N441 Care Plan

Lakeview College of Nursing

Jamal Drea

Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
2/13/23	P.R.	74	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	"Community action agency"	Married	Clarithromycin, duloxetine, propoxyphone
Code Status	**Height**	**Weight**	
FULL	5'4" (162.6 cm)	224 lbs (101.6 kg)	

Medical History (5 Points)

Past Medical History: Asthma, T2DM, HTN, hyperlipidemia, decreased thyroid activity, CVA

Past Surgical History:cholecystectomy, hysterectomy, carpal tunnel release (wrists bilaterally), knee arthroscopy (bilateral)

Family History: N/A

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

Assistive Devices: Uses 4 wheel walker and wheelchair at home

Living Situation: Lives in house with husband and stepdaughter

Education Level: N/A

Admission Assessment

Chief Complaint (2 points): Neck pain, vomiting

History of Present Illness – OLD CARTS (10 points): The patient is a 74 year old woman who presented to the ED with complaints of neck pain and vomiting after being transported by EMS. Health history was collected through the patient's daughter because of their altered mental status. The daughter reports that P.R. was vomiting all day the day before admission and was unable to keep their meals down. Constant abdominal pain and

left arm pain were also reported. Heart rate was recorded as low as 42 bpm, blood pressure was elevated at 143/65, temperature was decreased at 96.1 degrees F, respirations were 16/minute, and O2 sat was 100%. Fluids and norepinephrine were administered to the patient. The patient was intubated to maintain their airway.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Sepsis (related to UTI)

Secondary Diagnosis (if applicable): Acute respiratory failure with hypoxia

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

Sepsis is an inflammatory disorder that results as a response by the body to a widespread infection. This immune response is severe and can lead to organ failure that results in death in untreated. Urosepsis, or an infection that originates in the urinary tract, is the original cause for about 25% of sepsis cases. If urosepsis is suspected, a urinalysis with a urine culture should be performed to diagnose the patient (Porat et al., 2022). The patient had a urinalysis done, and the results included cloudy urine with an increase in white blood cells, red blood cells, and leukoesterase. Elevated WBC and leukoesterase in the urine is consistent with a urinary tract infection. There was also hematuria in the sample that occurred as a result of the patient's diagnosed cystitis (Pagana, 2018). The effects of sepsis are initiated through a mechanism of innate immunity in which pathogens activate binding of neutrophils and macrophages, monocytes, and natural killer T cells leading to proinflammatory pathways. Signs of severe sepsis include fever of 38 degrees celsius or hypothermia with 36 degrees celsius or lower. Other signs are tachycardia, tachypnea, or PaCO2 under 32 mmHg (Guliciuc et al., 2021). The initial assessment for the

patient showed a temperature of 35.6 degrees celsius and ABG results had PaCO2 at 30 and 26 mmHg between two tests. Additional signs of sepsis are respiratory dysfunction, impaired kidney function, and change in mental status (Porat et al., 2022). The patient experienced acute respiratory failure, showed a significantly elevated level of creatinine that suggests poor renal function, and showed confusion during assessment. Treatment for urosepsis is done through the administration of antibiotics and fluids. The patient is prescribed fluids and cefepime intravenously, which is a cephalosporin used for urinary tract infections.

Pathophysiology References (2) (APA):

Guliciuc, M., Maier, A. C., Maier, I. M., Kraft, A., Cucuruzac, R. R., Marinescu, M., Şerban, C., Rebegea, L., Constantin, G. B., & Firescu, D. (2021). The urosepsis: A literature review. *Medicina (Lithuania), 57*(9), 872. https://doi.org/10.3390/medicina57090872

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

Porat, A., Bhutta, B.S., Kesler, S. (2022). Urosepsis. *StatPearls*. Treasure Island StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK482344/

