reported (in the emergency department) that he consumes vodka daily. Unable to determine how much alcohol he consumes or the length of time he has been drinking or smoking because he was intubated and sedated during my assessment.

Assistive Devices: This patient does not use assistive devices.

Living Situation: He lives at home with his mother.

Education Level: Unable to determine because the patient was intubated and sedated.

Admission Assessment

Chief Complaint (2 points): Cardiac Arrest

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

On 09/09/2022, a 28-year-old Caucasian male came to the emergency department for persistent nausea and vomiting that he had been experiencing for several days. His laboratory

results showed a potassium level of two. He was going to be admitted for treatment. However, he left against medical advice. On 09/11/2022, per his mother, he began hallucinating and became aggressive. He left his house and was found in a park unresponsive, pulseless, and covered in coffee-ground emesis. Emergency medical services performed cardiopulmonary resuscitation and administered two doses of epinephrine and amiodarone, resulting in a normal sinus rhythm. The exact time frame the patient was unresponsive is unknown. He was transported to the emergency department at Sacred Heart Medical Center. While in the emergency department, he displayed hypoxia and agitation, requiring intubation. Once stabilized, he was transferred to the intensive care unit. He receives mechanical ventilation and dialysis almost daily to manage his respiratory and acute renal failure.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Respiratory Failure

Secondary Diagnosis (if applicable): Acute Renal Failure

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

Acute respiratory failure is a life-threatening condition where the blood lacks sufficient oxygen because the alveoli are not adequately exchanging carbon dioxide and oxygen (Hinkle & Cheever, 2018). Common causes include anesthesia, chronic obstructive pulmonary disease, myocardial infarction, chest trauma, pneumonia, acute respiratory distress syndrome, heart failure, musculoskeletal conditions such as myasthenia gravis, and pulmonary embolism (Hinkle & Cheever, 2018). Patients can experience headaches, confusion, shortness of breath, fatigue, restlessness, and excessive sweating (Hinkle & Cheever, 2018). (Hinkle & Cheever, 2018). Physical exam findings include a heart rate above one hundred beats per minute, a respiratory rate above twenty breaths per minute, diminished breath sounds, speaking in short sentences,

cyanosis, and increased work of breathing (Hinkle & Cheever, 2018). It is diagnosed by chest x-ray, computed tomography (CT), and arterial blood gases (Capriotti, 2020). The chest x-ray and CT scan allow providers to find the cause (Capriotti, 2020). The arterial blood gas supplies information about the patient's gas exchange (Capriotti, 2020). The arterial blood oxygen level must be less than sixty, the pH less than 7.35, and the carbon dioxide level greater than fifty for a diagnosis of acute respiratory failure (Capriotti, 2020). The treatment goals are to address the initial cause and improve gas exchange (Hinkle & Cheever, 2018). The standard treatment is placing an endotracheal tube and supplying oxygen via mechanical ventilation (Hinkle & Cheever, 2018). Nursing management includes assessing the patient's respiratory function, arterial blood gases, vital signs, and oxygen saturation (Hinkle & Cheever, 2018). In addition, turning the patient every two hours and supplying oral care and suctioning to prevent additional complications (Hinkle & Cheever, 2018). It is unclear what caused this patient's respiratory failure as he presented with it following cardiac arrest. However, it could have been caused by damage to his lungs during cardiopulmonary resuscitation. The chest x-ray and CT scan that were performed did not identify a cause. He was diagnosed based on his arterial blood gases. The lack of oxygen in his blood has appeared to have caused multi-organ failure. He now also has rhabdomyolysis, acute renal failure, and pancreatitis. His respiratory failure is being addressed by mechanical ventilation via an endotracheal tube. He developed hospital-acquired pneumonia, which is being treated with methylprednisolone and cefazoline.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of*

medical-surgical nursing (14th ed.). Wolters Kluwer.

