N441 Care Plan

Lakeview College of Nursing

Deanna Braden

Demographics (3 points)

Date of Admission 09/09/2022	**Client Initials** J.K.	**Age** 39 years old	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Intellectually Disabled	**Marital Status** Single	**Allergies** Ceclor (unknown) Hep A and B Adult Vaccines (unknown) Hepatitis B Immune Globulin (unknown) Influenza Virus Vaccine (unknown) Penicillin (unknown) Tuberculin Purified Protein Derivative (unknown)
Code Status Full	**Height** 165.1 centimeters	**Weight** 58.8 kilograms	

Medical History (5 Points)

Past Medical History: The patient has a past medical history of acid reflux, ADHD, rhinitis, anxiety, autistic spectrum disorder, schizophrenia, bipolar manic-depressive disorder, psychotic disorder, constipation, dysphagia, GERD, osteoporosis, acid reflux, allergic rhinitis, dysphagia, hypersalivation, insomnia, lactose intolerance, leukopenia, tachycardia, and profound intellectual disability.

Past Surgical History: Past surgical history is unknown.

Family History: Family history is unknown.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient does not consume or use alcohol, tobacco, or recreational drugs.

Assistive Devices: The patient does not use assistive devices.

Living Situation: The patient lives in a group home for the intellectually disabled run by the Moultrie County Beacon.

Education Level: The patient did not attend school.

Admission Assessment

Chief Complaint (2 points): Lethargy and altered mental state.

History of Present Illness – OLD CARTS (10 points): On February 9, 2022, a 39-year-old Caucasian male from the Moultrie County Beacon group home for the intellectually disabled was brought to Sarah Bush emergency room for concerns of lethargy and altered mental status after a medication change of Guanfacine 1 mg for ADHD. The Direct Support Personnel (DSP) from the group home stated that the patient has been incontinent for the past two days and started showing signs of being lethargic a week ago that has increased every day since. The DSP stated that the patient is usually verbal with a limited vocabulary, has a healthy appetite, and is constantly moving/walking around, but is now not wanting to eat, get out of bed, and is non-verbal. The patient is unable to provide information about pain, treatment, aggravating factors, or relieving factors because of his altered state and intellectual disability.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): N/A

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

Acute respiratory failure can occur from the lungs not being able to remove carbon dioxide from the blood or from the air sacs (alveoli) in your lungs building up with fluid. With fluid build-up, the lungs cannot release oxygen into the blood. This results in the organs not getting enough oxygen-rich blood to function (Capriotti, 2020). Respiratory failure occurs whenever the capillaries or tiny blood vessels that surround the air sacs cannot properly

exchange carbon dioxide for oxygen (Capriotti, 2022). Respiratory failure can be acute or chronic. With acute respiratory failure, the symptoms will be immediate from not having enough oxygen in your body and could lead to death if not treated quickly (Capriotti, 2022).

Symptoms of acute respiratory failure depend on the levels of carbon dioxide and oxygen in your blood and the underlying cause (Hinkle, 2018). High carbon dioxide levels can cause rapid breathing and confusion. The patient was experiencing confusion when he was brought to the emergency room. Low oxygen levels can cause an inability to breathe and a blue color in the skin, fingertips, or lips. Other symptoms of acute respiratory failure include restlessness, anxiety, sleepiness, lethargy, loss of consciousness, rapid and shallow breathing, racing heart, arrhythmias, and profuse sweating (Hinkle, 2018). The patient was lethargic when he was brought to the emergency room. Risk factors for acute respiratory failure are tobacco use, drinking excessively, a family history of respiratory disease or conditions, an injury to the spine, brain, or chest, a compromised immune system, and having a chronic respiratory problem, such as COPD (Hinkle, 2018).

Immediate medical attention is required for acute respiratory failure. To diagnose acute respiratory failure the following will be performed: a physical exam will be performed, a family history, oxygen and carbon dioxide levels, and a chest X-ray (Hinkle, 2018). The patient received all of these for his diagnosis. Labs that are done consist of a complete blood count, chemistries, liver function tests, coagulation studies, and arterial blood gas (ABG) analysis (Hinkle, 2018). The patient had elevated PaCO2, INR, PT, and glucose, and low RBC, Hgb, Hct, and creatinine. Treatment for acute respiratory failure consists of treating the underlying conditions. The provider may prescribe pain medications or medications to help with breathing and opening the lungs (Hinkle, 2018). Oxygen from an oxygen tank is given to patients that can

breathe adequately, and a breathing tube is inserted for patient's that cannot breathe adequately (Hinkle, 2018). If prolonged ventilation support is required, then a tracheostomy may be placed. The patient was in an unstable condition and was not able to breathe on his own, so he was intubated and sedated.