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	4.2-5.4	4.22	4.16	RBC count is on the lower side, which could be due to dietary

				deficiency or impaired renal function, evidenced by creatinine (Pagana, 2018).
Hgb	**12-16**	**11.9**	**11.7**	**The patient is currently on antibiotics, which could cause a lower amount of hemoglobin (Pagana, 2018).**
Hct	**37-47%**	**35.1**	**35.2**	**Hematocrit reflects the Hgb and RBC levels, which explains the patient's Hct being below the normal range (Pagana, 2018).**
Platelets	**150-400**	**110**	**103**	**The patient is on medications like cefepime and aspirin that could result in thrombocytopenia. It could also be caused by acute infection (Pagana, 2018).**
WBC	**5-10**	**5.1**	**6**	
Neutrophils	**55-70%**	**69.6**	**78.1**	**An increase in neutrophil count is related to physical stress and acute infection (Pagana, 2018).**
Lymphocytes	**20-40%**	**22.8**	**10.7**	**Decrease lymphocyte count is attributed to the patient's diagnosed sepsis (Pagana, 2018).**
Monocytes	**2-8%**	**6.5**	**10.7**	**Monocytosis is connected to infection (Pagana, 2018).**
Eosinophils	**0-4%**	**0.6**	**0.1**	
Bands	**0.5-1%**	**N/A**	**N/A**	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**136-145**	**138**	**140**	
K+	**3.5-5.0**	**3.9**	**3.7**	
Cl-	**98-106**	**106**	**109**	**Chloride is slightly increased, which could be caused by dehydration (as evidenced by BUN) or the patient's use of NSAIDs like Tylenol.**

CO2	**23-30**	**20**	**19**	**Decreased levels of CO2 are related to impaired renal function as evidenced by elevated creatinine and BUN (Pagana, 2018).**
Glucose	**82-115**	**234**	**281**	**Hyperglycemia is due to the patient's history of T2DM (Pagana, 2018).**
BUN	**10-20**	**57**	**52**	**Sepsis and dehydration are possible causes of the patient's increased BUN levels (Pagana, 2018).**
Creatinine	**0.5-1.1**	**1.93**	**2.09**	**Creatinine could be increased because of the patient's UTI along with dehydration (Pagana, 2018).**
Albumin	**3.5-5.0**	**3**	**3**	**Decreased albumin is related to acute infection and stress. A CT of the patient's abdomen showed cirrhosis of the liver, which could also contribute to decreased albumin (Pagana, 2018).**
Calcium	**9-10.5**	**9.9**	**9.5**	
Mag	**1.3-2.1**	**2.1**	**N/A**	
Phosphate	**3-4.5**	**3.2**	**N/A**	
Bilirubin	**0.3-1.0**	**0.5**	**0.5**	
Alk Phos	**30-120**	**112**	**106**	
AST	**0-35**	**19**	**14**	
ALT	**4-36**	**13**	**11**	
Amylase	**6.6-35.2**	**N/A**	**N/A**	
Lipase	**0-160**	**57.6**	**N/A**	
Lactic Acid	**5-20 (venous) or 3-7 (arterial)**	**1.8**	**N/A**	

Troponin	**<0.1 (troponin T) or <0.03 (troponin I)**	**<0.3**	**N/A**	
CK-MB	**0**	**N/A**	**N/A**	
Total CK	**55-170**	**32**	**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	**0.8-1.1**	**N/A**	**N/A**	
PT	**11-12.5**	**N/A**	**N/A**	
PTT	**25-35**	**N/A**	**N/A**	
D-Dimer	**< 250**	**N/A**	**N/A**	
BNP	**< 100**	**68**	**N/A**	
HDL	**> 55**	**N/A**	**N/A**	
LDL	**< 130**	**N/A**	**N/A**	
Cholesterol	**< 200**	**N/A**	**N/A**	
Triglycerides	**40-160**	**78**	**N/A**	
Hgb A1c	**<9%**	**8.1**	**N/A**	
TSH	**2-10**	**0.779**	**N/A**	**TSH levels are decreased because of the patient's history of decreased thyroid function (Pagana, 2018).**

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	Amber-Light yellow and clear	Yellow and cloudy	N/A	Cloudy urine is indicative of urinary tract infection, which is the cause of the patient's sepsis (Pagana, 2018).
pH	4.6-8	5.5	N/A	
Specific Gravity	1.005-1.030	1.013	N/A	
Glucose	Negative	Negative	N/A	
Protein	0-8	Trace	N/A	Protein in the urine could be caused by diabetes mellitus (Pagana, 2018).
Ketones	Negative	Negative	N/A	
WBC	0-4	21-50	N/A	Increased WBC levels in the urine is caused by bacterial infection in the urinary tract (Pagana, 2018).
RBC	<2	6-10	N/A	Increased RBC levels in the urine is evidence of cystitis (Pagana, 2018).
Leukoesterase	Negative	3+	N/A	The presence of leukoesterase is evidence of a possible UTI, later confirmed for the patient (Pagana, 2018).