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.5-5.8	4.21	2.44	Chronic alcoholism can cause bleeding in the gastrointestinal tract, resulting in iron-deficiency and anemia (Hinkle & Cheever, 2018). Injury to the kidneys decreases erythropoietin production, resulting in decreased RBC production (Hinkle & Cheever, 2018). Hepatitis causes the liver to breakdown RBCs (Capriotti, 2020).
Hgb	13-16.5	15.3	9	Low iron affects red blood cell production, resulting in decreased hemoglobin in the blood (Capriotti, 2020). Hepatitis causes the liver to breakdown RBCs, resulting in low hemoglobin in the blood (Capriotti, 2020).
Hct	38-50	43.7	25.4	Hematocrit is the percentage of red blood cells in the blood (Capriotti, 2020). This patient has low red blood cells due to his kidneys inadequately producing erythropoietin (Capriotti, 2020). Hepatitis causes the liver to breakdown RBCs, reducing the hematocrit (Capriotti, 2020).
Platelets	140-440	162	185	
WBC	4-12	7.3	12.6	White blood cells are elevated when inflammation or an infection are present (Hinkle & Cheever, 2018). This patient currently has pneumonia and inflammation throughout his body caused by hepatitis, rhabdomyolysis, pancreatitis, respiratory failure, and

				cardiac arrest.
Neutrophils	40-68%	85.5	88.3	Neutrophil production increases due to inflammation and infectious processes (Capriotti, 2020). This patient currently has pneumonia and inflammation throughout his body caused by hepatitis, rhabdomyolysis, pancreatitis, respiratory failure, and cardiac arrest.
Lymphocytes	19-49	4.8	4.7	Lymphocyte production increases due to inflammation and infectious processes (Capriotti, 2020). This patient currently has pneumonia and inflammation throughout his body caused by hepatitis, rhabdomyolysis, pancreatitis, respiratory failure, and cardiac arrest.
Monocytes	3-13	8.9	6.7	
Eosinophils	0-8%	0.2	0	
Bands	0-0.5	0	0	

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	127	136	Vomiting can cause low sodium levels due to loss of sodium through emesis (Hinkle & Cheever, 2018).
K+	3.5-5.1	2	4.3	Excessive vomiting causes low potassium due to it leaving the body through emesis (Capriotti, 2020). Alcoholism can cause low potassium levels due to inadequate nutrition (Capriotti, 2020).

Cl-	98-107	54	96	Vomiting can cause low chloride levels due to loss of chloride through emesis (Hinkle & Cheever, 2018). Sodium and potassium deficiencies and gastric suctioning can also chloride deficiencies (Hinkle & Cheever, 2018). This patient has both sodium and potassium deficiencies and an OG tube removing gastric secretions.
CO2	21-31	20	26	Insufficient blood flow to the organs can cause low blood carbon dioxide levels (St. John, 2022). This patient had cardiac arrest resulting in inadequate organ perfusion.
Glucose	70-99	241	135	The liver metabolizes and regulates glucose levels (Hinkle & Cheever, 2018). This patient has alcoholic hepatitis impairing the functionality of his liver. Stress and pancreatitis also increase blood glucose levels (Capriotti, 2020). This patient's body is under stress, and he has pancreatitis. Protonix, solu-medrol, and lactulose can cause elevated blood glucose levels (Jones & Bartlett Learning, 2020).
BUN	7-25	44	60	BUN increases with dehydration and this patient experienced excessive vomiting for days (Hinkle & Cheever, 2018). BUN is also elevated when there is injury to the kidneys (Hinkle & Cheever, 2018).
Creatinine	0.5-1.2	2.81	3.71	Creatinine increases with dehydration and this patient experienced excessive vomiting for days (Hinkle & Cheever, 2018). Creatinine is also elevated when there is injury to the kidneys or muscle metabolism (Hinkle & Cheever, 2018). This patient has acute renal failure and rhabdomyolysis.
Albumin	3.5-5.7	3.3	3.6	Alcoholism can cause low albumin levels due to liver damage and inadequate protein consumption