Pathophysiology References (2) (APA):

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

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	3.80-5.41	3.16 (L)	3.43 (L)	Respiratory issues, impaired nutritional state, and elevated pH and PaO2 levels are causation factors for a low RBC count (Van Leeuwen & Bladh, 2021). The patient has a diagnosis of acute respiratory failure, is lethargic and not eating, and has elevated pH and PaO2.
Hgb	11.3-15.2	9.7 (L)	10.6 (L)	Low Hgb is a result of low RBC count. With anemia, the lungs overcompensate to bring in more oxygen, causing breathing difficulties (Van Leeuwen & Bladh, 2021). The patient has a diagnosis of acute respiratory failure.
Hct	33.2-45.3	28.7 (L)	30.9 (L)	Low Hct is a result of low RBC count.

				With anemia, the lungs overcompensate to bring in more oxygen, causing breathing difficulties (Van Leeuwen & Bladh, 2021). The patient has a diagnosis of acute respiratory failure.
Platelets	149-393	252	241	
WBC	4.0-11.7	7.9	11.6	
Neutrophils	45.3-79.0	65.0	78.0	
Lymphocytes	11.8-45.9	21.7	12.7	
Monocytes	4.4-12.0	10.4	6.8	
Eosinophils	0.0-6.3	2.2	1.3	
Bands	0.2-1.6	0.7	0.8	

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-	136-145	141	140	
K+	3.5-5.1	4.1	4.4	
Cl-	98-107	103	103	
CO2	21-31	34 (H)	28	High CO2 is due to the patient being diagnosed with acute respiratory failure (Van Leeuwen & Bladh, 2021).
Glucose	74-109	125 (H)	124 (H)	The patient's glucose could be elevated because of dehydration from not wanting to eat or drink for a week prior to being admitted to the hospital (Van Leeuwen & Bladh, 2021).
BUN	7-25	24	24	
Creatinine	0.60-1.20	0.45 (L)	0.49 (L)	Low creatinine can be a result of malnutrition (Van Leeuwen &

				Bladh, 2021).
Albumin	3.5-5.2	N/A	N/A	
Calcium	8.6-10.3	8.9	9.1	
Mag	1.6-2.4	1.7	1.9	
Phosphate	2.5-4.5	4.9	3.7	
Bilirubin	0.3-1.0	0.3	0.3	
Alk Phos	34-104	52	57	
AST	13-39	17	18	
ALT	7-52	18	21	
Amylase	30-110	N/A	N/A	
Lipase	24-151	N/A	N/A	
Lactic Acid	0.5-2.0	0.6	N/A	
Troponin	0.000-0.030	< 0.010	N/A	
CK-MB	5-25	N/A	N/A	
Total CK	30-223	N/A	N/A	

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	0.86-1.14	1.04	1.37 (H)	An elevated INR is due to the patient's diagnosis of acute respiratory failure (Hinkle & Cheever, 2018).
PT	11.9-15.0	14.0	17.3 (H)	An elevated PT is due to the patient's diagnosis of acute respiratory failure (Hinkle &

				Cheever, 2018).
PTT	22.6-35.3	N/A	N/A	
D-Dimer	0.00-0.62	N/A	N/A	
BNP	0-100	N/A	N/A	
HDL	23-92	N/A	N/A	
LDL	<100	N/A	N/A	
Cholesterol	<199	N/A	N/A	
Triglycerides	0-149	N/A	N/A	
Hgb A1c	<6.4	N/A	N/A	
TSH	0.45-5.33	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	Yellow/clear	Light Yellow/Clear	Light Yellow/Clear	
pH	5.0-8.0	6.0	6.5	
Specific Gravity	1.005-1.034	1.030	1.028	
Glucose	Negative	Negative	Negative	
Protein	Negative	Negative	Negative	
Ketones	Negative	Negative	Negative	
WBC	0.0-5.0	1.0	2.0	
RBC	0-3	3	3	
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	7.43	7.44	
PaO2	35.0-45.0	45.0	42.4	
PaCO2	75.0-85.0	203.0 (H)	131.0 (H)	The patient has an elevated PaCO2 level due to acute respiratory failure.
HCO3	22.0-26.0	26.0	25.9	
SaO2	95% - 100%	100.0	99.8	

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/No growth	Positive/Growth	N/A	Proteus mirabilis >100,000 cpu/mL The patient was diagnosed with a urinary tract infection (UTI).
Blood Culture	Negative/No growth	Negative/No growth	N/A	
Sputum Culture	Negative/No growth	Positive/Growth	N/A	Candida albicans (Fungus isolated - No sensitivity performed) The patient was diagnosed with a yeast infection.
Stool Culture	Negative/No growth	Negative/No growth	N/A	

Lab Correlations Reference (1) (APA):

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

Sarah Bush Lincoln Health Center. (2021). *Cerner*. https://www.sarahbush.org/

Van Leeuwen, A. M., & Bladh, M. L. (2021). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications* (9th ed.). F.A. Davis.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

On 9/9/2022, the patient had a CT Head without Contrast. The CT showed No hemorrhage, unremarkable white matter, no mass effect, and no ventriculomegaly. Visualized sinuses are unremarkable with no fluid levels.