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**	**7.48**	**7.52**	**Elevated pH is associated with respiratory or metabolic alkalosis (Pagana, 2018).**
PaO2	**80-100**	**119**	**81**	**PaO2 is elevated, likely because of hyperventilation that was done to treat the patient's acute respiratory failure (Pagana, 2018).**
PaCO2	**35-45**	**30**	**26**	**Decreased PaCO2 indicates respiratory alkalosis and is related to hyperventilation (Pagana, 2018).**
HCO3	**21-28**	**22.5**	**22.3**	
SaO2	**95-100%**	**99**	**97**	

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 (<100,000)**	**>100,000 gram negative bacilli**	**N/A**	**A positive urine culture is evident of urinary tract infection (Pagana, 2018).**
Blood Culture	**Negative**	**Negative**	**Negative**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). ***Mosby's Diagnostic and Laboratory Test Reference*** **(14th ed.). Mosby.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- **CT pelvis/abdomen w/o contrast (No evidence of bowel obstruction, uterus and gallbladder surgically absent, hepatosplenomegaly, cirrhotic morphology of liver)**
- **CT head w/o contrast (stable findings, no acute hemorrhage)**
- **CXR (mild pulmonary congestion and edema, atelectasis, ET tube position is satisfactory)**

Diagnostic Test Correlation (5 points): A chest x-ray is performed to evaluate the pulmonary and cardiac systems to find inflammation, fluid or air accumulation, calcification, fractures, and location of devices. A CT of the pelvis and abdomen is done to visualize pathologic conditions associated with the liver, kidneys, intestines, pancreas, and pelvic structures like the uterus. A CT of the head is performed to assess brain tissue for bleeding or other abnormalities (Pagana, 2018).

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). ***Mosby's Diagnostic and Laboratory Test Reference*** **(14th ed.). Mosby.**

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

Home Medications (5 required)

Brand/Generic	**Ventolin HFA (albuterol)**	**Lipitor (atorvastatin)**	**Synthroid (levothyroxine)**	**Toprol-XL (metoprolol succinate)**	**Aspirin (acetylsalicylic acid)**
Dose	**1-2 puffs**	**80 mg**	**50 mcg**	**25 mg**	**81 mg**
Frequency	**Q6H prn wheezing**	**Daily**	**Daily**	**Daily**	**Daily**
Route	**Inhalation**	**Oral**	**Oral**	**Oral**	**Oral**

Classification	**Pharmacologic class: Adrenergic** **Therapeutic class: Bronchodilator**	**Pharmacologic class: HMG-CoA reductase inhibitor** **Therapeutic class: Antihyperlipidemic**	**Pharmacologic class:Synthetic thyroxine** **Therapeutic class: Thyroid hormone replacement**	**Pharmacologic class: Beta1-adrenergic blocker** **Therapeutic class: Antianginal, antihypertensive**	**Pharmacologic class: Salicylate** **Therapeutic class: NSAID**
Mechanism of Action	**Stimulates beta2-adrenergic receptors in lungs, resulting in relaxation of bronchial smooth muscle with little effect on heart rate.**	**Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown.**	**Replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis.**	**Inhibits stimulation of beta1 -receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand. These effects help relieve angina, minimize cardiac tissue damage from a myocardial infarction, and help relieve symptoms of heart failure. Metoprolol also helps reduce blood pressure by decreasing renal release of renin**	**Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis. Prostaglandins, important mediators in the inflammatory response, cause local vasodilation with swelling and pain. With blocking of cyclooxygenase and inhibition of prostaglandins, inflammatory symptoms subside. Pain is also relieved because prostaglandins play a role in pain transmission from the periphery to the spinal cord. Aspirin inhibits platelet aggregation by interfering with production of thromboxane A2, a substance that**