				(Hinkle & Cheever, 2018).
Calcium	8.6-10.3	9	8.8	
Mag	1.6-2.6	1.7	2.4	
Phosphate (phosphorus)	2.4-4.5	4.1	4.2	
Bilirubin	0.2-0.8	6	N/A	Liver damage causes increased bilirubin in the blood due to the liver not being able to conjugate or excrete it (Capriotti, 2020).
Alk Phos	34-104	128	309	Alkaline phosphatase is elevated with liver dysfunction (Capriotti, 2020). This patient has alcohol induced hepatitis.
AST	13-39	132	152	AST is elevated with liver dysfunction caused by alcohol (Capriotti, 2020). This patient has alcohol- induced hepatitis.
ALT	7-52	70	55	ALT is elevated with liver dysfunction (Capriotti, 2020). This patient has alcohol- induced hepatitis.
Amylase	29-103	64	N/A	
Lipase	11-82	126	268	Lipase is elevated with pancreatitis, this patient has indications of pancreatitis caused by alcohol abuse (Capriotti, 2020).
Lactic Acid	0.5-2	29.5	N/A	Lactic acid increases due to tissue breakdown (Hinkle & Cheever, 2018). This patient has rhabdomyolysis.
Troponin	0-0.04	0.046	N/A	Troponin increases due to cardiac tissue damage (Capriotti, 2020). This patient experienced cardiac arrest.
CK-MB	5-25	Not drawn	N/A	
Total CK	30-223	433	311	CK increases due to tissue damage (Capriotti, 2020). This patient experienced cardiac arrest and currently has rhabdomyolysis.

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	1.5	N/A	The liver produces clotting factors (Capriotti, 2020). Therefore, damage to the liver would increase bleeding time.
PT	25-36	37	N/A	The liver produces clotting factors (Capriotti, 2020). Therefore, damage to the liver would increase bleeding time.
PTT	10.1-13.1	16.6	N/A	The liver produces clotting factors (Capriotti, 2020). Therefore, damage to the liver would increase bleeding time.
D-Dimer	<250	N/A	N/A	
BNP	<100	N/A	N/A	
HDL	>60	N/A	N/A	
LDL	<130	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	<150	338	391	Alcohol use and liver impairment increase triglyceride levels (Hinkle & Cheever, 2018).
Hgb A1c	4-5.6% Diabetic-<7%	N/A	N/A	
TSH	0.270-4.2	0.609	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	Yellow and clear	N/A	N/A	
pH	5.0-7.0	N/A	N/A	
Specific Gravity	1.003-1.005	N/A	N/A	

Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0-25	N/A	N/A	
RBC	0-20	N/A	N/A	
Leukoesterase	Negative	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	7.26	7.44	A pH below 7.35 indicates acidosis (Hinkle & Cheever, 2018). This patient was in respiratory acidosis.
PaO2	80-100	324	73	This patient was receiving mechanical ventilation. An increased PaO2 indicates he was receiving too much oxygen (Hinkle & Cheever, 2018).
PaCO2	35-45	50	38	A CO2 level greater than 45 indicates acidosis (Hinkle & Cheever, 2018). This patient was in respiratory acidosis.
HCO3	22-26	22.5	25.8	
SaO2	95-100%	99	92	Inadequate ventilation caused by respiratory problems decreases oxygen saturation (Capriotti, 2020). This patient has respiratory failure.

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	N/A	N/A	
Blood Culture	Negative	Positive for S. aureus	N/A	Bacteria in the lungs can move into the bloodstream, resulting in a positive blood culture (Hinkle & Cheever, 2018).
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

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

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

St. John, T. M. (2022, August 5). *Causes of low carbon dioxide in the blood*. Livestrong. https://www.livestrong.com/article/208566-what-are-the-causes-of-low-carbon-dioxide-in-the-blood/

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

09/11/2022- CT of the head without contrast- Finding: No cranial abnormalities, bleeding, or evidence of stroke.

09/11/2022- Chest X-Ray- Finding: No evidence of pneumothorax, lungs are clear, endotracheal tube above carina, and heart is normal size.