9/30/2022, the patient had a XR Chest IV ET Tube Placement. Impressions showed tracheostomy tube with tip 4.7 centimeters above the carina, right sided PICC line in good position, esophagogastric tube courses below the diaphragm off the field of view, and negative for focal airspace consolidation, pleural effusion, or pneumothorax.

Diagnostic Test Correlation (5 points):

The CT Head without Contrast was used to evaluate for intracranial hemorrhage or other acute intracranial abnormality. A non-contrast Head CT is used for detecting acute hemorrhage in the brain (Van Leeuwen & Bladh, 2021). This test is used on patients with acute CNS symptoms. The test usually takes about 30 to 60 minutes. The patient had this test to rule out hemorrhage or fluid around the brain.

The XR Chest IV ET was used to make sure that placement of the Tracheostomy tube was in the correct place for the patient. A chest X-ray is used after placement of an endotracheal tube to determine the position of its tip (Van Leeuwen & Bladh, 2021). The main bronchi, carina, and trachea are identifiable on the chest X-ray when it is viewed on a high-quality screen (Van Leeuwen & Bladh, 2021). The ET tube tip is correctly located in the trachea, 5 cm above the

carina, and most ET tubes have an inflatable cuff which forms a seal against the trachea (Van Leeuwen & Bladh, 2021).

Diagnostic Test Reference (1) (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2021). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications* (9th ed.). F.A. Davis.

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

Home Medications (5 required)

Brand/Generic	**loxapine (Adasuve)**	**lithium (Lithobid)**	**clonazepam (Klonopin)**	**guanfacine (Intunive)**	**quetiapine (Seroquel)**
Dose	100 mg	300 mg	0.5 mg	1 mg Morning 2 mg – Nightly	200 mg
Frequency	BID	Every morning and every night	Nightly	1 mg Morning 2 mg Nightly	BID
Route	Oral	Oral	Oral	Oral	Oral
Classification	Antipsychotic neuroleptic and Dibenzoazepine	Psychotropic agent-antimanic and Alkali metal iron salt	Anticonvulsant and Benzodiazepine derivative	Alpha2 Adrenergic Agonists and ADHD Agents	Antipsychotic and Di benzothiazepine
Mechanism of Action	Pharmacologically, Loxapine is a tranquilizer for which the	May alter sodium, potassium iron transport	Inhibits spike, wave formation during absence seizures; decreases	Stimulates postsynaptic alfa-2A adrenergic receptors so	Functions as an antagonist at multiple neurotransmitter receptors

	exact mode of action has not been established (Jones & Bartlett, 2020).	across cell membrane in nerve, muscle cells; may balance biogenic amines of norepinephrine, serotonin in CNS areas involved in emotional responses (Jones & Bartlett, 2020).	amplitude, frequency, duration, spread of discharge during minor motor seizures (Jones & Bartlett, 2020).	it inhibits the production of cAMP and closes HCN channels enhancing the effectiveness of the signal of the pyramidal neurons of the prefrontal cortex, thus improving working memory and attention (Jones & Bartlett, 2020).	in the brain, including dopamine and adrenergic receptors (Jones & Bartlett, 2020).
Reason Client Taking	Acute agitation associated with schizophrenia and anxiety	Prevention of bipolar manic-depressive psychosis.	Panic disorder, anxiety, and insomnia	Attention deficit hyperactivity disorder (ADHD)	Mania, schizophrenia, and agitation
Contraindications (2)	Severe drug-induced CNS depression, hypersensitivity, and coma (Jones & Bartlett, 2020).	Severe cardiac/renal disease. Severe dehydration (Jones & Bartlett, 2020).	Coadministration with other CNS depressants, especially opiates. Chronic respiratory disease (Jones & Bartlett, 2020).	CNS depressants, hypertension, and hypersensitivity to guanfacine or to any component of the product (Jones & Bartlett, 2020).	Seizures, QT prolongation, and brain tumor (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Difficulty breathing and confusion (Jones & Bartlett, 2020).	Urinary incontinence and tinnitus (Jones & Bartlett, 2020).	Thrombocytopenia and anemia (Jones & Bartlett, 2020).	Dry mouth and abdominal or stomach pain (Jones & Bartlett, 2020).	Leukopenia and tachycardia (Jones & Bartlett, 2020).