					stimulates platelet aggregation. Aspirin acts on the heat-regulating center in the hypothalamus and causes peripheral vasodilation, diaphoresis, and heat loss.
Reason Client Taking	**The patient takes this medication to treat dyspnea related to their asthma and COPD**	**The patient uses this medication for their hyperlipidemia and to decrease the risk of acute cardiovascular events.**	**The patient takes this drug due to their history of decreased thyroid activity.**	**The patient takes this medication to manage their hypertension.**	**The patient takes this drug to reduce the risk of MI and ischemic stroke**
Contraindications (2)	**Hypersensitivity to albuterol or its components. Caution with hypertension, hypokalemia, and arrhythmia.**	**Active hepatic disease or hypersensitivity to atorvastatin.**	**Uncorrected adrenal insufficiency or hypersensitivity to levothyroxine.**	**Hypersensitivity to metoprolol or other beta blockers. Heart rate less than 45 bpm.**	**Active bleeding or hypersensitivity to aspirin or other NSAIDs.**
Side Effects/Adverse Reactions (2)	**Arrhythmia, tachycardia**	**Hypoglycemia, arrhythmias**	**Angioedema, heart failure**	**Bronchospasm, leukopenia**	**Thrombocytopenia, angioedema**
Nursing Considerations (2)	**The patient should increase fluid intake with the use of this medication. The patient should hold their breath after administration to promote contact with the lungs.**	**Monitor diabetic patient's blood glucose levels because of atorvastatin's ability to affect blood glucose control. Notify the provider if the patient develops signs like muscle pain, weakness, or fever.**	**Administer the medication 30-60 minutes before breakfast. Monitor blood glucose level of diabetic patient because the drug could worsen glycemic control.**	**An ECG of the patient should be done to make sure there is no heart block. Check for signs of poor glucose control on diabetic patients.**	**Ask if the patient experiences tinnitus. Question the patient for a history of recent bleeding.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Assess lung sounds, blood pressure, and heart rate. Assess rate, rhythm, and depth of respirations.**	**Expect liver function tests to be performed before the use of this drug. Monitor blood glucose levels.**	**Obtain baseline TSH, weight, and vital signs.**	**Assess for history of GI bleed, peptic ulcer disease, or OTC use of aspirin containing products. Assess pain**	**Check vital signs, especially blood pressure for hypotension.**

				location and duration.	
Client Teaching needs (2)	**Educate the patient on rinsing their mouth after using this medication to avoid dryness and infection. Tell the patient to avoid excessive caffeine because of the potential for tachycardia as a side effect.**	**Tell the patient to take this drug at the same time each day. Instruct the patient to take a missed dose as soon as possible unless it's close to the next dose.**	**Tell the patient to take this medication with a glass of water to prevent heartburn. Instruct the patient to take antacids and calcium or iron supplements at least 4 hours from levothyroxine doses.**	**Instruct the patient to take the drug with food at the same time each day. Tell the patient not to stop taking the druug abruptly.**	**Tell the patient to take aspirin with food or after meals because it may cause GI upset on an empty stomach. Advise the client to take the drug with a glass of water at the same time everyday and to avoid alcohol.**

Hospital Medications (5 required)

Brand/Generic	**Maxipime (cefepime hydrochloride)**	**Protonix (pantoprazole)**	**Porcine heparin (heparin sodium)**	**Tylenol (acetaminophen)**	**Lantus (insulin glargine)**
Dose	**1 g**	**40 mg**	**5000 units**	**650 mg**	**92 units**
Frequency	**Q12H**	**BID**	**Q8H**	**Q4H prn mild/severe pain**	**Every morning**
Route	**IV**	**IV**	**SubQ**	**Oral**	**SubQ**
Classification	**Pharmacological class: Fourth-generation cephalosporin Therapeutic class: Antibioitic**	**Pharmacologic al class: Proton pump inhibitor Therapeutic class: Antiulcer**	**Pharmacologic al class: Anticoagulant Therapeutic class: Anticoagulant**	**Pharmacologic al class: Nonsalicylate Therapeutic class: Antipyretic, nonopioid analgesic**	**Pharmacolog ical class: Exogenous insulin Therapeutic class: Antidiabetic**
Mechanism of Action	**Interferes with bacterial cell wall synthesis by inhibiting**	**Irreversibly binds to, inhibits hydrogen**	**Binds with antithrombin III, enhancing antithrombin**	**Inhibits the enzyme cyclooxygenase, blocking**	**Acts via specific receptor to regulate**