09/11/2022- Abdominal ultrasound- Finding: Fatty liver changes

09/11/2022- EKG- Finding: Sinus tachycardia, enlarged left atrium, prolonged QT interval

09/12/2022- transthoracic echocardiogram (2D)- Finding: Mild mitral valve regurgitation, no changes to aortic valve, normal left ventricle, and ejection fraction approximately 55-60%.

09/20/2022- Chest X-Ray- Finding: Pneumonia, and significant bilateral pulmonary infiltrates.

Diagnostic Test Correlation (5 points):

Computed tomography produces two-dimensional brain images to assess for vascular abnormalities, clots, evidence of stroke, and brain damage (Capriotti, 2020). This test was performed to evaluate this patient for evidence of stroke, which can cause cardiac arrest, and assess for brain damage due to lack of oxygen to his brain during the arrest.

A chest x-ray is performed to assess the heart and lungs for abnormalities and verify the placement of tubes (Hinkle & Cheever, 2018). This patient experienced cardiac arrest and was diagnosed with respiratory failure. Therefore, this test allows physicians to identify physical changes in his heart and the possible cause of his respiratory failure. It also confirmed his pneumonia and the location of his endotracheal tube.

An abdominal ultrasound is performed to visualize and diagnose abdominal organ abnormalities (Capriotti, 2020). This patient abuses alcohol. Therefore, this test was needed to assess for changes caused by his drinking. It aided in the diagnosis of alcoholic hepatitis.

Transthoracic echocardiography produces images of the heart and its structures to identify ejection fraction, muscle changes, and valvular disorders (Capriotti, 2020). This test was performed to assess this patient's heart for damage following cardiac arrest.

An electrocardiogram assesses the heart's electrical conduction to diagnose dysrhythmias, conduction issues, and myocardial injury (Hinkle & Cheever, 2018). This test was performed on this patient because he experienced cardiac arrest and had low potassium levels, which can cause dysrhythmias (Hinkle & Cheever, 2018).

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

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

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

Home Medications (5 required): Note*Patient did not have any home meds. Therefore, ten hospital meds were used.

Brand/Generic	Precedex/ dexmedetomidine HCl in NaCl	Colace/ docusate sodium	Fentalis/ fentanyl	Folvite/folic acid	Beprin/heparin sodium
Dose	13.16 mcg/hr	100 mg	100 mcg/hr	1 mg	5000 units
Frequency	Continuous	BID	Continuous	Daily	BID
Route	IV	PO/OG	IV PCA	IV	Subcutaneous
Classification	Sedative/hypnotic	Laxative/ stool softener	Opioid/opioid analgesic	hematinic/ water-soluble vitamin	Anticoagulant/ hematologic

Mechanism of Action	Induces sedation by decreasing noradrenergic neuron activity in the brain stem	Acts as a surfactant that softens stools by decreasing surface tension between oil and water in feces	Binds to opioid receptors to decrease response to pain	Replaces diminished folic acid to help with cell division	Binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin
Reason Client Taking	To keep the patient sedated and calm while intubated	To treat constipation due to immobility	To keep him pain free while intubated	To improve RBC production, to increase diminished vitamin level caused by alcohol consumption	To prevent DVT due to immobility To prevent clotting of his dialysis catheter
Contraindications (2)	Heart blocks Severe heart failure	Fecal impaction Hypersensitivity to docusate salts	Respiratory depression Hypersensitivity to fentanyl or its components	Hypersensitivity to folic acid Undiagnosed anemia	Hypersensitivity to heparin Uncontrolled active bleeding
Side Effects/Adverse Reactions (2)	Low blood pressure Decreased heart rate	Dizziness Palpations	Respiratory depression Hypotension	Gas Nausea	Hematemesis Hemorrhage
Nursing Considerations (2)	Do not use for more than 24 hours Use cautiously in patients with hepatic impairment	Prolonged use can cause electrolyte imbalances Daily use can cause dependence	Use cautiously in hypoxic/hypercapnic patients Use cautiously in patients with a history of substance abuse	Administer 1 hour before or 2 hours after antacids Keep oxygen nearby in case of allergic reaction	Use cautiously in alcoholics Alternate injection sites
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess heart rate and heart sounds Assess blood pressure before administering	Determine when the patient last had a bowel movement Monitor electrolyte levels and stool consistency	Assess patient's level of pain Assess respiratory rate and rhythm	Monitor CBC Assess patient for fatigue, weakness, and shortness of breath before and during	Monitor aPTT and platelets Assess for signs of bleeding (nose, gums, urine, and stool)