Nursing Considerations (2)	Monitor signs of allergic reactions, including pulmonary symptoms (tightness in the throat and chest, wheezing, cough, dyspnea) or skin reactions (rash, pruritus, urticaria). Notify physician immediately if these reactions occur (Jones & Bartlett, 2020).	Assess mental status for manic symptoms, mood, behavior before, and during treatment. Watch for signs and symptoms of toxicity (diarrhea, vomiting, tremor, twitching) (Jones & Bartlett, 2020).	Assess for seizures. Abrupt discontinuation may increase seizures (Jones & Bartlett, 2020).	May cause low blood pressure, orthostasis, slow heart rate, and fainting. Avoid abrupt withdrawal (can result in anxiety, nervousness, and rebound hypertension) (Jones & Bartlett, 2020).	Assess CV status: QT prolongation, tachycardia, orthostatic BP. Evaluate therapeutic response: decrease in emotional excitement, hallucinations, delusions, and paranoia (Jones & Bartlett, 2020).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor baseline BP pattern prior and during therapy, observe for extrapyramidal effects such as acute dystonia during early therapy, monitor I&O and bowel elimination patterns and check for bladder distention (Jones & Bartlett, 2020).	Serum lithium levels 2 times per week initially, then every 2 months (Therapeutic level: 0.5-1.5 mEq/L). Toxic level > 1.5 mcg/L; the drug has a narrow therapeutic index. Weight, sodium intake, skin turgor, urine for albuminuria, glycosuria, and uric acid, neurologic status, ECG (Jones &	Blood studies: RBC, Hct, Hgb, reticulocyte counts every week for 4 weeks, then monthly and Hepatic studies: ALT, AST, bilirubin, creatinine (Jones & Bartlett, 2020).	Blood pressure and heart rate (Jones & Bartlett, 2020).	Mental status, AMS assessment, orientation, LOC, reflexes, gait coordination, sleep pattern disturbances, suicidal thoughts, QT prolongation, pulse, blood pressure, respirations, baseline blood glucose, LFTs, neurologic function, ophthalmologic exam, weight, glucose, thyroid function tests, serum electrolytes / creatinine /

		Bartlett, 2020).			lipid profile (Jones & Bartlett, 2020).
Client Teaching needs (2)	Do not change dosage regimen in any way without physician approval and avoid self-dosing with over-the-counter drugs unless approved by the physician (Jones & Bartlett, 2020).	Symptoms of minor toxicity, monitor urine specific gravity, emphasize need for follow-up care to determine lithium levels, monitor lithium levels to ensure effective levels and treatment, not to operate machinery until lithium levels are stable (Jones & Bartlett, 2020).	Carry emergency ID bracelet stating name, products taken, condition, prescriber's name, phone number and teach to continue with follow-up exams, lab work (Jones & Bartlett, 2020).	Employ measures to keep mouth moist; saliva substitutes and do not self-medicate with over-the-counter drugs such as cough syrup or sleeping medications without consulting your physician (Jones & Bartlett, 2020).	Not to become overheated, to drink plenty of fluids and to rise slowly to prevent orthostatic hypotension (Jones & Bartlett, 2020).

Hospital Medications (5 required)

Brand/Generic	ondansetron (Zofran)	famotidine (Pepsid)	enoxaparin (Lovenox)	furosemide (Lasix)	benztropine (Cogentin)
Dose	4 mg = 2 mL	20 mg = 1 tab	40 mg = 0.4 mL	40 mg = 4 mL	1 mg = 1 tab

Frequency	Every 6 hours PRN	BID	Daily	Daily	BID
Route	IV Push	NG Tube	Subcutaneous Injectable	IV Push Injectable	NG Tube
Classification	Selective serotonin receptor antagonist. Antiemetic	H2 histamine receptor antagonist	Anticoagulant, antithrombotic. Low molecular-weight heparin	Loop diuretic. Antihypertensive, diuretic	Cholinergic blocker, antiparkinsonian agent; Tertiary amine
Mechanism of Action	Reduces nausea and vomiting by blocking serotonin receptors in the small intestine and CNS (Jones & Bartlett, 2020).	Competitively inhibits histamine at histamine h2 receptor site, decreasing gastric secretion while pepsin remains at a stable level (Jones & Bartlett, 2020).	Binds to antithrombin III inactivating factors Xa/IIa,, resulting in a higher ratio of anti-factor Xa to IIa (Jones & Bartlett, 2020).	Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation (Jones & Bartlett, 2020).	Blockade of central acetylcholine receptors, balances cholinergic activity (Jones & Bartlett, 2020).
Reason Client Taking	Nausea	GERD	Prevention of DVT and PE	Prevent/ reduce Edema	Hypersalivation
Contraindications (2)	Congenital long QT syndrome, hypersensitivity to ondansetron (Jones & Bartlett, 2020).	Hypersensitivity and Severe renal/hepatic disease (Jones & Bartlett, 2020).	Active major bleeding, hemophilia, leukemia with bleeding. Thrombocytopenic purpura (Jones & Bartlett, 2020).	Anuria and hypersensitivity to furosemide or its components (Jones & Bartlett, 2020).	Tardive dyskinesia and closed-angle glaucoma (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Intestinal obstruction, hypotension (Jones & Bartlett, 2020).	Headache and constipation (Jones & Bartlett, 2020).	Ecchymosis, Fever (Jones & Bartlett, 2020).	Arrhythmias and hyperglycemia (Jones & Bartlett, 2020).	Anxiety and confusion (Jones & Bartlett, 2020).
Nursing Considerations	Be aware that ondansetron	Increase in bulk and fluids in diet	Monitor for bleeding. Evaluate	Use cautiously in patients with	Assess paralytic ileus: abdominal pain,