	the final step in the cross-linking of peptidoglycan strands. Peptidoglycan makes cell membranes rigid and protective. Without it, bacterial cells rupture and die.	**potassium adenosine triphosphate, an enzyme on surface of gastric parietal cells. Inhibits hydrogen ion transport into gastric lumen.**	**III's inactivation of the coagulation enzymes thrombin (factor IIa) and factors Xa and XIa. At low doses, heparin inhibits factor Xa and prevents conversion of prothrombin to thrombin. Thrombin is needed for conversion of fibrinogen to fibrin; without fibrin, clots can't form. At high doses, heparin inactivates thrombin, preventing fibrin formation and existing clot extension.**	**prostagland in production and interfering with pain impulsegenerat ion in the peripheral nervous system. Acetaminop hen also acts directly on temperatur e-regulating center in the hypothalam us by inhibiting synthesis of prostagland in E2 .**	**metabolism of carbohydrat es, protein, and fats. Acts on liver, skeletal muscle, and adipose tissue.**
Reason Client Taking	**The patient is taking this drug to threat their infection.**	**This patient is taking this drug to prevent the formation of gastric ulcers**	**The patient is taking this drug for prophylaxis of thromboemboli c complications.**	**The patient could take this drug to treat pain.**	**The patient takes long-acting insulin because they have T2DM.**
Contraindications (2)	**Hypersensitiv ity to beta-lactam antibiotics or penicillins**	**Hypersensitivit y to pantoprazole or substituted benzimidazoles**	**History of heparin-induce d thrombocytope nia or hypersensitivit y to heparin or pork**	**Hypersensit ivity to acetaminop hen or severe hepatic impairment**	**Hypersensiti vity to insulin or hypoglycemi a**
Side Effects/Adverse Reactions (2)	**Nephrotoxicity, thrombocytope nia**	**Hyponatremia, angioedema**	**Dyspnea, abdominal pain**	**Hypotension, hepatotoxicity**	**Hypoglycemi a, swelling**
Nursing Considerations (2)	**Obtain culture and sensitivity test results. Reconsititute using manufacturer 's guidelines.**	**Monitor the patient for hypomagnesmi a that can be caused from long-term use.**	**Heparin should only be given subcutaneously or intravenously. Use heparin cautiously in patients over age 60, especially women.**	**Monitor renal function. Long term use could affect liver function.**	**Assess for signs of hyperglycem ia like polyuria, polyphagia, or polydipsia. Assess for hypoglycemi a with diaphoresis, tremors,**

					dizziness, headache, or tachycardia.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor BUN and creatinine levels for signs of nephrotoxicity.**	**Assess for abdominal pain, nausea, and diarrhea**	**Obtain CBC, PT/INR, and aPTT. Question history of recent trauma or GI bleeding.**	**Monitor AST, ALT, and bilirubin levels. Monitor BUN and creatinine levels.**	**Serum glucose level. Assess for signs of hyperglycemia or hypoglycemia.**
Client Teaching needs (2)	**The patient should know to report severe diarrhea even if it is 2 months after the last dose. Instruct the patient that they will need continue therapy for the full length of treatment.**	**Tell the patient to report prolonged/severe diarrhea or decreases in urine output.**	**Tell the patient to report any abnormal signs or symptoms to their provider, even weeks after heparin has been discontinued. Advise the patient that heparin can interact with aspirin and ibuprofen.**	**Tell the patient to follow manufacturer's label and dosage guidelines. Educate on signs of hepatotoxicity in order to report them.**	**Tell the patient to reports signs and symptoms of hyperglycemia or hypoglycemia. Educate patient on diet in controlling glucose levels.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). ***2021 Nurse's Drug Handbook*** **(19 th ed.). Jones & Bartlett Learning.**

Kizior, R. J. (2021). ***Saunders Nursing Drug Handbook 2021*****. Elsevier.**

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 **Alert and oriented x4 (x1 to self only earlier)** **No acute distress** **Patient's appearance is clean**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:**	 **Normal** **Dry** **Warm on palpation**