				therapy	
Client Teaching needs (2)	Instruct patient's family to report nausea and vomiting and fever Report pale or blue skin, indicating low oxygen	Instruct patient not to take this medication when they are experiencing abdominal pain or vomiting. Advise patient to take with a full glass of water.	Take medication as prescribed Avoid alcohol while taking this medication because it will increase the effects of fentanyl	Report rash or trouble breathing to the provider This medication is used short term, it is used until levels are stable	Use a soft bristled toothbrush to prevent injury to the gums which will increase bleeding Do not take NSAIDs or aspirin while using heparin because they increase bleeding

Hospital Medications (5 required)

Brand/ Generic	Enulose/ lactulose	Reglan/ metoclopramide hydrochloride	Kefzol/cefazolin sodium	Protonix/ pantoprazole	Solu-medrol/ methylprednisolone sodium succinate
Dose	10 g	5 mg	2 g	40 mg	40 mg
Frequency	TID	TID	Once	BID	TID
Route	PO/OG	IV	IV	IV	IV
Classification	Colonic acidifier/Disaccharide	Antiemetic/ Upper GI stimulant	Cephalosporin/ antibiotic	Proton pump inhibitor/antiulcer	Glucocorticoid/ corticosteroid
Mechanism of Action	Makes intestinal contents more acidic than blood to prevent ammonia from diffusing into the blood so that it can be expelled in feces	Reduces gastric reflux by stimulating contraction of gastrointestinal smooth muscle	Interferes with bacterial cell wall division making it rigid, resulting in lysis	Inhibits the hydrogen-potassium-adenosine triphosphatase system in gastric cells to reduce gastric acid production	Suppresses inflammation and immune response by stopping neutrophil and monocyte recruitment at inflammation sites

Reason Client Taking	To reduce blood ammonia levels, addressing possible hepatic encephalopathy caused by liver impairment	This patient had excessive gastric residual. This medication promotes gastric emptying	To treat pneumonia caused by S. aureus	To prevent the development of a gastric ulcer, a common complication of intubation	To reduce lung inflammation and improve respiratory function
Contraindications (2)	Low-galactose diet Hypersensitivity to lactulose	History of dystonic reaction to metoclopramide Medications that cause extrapyramidal reactions such as phenothiazine	Hypersensitivity to cephalosporins Penicillin allergy	Concurrent therapy with rilpivirine-containing products Hypersensitivity to pantoprazole or its components	Fungal infections Hypersensitivity to cow's milk
Side Effects/Adverse Reactions (2)	Hyperglycemia Hypokalemia	Bronchospasm Bradycardia	Hearing loss Renal failure	Hyperglycemia Hyponatremia	Hyperglycemia Pancreatitis
Nursing Considerations (2)	Fluid replacement is necessary if the patient has frequent bowel movements Periodically assess electrolyte levels	Use cautiously in patients with hypertension Do not give to patients receiving monoamine oxidase inhibitors because it increases the risk of hypertensive crisis	Use cautiously in patients with decreased renal function Allergic reaction can result within minutes of administration Inject over 3-5 minutes	Reconstitute this drug with 10 mL of normal saline and give over 3 minutes Monitor for decreased urine output or blood in the urine because this drug can cause acute interstitial nephritis	Use cautiously in patients with impaired renal function because hypernatremia and edema can occur Administer in the morning because this is when cortisol is produced
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor blood ammonia level Monitor blood glucose level	Assess patient for diarrhea, nausea, vomiting, and diminished bowel sounds before administration Assess for fluid overload because this	Monitor BUN and creatinine Assess patency of IV	Review sodium and magnesium labs because these values can decrease while taking this drug Test blood glucose because this	Monitor blood glucose Assess patient's weight to monitor for fluid retention