(2)	can cause a prolonged QT interval and monitor for signs and symptoms of serotonin syndrome (Jones & Bartlett, 2020).	to prevent constipation . Assess for ulcers: epigastric pain, abdominal pain, occult blood in emesis, stools (Jones & Bartlett, 2020).	therapeutic response: prevention of DVT/PE (Jones & Bartlett, 2020).	advanced hepatic cirrhosis. Be aware that patients who are allergic to sulfonamides may also be allergic to furosemide. Monitor patient closely (Jones & Bartlett, 2020).	intermittent constipation/diarrhea. Use caution during hot weather; product may increase susceptibility to heat stroke by decreasing sweating (Jones & Bartlett, 2020).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor for electrolyte imbalance, adverse reactions, and EKG changes (Jones & Bartlett, 2020).	Renal function, Intragastric pH, serum creatinine/BUN baseline and periodically, for bleeding, hematuria, occult blood in stools, abdominal pain (Jones & Bartlett, 2020).	Blood studies (Hct/gb, CBC, coagulation studies, platelets, occult blood in stools, BUN, Creatinine (Jones & Bartlett, 2020).	Weight before and periodically during therapy, BP, hepatic and renal function, BUN, blood glucose, serum creatinine, electrolyte, and uric acid levels (Jones & Bartlett, 2020).	I & O ratios, mental status, LOC, gait, and BP (Jones & Bartlett, 2020).
Client Teaching needs (2)	Instruct the patient to report signs of hypersensitivity such as a rash immediately and advise the patient to seek immediate medical attention if symptoms persist or worsen (Jones & Bartlett,	About possibility of decreased libido that is reversible after discontinuing therapy. To avoid irritating foods, aspirin, NSAIDs, extreme temperature foods, alcohol that may irritate GI system	To report any signs of bleeding. Report dizziness, rash, breathing changes (Jones & Bartlett, 2020).	Take at the same time each day to maintain therapeutic effect. Change position slowly to minimize effects of orthostatic hypotension and to take with food or milk to reduce GI distress (Jones & Bartlett, 2020).	Report urinary hesitancy/retention, dysuria. Change positions slowly to prevent orthostatic hypotension (Jones & Bartlett, 2020).

	2020).	(Jones & Bartlett, 2020).			

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Unable to assess due to intubation and sedation. The patient's overall appearance was appropriate considering the circumstances.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin color: The skin color was appropriate for ethnicity Character/Temperature: warm and dry. Turgor: Elasticity The patient did not have and rashes/bruises/wounds. Braden Score: 7 (Indicates the patient is a high risk for impaired skin integrity).
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Unable to assess some parts due to intubation and sedation (Nose, swallowing, inside of mouth) The patient's head and neck were symmetrical. Ears symmetrically placed on each side of the head, tympanic membranes pearly gray with minimal cerumen present, and no drainage or bleeding. Eyes were placed equally and bilaterally. Pupil size 3mm, PERRLA Mouth/Teeth: Plague, Frothy sputum, ulcers, and had his teeth clenched shut.
CARDIOVASCULAR: **Heart sounds:**	Heart Sounds: Normal for S1 and S2, no friction rubs, gallops, or murmurs detected in S3 and S4.

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:**	Peripheral pulses: 3+ upper and lower extremities. Cap Refill less than 3 seconds upper and lower extremities. No lymphadenopathy, No JVD. No signs of neck vein distention. No signs of Edema. PR: 0.16 seconds QRS: 0.12 seconds QT: 0.40 seconds Rate: 80 bpm Regularity: Regular Sinus Rhythm
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character** **ET Tube: N/A** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Unable to assess some parts due to intubation and sedation Breath sounds: The patient was intubated and sedated. Stack breathing bilaterally, in upper and lower lobes anteriorly. Not able to assess posteriorly due to intubation. Respiration Rate: 18 FiO2: 28 Total volume (TV): 350 PEEP: 8.0 VAP prevention measures: Hand hygiene, clean gloves, suctioning every 2 hours and as needed, oral care every 2 hours and as needed, brush the patient's teeth every 2 hours, recap suction tube, and clean around the ET tube carefully (Hinkle & Cheever, 2018) .
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:**	Diet at home: Regular Current Diet: Intubated and Sedated Height: 165.1 cm Weight: 58.8 kg Bowel Sounds: Active in all 4 quadrants. Unable to assess due to intubation and sedation: last BM and Pain. No abdominal masses, distention, incisions, scars, drains, or wounds.