Turgor: **Rashes:** **Bruises:** **Wounds:** **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	**Normal skin turgor, no tenting present** **No rashes noted** **Bruising present on hands and left lower leg** **Wound on right leg** **14** **No drainage present**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is normocephalic and trachea is midline with no wounds.** **External ears appear normal with no lesions.** **Sclera is white nd conjunctiva is pink.** **PERRL.** **Nose appears normal and midline with pink mucosa** **Patient does not have teeth.**
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:**	**Normal S1 and S2 heart sounds** **Normal heart rate and rhythm** **Peripheral pulses 2+ and symmetric** **Capillary refill <2 seconds** **No neck vein distention** **No edema is present**
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:**	**Labored breathing with no accessory muscle use.** **Intermittent wheezing with no other adventious breath sounds present.** **Normal respiratory rate and pattern.** **ET tube was discontinued today.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:**	**Diabetic** **Consistent carbohydrate diet** **162.6 cm** **101.6 kg** **Normoactive bowel sounds in all quadrants** **Last BM was around 1330**

Palpation: Pain, Mass etc.: **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	**No pain or masses noted on palpation.** **Abdomen is soft and nontender.** **No distention present.** **No incisions in abdominal region.** **No scars in abdominal region.** **No drainage present.** **No wounds in abdominal region.** **No ostomy** **18 Fr NG tube** **No feeding/PEG tube**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	 **Yellow** **Cloudy (according to urinalysis)** **1000 mL** **No pain reported with urination.** **No dialysis** **16 Fr Urethral catheter**
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 reports of numbness or tingling** **Limited ROM** **Patient uses a wheelchair and walker for mobility** **Strength is equally weak bilaterally** **ADL assistance ✓** **Fall risk ✓** **Morse fall score: 70** **Needs assistance with equipment and mobility**
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:**	 **MAEW X** **PERLA ✓** **Strength equal in extremities bilaterally** **Oriented x4 currently** **Calm, appears to know limitations** **Normal speech pattern** **Normal sensory function**

LOC:	**Conscious and alert**
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):**	 **Patient is visited by family** **Adult** **N/A** **Patient lives with family and has assistive devices for mobility. Patient appears to have family support according to multiple visitors throughout the day.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1000	85	183/68	16	97.8 F	100
1330	73	154/49	16	97.8 F	100

Vital Sign Trends/Correlation: Pulse and blood pressure have decreased. Respiratory rate, temperature, and oxygen saturation have remained constant.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1000	0	N/A	N/A	N/A	N/A
1100	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:**	**20 G** **Right forearm and left AC** **2/13/23** **IV is open and functional**

Signs of erythema, drainage, etc.: **IV dressing assessment:**	**No signs of erythema, drainage, or infiltration** **IV is secure**
Other Lines (PICC, Port, central line, etc.)	**N/A**
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:**	**N/A**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
350	**1000**

Nursing Care

Summary of Care (2 points)

Overview of care: CCU care dependent

Procedures/testing done: CXR, CT abdomen/pelvis w/o contrast, CT head w/o contrast

Complaints/Issues: Acute respiratory failure

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Moved to CHO diet today. Not tolerating activity yet due to weakness.

Physician notifications: N/A

Future plans for client: Antibiotic therapy, possibly physical therapy

Discharge Planning (2 points)

Discharge location: 4E

Home health needs (if applicable): N/A

Equipment needs (if applicable): Wheelchair for mobility

Follow up plan: Not known at this time

Education needs: Medications (refused treatment), ROM exercises

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. Risk for impaired gas exchange related to extubation as evidenced by	**The patient was cleared by the provider to be extubated**	**1. Assess and record pulmonary status frequently if the patient's**	**1. The patient will have normal breath sounds and have ABG levels in their expected ranges.**	**The client will have stable vital signs and ABGs. The patient's family will understand the**