		medication increases aldosterone level		drug can cause hyperglycemia	
Client Teaching needs (2)	Report abdominal swelling and excessive diarrhea Take this medication with food	Do not drink alcohol with this medication because it can increase the CNS effects of this medication Inform the patient to report involuntary movements of the hands, face, legs, or tongue, indicating tardive dyskinesia	Report fever, itching, rash, or swelling at the IV site Report bloody or watery stools occurring within two months of therapy	Notify provider about diarrhea because this drug can cause Clostridium difficile Notify provider if urine output decreases while on this medication	Avoid crowds and sick individuals because this medication reduces immune system function Increase calcium and vitamin D intake or take supplements

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:**	 Unable to assess because patient is intubated and sedated. No acute distress noted. This patient is well-groomed
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present:** **Y☒** **N ☐** **Type:** OG	 Generalized jaundice Dry Warm Skin turgor assessed with immediate recoil No rashes noted. Large bruises under left eye, on right hand, and several on posterior. Abrasions on right elbow and right knee. Small stage 1 pressure injury on sacrum. Braden score: 10, patient is immobile, responds to verbal commands, is occasionally moist, and requires 2 staff members for position changes.

HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck symmetrical. The trachea is midline without deviation. No lymphadenopathy inspected or palpated. Thyroid is nonpalpable. Bilateral auricles are pink without drainage or lesions noted. Bilateral PERRLA, although small. Bilateral Sclera are yellow with subconjunctival hemorrhages. Conjunctiva is pink. The nose is free of discharge and lesions. Dentition is poor. Throat is pink, moist, and without lesions. Tonsils 1+.
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. No audible murmur, gallops, or rubs noted. Pulses 2+ throughout bilaterally. Capillary refill normal, less than 3 seconds. No edema inspected or palpated in extremities.
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:**	Breath sounds even, regular and nonlabored bilaterally. No crackles, wheezes, or rhonchi noted. 7.5 25 at the lips 20 30% 450 mL 5 Suctioning and oral care Q2H. The head of the bed is elevated at 30 degrees. Gastric residual is being assessed Q4H.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:**	 Regular TPN through OG, started at 1100 5’10” 163 lb. 2.3 oz Normoactive Yesterday, 09/19/2022 No grimacing with palpation. No abdominal

Inspection: **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☒ N ☐** **Size:** 16Fr **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	distention, incisions, scars, drains, wounds, or masses palpated. OG producing brown/green output via low-intermittent suction. Receiving TPN via OG.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☒ N ☐** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** Indwelling-foley catheter **Size:** 16 Fr **CAUTI prevention measures:**	Brown Clear Scant, <10 mL during shift Genitalia clean without rashes or lesions. Perform indwelling foley catheter care once per shift. Remove the catheter as soon as possible.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 50 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	No neurovascular abnormalities noted. Unable to determine because patient is intubated and sedated. 3/5 and equal in upper extremities, patient responded to verbal command to assess upper extremities, but he would not move his lower extremities. Therefore, unable to determine currently. Patient is bedfast and requires complete assistance with position changes.
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	3/5 and equal in upper extremities, patient responded to verbal command to assess upper extremities but would not move his lower extremities. Therefore, unable to determine currently. Unable to determine orientation, speech, LOC, or mental status because patient is intubated and sedated.

Sensory: **LOC:**	
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 determine because patient is intubated and sedated.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0701	92	107/75	20	99.9	97%- mechanical ventilation
1212	95	108/67	27	100.4	95%- Mechanical ventilation

Vital Sign Trends/Correlation: This patient's temperature, although normal, is elevated. He has pneumonia which can cause a fever. His respiratory rate was elevated due to him over breathing the ventilator. His vital signs remained stable throughout this shift.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1100	CPOT	Not able to determine	1	Patient moves muscles for protection.	Patient is receiving fentanyl continuously. I suctioned his

					mouth and endotracheal tube several times, which seemed to calm him.
1326	CPOT	Not able to determine	1	Patient moves muscles for protection.	Patient is receiving fentanyl continuously. I suctioned his mouth and endotracheal tube several times, which seemed to calm him.