Incisions: None **Scars: None** **Drains: None** **Wounds: None** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☒ N ☐** **Size: 16 French** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	NG: 16 French
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** French **Size: 16** **CAUTI prevention measures:**	Color and Character: Clear, light yellow. Unable to assess odor or pain with urination due to catheter and intubation and sedation. Quantity of urine: 125 mL output in catheter during my clinical rotation. Catheter: 16 French (Indwelling/Continuous) Genitals: No swelling, redness, or skin breakdown. CAUTI prevention: Hand hygiene, sterile placement technique, collection bag below level of bladder and not hooked on the bed, check for blockages or kinks, and perform perineal and catheter care every 8 hours or as needed.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 70 (High Risk) **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Neuro Status, Strength: Unable to assess due to intubation and sedation. Unable to follow commands. ROM: Able to perform PROM. Morse Fall Score: 70 (High Risk) Supportive Devices: Heal protectors, low air loss bed, and moon boots. Activity/Mobility Status: Patient is intubated and sedated.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐**	Unable to assess due to intubation and sedation. Unable to follow commands. PERLA

Orientation: **Mental Status:** **Speech:** **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 assess due to intubation and sedation. Family not at bedside.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	63 bpm	114/71 mmHg	18	38.8 degrees C	97%
1000	65 bpm	119/71 mmHg	19	38.4 degrees C	97%

Vital Sign Trends/Correlation:

The patient's pulse, blood pressure, respiratory rate, and oxygen saturation level remained within therapeutic range during my clinical rotation. The patient's temperature was elevated due to being in acute respiratory failure. The nurse will continue to monitor.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
Unable to assess pain due to intubation and sedation.	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Unable to assess pain due to intubation and sedation.	**N/A**	**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:**	9-27-22 Central IV – Peripherally inserted central catheter (PICC) – Triple – Infusing 22.3 mcg/ hour of Presidex Dexmedetomidine. The IV is patent with no signs of erythema, phlebitis, drainage, or infiltration. Dressing is intact, clear, and dry.
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:**	CLABSI prevention measures: Hand hygiene, sterile technique for access and dressing changes, CUROS caps on open lines, alcohol wipes on port before administering medications, and applying CHG impregnated dressings.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
156.1 mL during my clinical rotation.	Urinary Catheter: 125 mL during my clinical rotation

Nursing Care

Summary of Care (2 points)

Overview of care: Performed a head-to-toe assessment, IV and dressing assessment, NG assessment, catheter assessment, and ventilator assessment for the patient. Some assessments

were not able to be performed due to the patient being intubated and sedated. Performed suctioning and mouth care with observation from the clinical instructor.

Procedures/testing done: The patient did not have any procedures or testing done during my clinical rotation.

Complaints/Issues: The patient was intubated and sedated. Unable to assess.

Vital signs (stable/unstable): The patient remained stable, and all vital signs were within normal range except for temperature during my clinical rotation. The patient's temperature was elevated due to being in acute respiratory failure. The nurse will continue to monitor.

Tolerating diet, activity, etc.: The patient was intubated and sedated. He had a continuous indwelling catheter and was on bed rest.

Physician notifications: There was not any Physician notifications during my clinical rotation.

Future plans for client: Intubation, sedation, and continuous monitoring will continue until further notified by the primary.

Discharge Planning (2 points)

Discharge location: The discharge plans have not been determined for this patient due to being intubated and sedated. He does live in a group home for the intellectually disabled through the Moultrie County Beacon.

Home health needs (if applicable): Home health needs have not been determined for this patient at this time.

Equipment needs (if applicable): Equipment needs have not been determined for this patient at this time.

Follow up plan: A follow up plan has not been determined for this patient at this time.

Education needs: The patient is intellectually disabled. Education needs are undetermined currently.

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.
Ineffective Airway Clearance "related to" decreased energy and fatigue "as evidenced by" abnormal breath sounds	I chose this nursing diagnoses due to the patient being intubated and sedated for Acute Respiratory Failure.	1.Institute airway suctioning as indicated based on the presence of adventitious breath sounds and/or increased ventilatory pressure (Hinkle & Cheever, 2018). 2.Hyperoxygenation as ordered to decrease formation of hypoxia and cardiac dysrhythmias related to suctioning procedure (Hinkle & Cheever, 2018).	Patient will maintain clear, open airways, as evidenced by normal breath sounds after suctioning (Hinkle & Cheever, 2018).	Unable to assess due to the patient being intubated and sedated.
Ineffective	I chose this	1. Auscultate the	Patient	Unable to assess

Breathing Pattern “related to” decreased lung expansion “as evidenced by” need for ventilator	nursing diagnosis because the patient was stack breathing and had abnormal breathing pattern.	lungs for the presence of normal or adventitious breath sounds (Hinkle & Cheever, 2018). 2.Monitor oxygen saturation prior to and after suctioning (Hinkle & Cheever, 2018).	maintains an effective breathing pattern, as evidenced by relaxed breathing at normal rate and depth and absence of dyspnea (Hinkle & Cheever, 2018).	due to the patient being intubated and sedated.
Impaired physical mobility related to intubation and sedation as evidenced by acute respiratory failure	I chose this nursing diagnosis due to the patient being intubated and sedated	1.Perform passive range of motion exercises to the patients upper and lower extremities (Hinkle & Cheever, 2018). 2. Medicate for pain per doctor’s orders and promote proper nutrition and hydration per doctor’s order (Hinkle & Cheever, 2018).	Patient will remain free of contractures and decubitus ulcers from impaired mobility (Hinkle & Cheever, 2018).	Unable to assess due to the patient being intubated and sedated.
Risk for impaired skin integrity as evidenced by patient is non-mobile related to intubation, sedation, and bedrest.	I chose this nursing diagnosis because of the importance of preventing skin integrity for this patient since he is intubated and sedated.	1. Assess for areas of possible skin breakdown. Use a heal protector on both feet and other devices for prevention of skin breakdown (Hinkle & Cheever, 2018). 2. Assess the amount of shear and friction on the patient’s skin (Hinkle & Cheever, 2018).	Promote circulation to tissues by reducing or eliminating pressure (Hinkle & Cheever, 2018).	Unable to assess due to the patient being intubated and sedated.

Risk for Ineffective Protection related to ventilator dependency as evidenced by the patient being intubated and sedated.	I chose this nursing diagnosis because of the importance of preventing ventilator associated pneumonia since this patient is intubated and sedated.	1.Review the ventilator settings every hour. Notify the respiratory unit of any discrepancy in the ventilator settings immediately (Hinkle & Cheever, 2018). 2.Assess for the signs of pulmonary infection (Hinkle & Cheever, 2018).	Patient will have a decreased potential for injury from barotrauma and ventilator associated pneumonia by continuous assessments and early interventions (Hinkle & Cheever, 2018).	Unable to assess due to the patient being intubated and sedated.

Other References (APA):

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

Concept Map (20 Points):

Subjective Data

The patient is not able to communicate or give subjective data because he is intubated and sedated. No family members were present.

Objective Data

Vitals:
BP: 114/71 mm Hg
HR: 63 bpm
Respirations: 18 breaths/min
Temp: 38.8 degree C (Elevated)
SaO2: 97%
FiO2: 28 ventilators
Humidification Temp: 37.0
Total volume: 350
PEEP: 8.0

Client Information

A 39-year-old Caucasian male with a past medical history of GERD, ADHD, Autistic Spectrum Disorder, Dysphagia, Anxiety, Allergy Rhinitis, and Acid Reflux was admitted for Acute Respiratory Failure with lethargy, altered level of consciousness, and fatigue. The patient currently lives at a group home for the intellectually disabled through the Moultrie County Beacon.

Nursing Diagnosis/Outcomes

1. Ineffective Airway Clearance "related to" decreased energy and fatigue "as evidenced by" abnormal breath sounds
   a. Patient will maintain clear, open airways, as evidenced by normal breath sounds after suctioning (Hinkle & Cheever, 2018).
2. Ineffective Breathing Pattern "related to" decreased lung expansion "as evidenced by" need for ventilator
   a. Patient maintains an effective breathing pattern, as evidenced by relaxed breathing at normal rate and depth and absence of dyspnea (Hinkle & Cheever, 2018).
3. Impaired physical mobility related to intubation and sedation as evidenced by acute respiratory failure
   a. Patient will remain free of contractures and decubitus ulcers from impaired mobility (Hinkle & Cheever, 2018).
4. Risk for impaired skin integrity as evidenced by patient is non-mobile related to intubation, sedation, and bedrest.
   a. Promote circulation to tissues by reducing or eliminating pressure (Hinkle & Cheever, 2018).
5. Risk for Ineffective Protection related to ventilator dependency as evidenced by the patient being intubated and sedated.
   a. Patient will have a decreased potential for injury from barotrauma and ventilator associated pneumonia by continuous assessments and early interventions (Hinkle & Cheever, 2018).