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:**	No peripheral IVs present.
Other Lines (PICC, Port, central line, etc.)	
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:**	9 Fr Triple lumen hemodialysis catheter in right internal jugular, 9Fr CVC in left internal jugular. Left- 09/14, right- 09/19 Patent. Received continuous infusions and dialysis without issues. No drainage or erythema noted. Clean, dry, and intact. 09/14, 09/19 Clean needless connector with alcohol before accessing. Always replace CUROS caps. Assess dressings twice a shift and change them weekly.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**

60 mL of sterile water with medication administration 20 mL TPN NS 80 mL Meropenem 100 mL Versed 38 mL	<10 mL scant, brown urine 200 mL OG output 200 mL from oral/endotracheal suctioning

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was bedfast during this shift. He received sedation to relax him. He was repositioned, suctioned, and received oral care every two hours. He was bathed and received foley catheter care.

Procedures/testing done: Radiology came up this morning and took a chest x-ray.

Complaints/Issues: The patient did not verbalize any complaints and there were not any issues. His condition remained stable throughout this shift.

Vital signs (stable/unstable): His vitals were assessed hourly and were stable throughout this shift.

Tolerating diet, activity, etc.: He did not leave the bed during this shift. He did not have a bowel movement and produced little urine output. TPN was started today at 1100. The patient is tolerating it well.

Physician notifications: The physician was not notified for this patient.

Future plans for client: His sedation was turned down and he is scheduled to be extubated later today.

Discharge Planning (2 points)

Discharge location: Currently undetermined. He may be discharged to an acute care setting due to his kidney function and inability to care for himself.

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan: If he recovers, he will need physical, speech, and occupational therapy to improve his speech, strength, and functionality. He will also need to follow up with his primary physician.

Education needs: If he recovers, this patient will need educated on a healthy diet and smoking cessation. He would also need educated about available resources that will help him with his alcohol addiction.

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • 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	This patient tried	**1.**Provide oral and	**1.** Within 1 hour of	Goal partially met- This

related to sedation and mechanical ventilation as evidenced by inability to clear secretions	coughing several times to clear his respiratory secretions but could not because he was intubated.	endotracheal suctioning every two hours and as needed **2.** Elevate the head of the bed	interventions, the patient will have clear breath sounds and a normal respiratory rate.	student elevated the head of the bed and performed oral and endotracheal suction twice during her shift. Following implementation of the interventions, the patient relaxed, his lung sounds were clear, and his respiratory rate was normal. However, his respiratory rate was 27 at 1212. The student/nurse must suction the patient more often and ensure he is receiving proper sedation to prevent hyperventilation .
2. Impaired skin integrity related to immobility as evidenced by reddened skin on sacrum	Skin protects the body from microbes, helps regulate body temperature, and maintains electrolyte balance (Capriotti, 2020). If the skin is	**1.**Assess the patient's skin twice per shift for changes. **2.** Reposition the patient every two hours avoiding pressure on the pressure injury.	**1.** The patient's pressure injury will show progressive healing over the next three days.	Goal partially met- This patient's skin was assessed twice during my shift, once by me, and once by the nurse. Per the nurse, his pressure injury did not change. He was only repositioned twice during my shift. The client