NOTE: UNABLE TO ASSESS OUTCOMES DUE TO PATIENT BEING INTUBATED AND SEDATED

Nursing Interventions

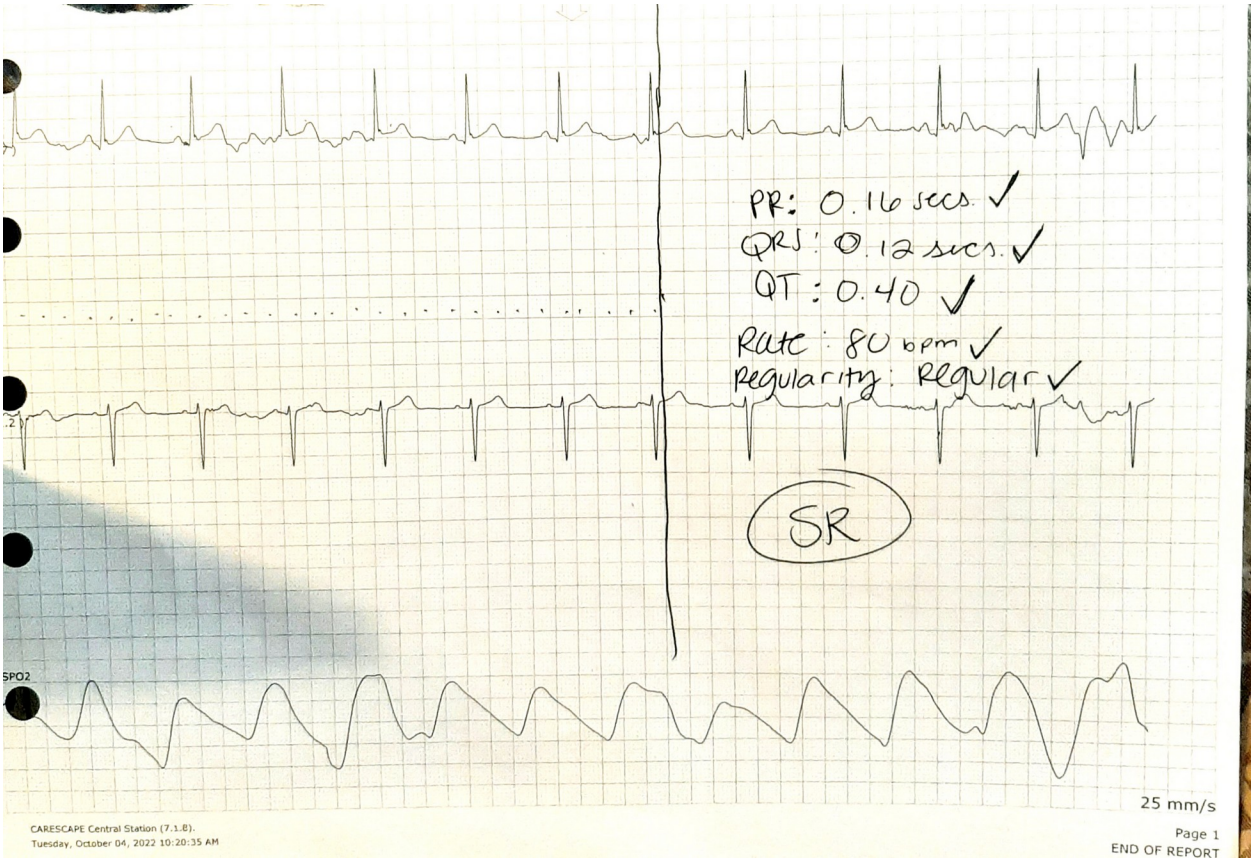
1.Institute airway suctioning as indicated based on the presence of adventitious breath sounds and/or increased ventilatory pressure (Hinkle & Cheever, 2018).
2.Hyperoxygenation as ordered to decrease formation of hypoxia and cardiac dysrhythmias related to suctioning procedure (Hinkle & Cheever, 2018).

1. Auscultate the lungs for the presence of normal or adventitious breath sounds (Hinkle & Cheever, 2018).
2.Monitor oxygen saturation prior to and after suctioning (Hinkle & Cheever, 2018).

.Perform passive range of motion exercises to the patients upper and lower xtremities (Hinkle & Cheever, 2018).
Medicate for pain per doctor's orders and promote proper nutrition and hydration er doctor's order (Hinkle & Cheever, 2018).

1. Assess for areas of possible skin breakdown. Use a heal protector on both feet and other devices for prevention of skin breakdown (Hinkle & Cheever, 2018).
2. Assess the amount of shear and friction on the patient's skin (Hinkle & Cheever, 2018).

1.Review the ventilator settings every hour. Notify the respiratory unit of any discrepancy in the ventilator settings immediately (Hinkle & Cheever, 2018).
2.Assess for the signs of pulmonary infection (Hinkle & Cheever, 2018).


PR: 0.16 secs. ✓
QRS: 0.12 secs. ✓
QT: 0.40 ✓
Rate: 80 bpm ✓
Regularity: Regular ✓
SR
SPO2
25 mm/s
CARESCAPE Central Station (7.1.8).
Tuesday, October 04, 2022 10:20:35 AM
Page 1
END OF REPORT