	impaired, the patient is at risk for infection, hypothermia, and electrolyte imbalance.			tolerated the interventions well. The nurse must continue repositioning the patient every two hours and evaluate the patient's skin every six hours for signs of healing.
3. Imbalanced nutrition: Less than body requirements related to increased metabolic need as evidenced by no nutritional intake in the last 9 days due	Inadequate nutrition delays wound healing and lowers the immune system (Capriotti, 2020).	**1**.Monitor albumin level and the patient's weight each shift. **2.** Administer TPN as prescribed.	**1.** The patient will gain 0.5 lb. per week while hospitalized (Swearingen & Wright, 2019).	Goal partially met- This student reviewed the patient's albumin level and weight. She began the TPN infusion at 1100. The patient tolerated the interventions well. The nurse should continue the interventions until the patient is discharged and notify the provider if the patient's weight does not increase.
4. Constipation related to opioid administration and immobility as evidenced by patient not producing a bowel movement today and a scant amount yesterday	Prolonged constipation can cause fecal impaction (Swearingen & Wright, 2019).	**1.**Assess the abdomen for distention and diminished or absent bowel sounds **2.** Administer stool softeners/laxative as prescribed	**1.** Within 48 hours, the patient will produce a soft, formed stool.	Goal partially met- This student assessed the patient's abdomen and administered a stool softener at 0900. The patient did not have a bowel movement during my shift.

				The nurse should continue the interventions and monitor for a bowel movement.
5. Risk for thromboembolism related to blood stasis as evidenced by immobility	Deep-vein thrombosis can result in a pulmonary embolism (Swearingen & Wright, 2019).	**1.**Apply sequential compression devices (SCDs) **2.** Administer anticoagulant as prescribed	**1.**During hospitalization, the patient will have normal extremity color and temperature	Goal partially met- The student ensured SCDs were on and administered heparin at 0900. During her physical assessment, the patient's extremities did not show signs of DVT. The patient tolerated the interventions well. The nurse must ensure the patient has on SCDs and continue administering heparin until he regains mobility.

Other References (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis.

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

"The patient's pressure injury looks the same as yesterday".
Patient found unresponsive. CPR performed in the field with return of NS rhythm.
Patient reported he had nausea and vomiting for several days.
"The patient produced a small amount of feces yesterday".
"He has not received a feeding since he's been here".
Patient reported that he smokes marijuana and half a pack of cigarettes daily.
"He drinks vodka daily".

Nursing Diagnosis/Outcomes

Ineffective airway clearance related to sedation and mechanical ventilation as evidenced by inability to clear secretions

Outcome: Within 1 hour of interventions, the patient will have clear breath sounds and a normal respiratory rate.

Impaired skin integrity related to immobility as evidenced by reddened skin on sacrum

Outcome: The patient's pressure injury will show progressive healing over the next three days.

Imbalanced nutrition: Less than body requirements related to increased metabolic need as evidenced by no nutritional intake in the last 9 days

Outcome: The patient will gain 0.5 lb. per week while hospitalized (Swearingen & Wright, 2019).

Constipation related to opioid administration and immobility as evidenced by patient not producing a bowel movement today and a scant amount yesterday

Outcome: Within 48 hours, the patient will produce a soft, formed stool.

k for thromboembolism related to blood stasis as evidenced by immobility

utcome: During hospitalization, the patient will have normal extremity color and temperature

Objective Data

Potassium level -2
BUN level- 60
Creatinine- 3.71
Abdominal ultrasound finding: Fatty liver disease
CXR- significant bilateral infiltrates
Stage 1 PI on sacrum
Patient is bedfast, sedated, and receiving mechanical ventilation
Patient is unable to clear airway secretions

Client Information

On 09/09/2022, a 28-year-old male with a history of alcohol abuse and anxiety presented to the ED with complaints of persistent nausea and vomiting and left AMA. On 09/11/2022, he returned via EMS following cardiac arrest

Nursing Interventions

Provide oral and endotracheal suctioning every two hours and as needed
Elevate the head of the bed
Assess the patient's skin twice per shift for changes.
Reposition the patient every two hours avoiding pressure on the pressure injury.
Monitor albumin level and the patient's weight each shift.
Administer TPN as prescribed.
Assess the abdomen for distention and diminished or absent bowel sounds
Administer stool softeners/laxative as prescribed
Apply sequential compression devices (SCDs)
Administer anticoagulant as prescribed