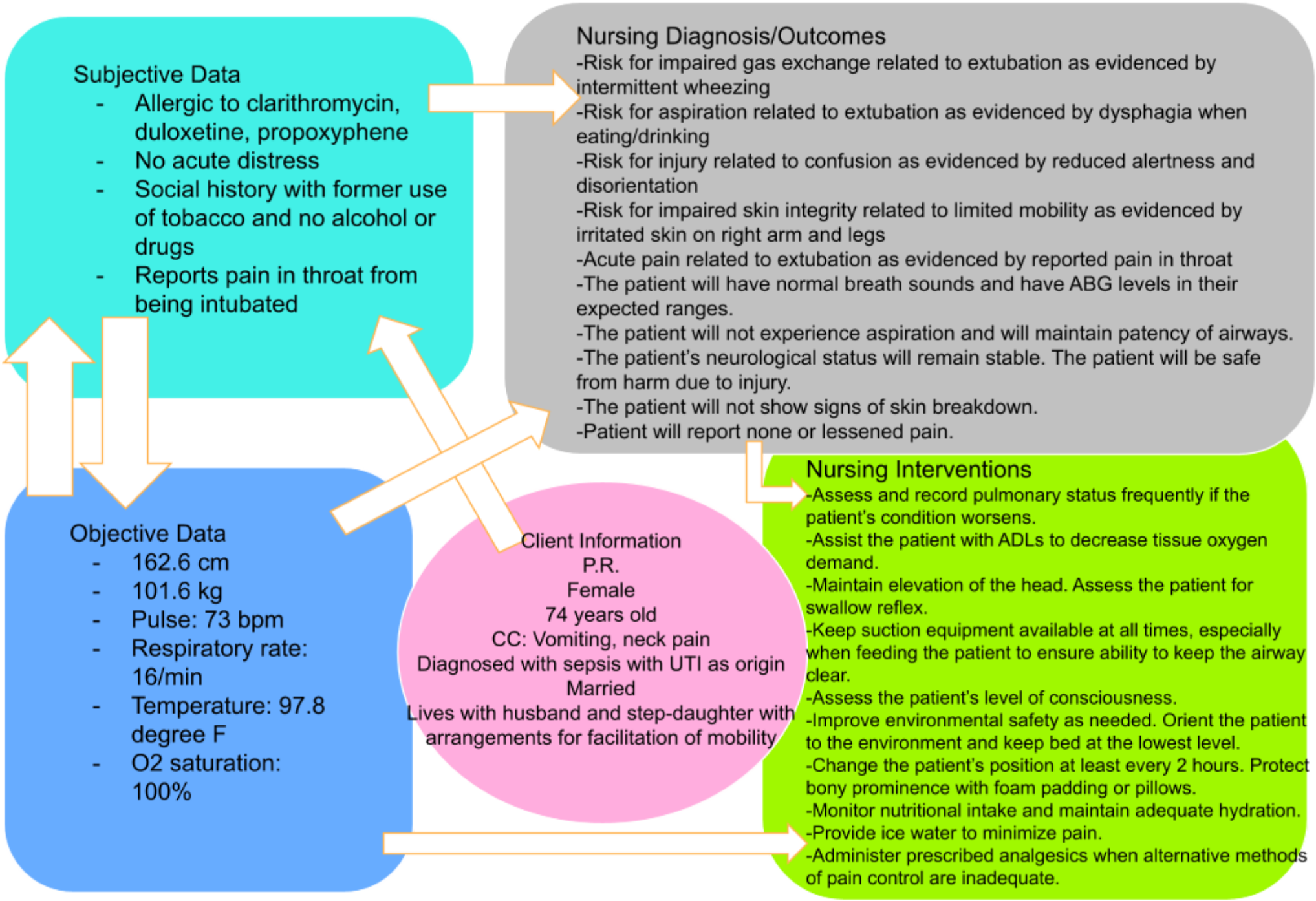
intermittent wheezing	**earlier in the morning because of their ability to tolerate spontaneous ventilation. The patient could be heard wheezing with increased effort of breathing from time to time.**	**condition worsens.** **2. Assist the patient with ADLs to decrease tissue oxygen demand.**		**status of their respiratory function and how it will be monitored closely**
2. Risk for aspiration related to extubation as evidenced by dysphagia when eating/drinking	**The patient would cough after ingesting food or water, which suggests dysphagia that can cause complicatio ns with the airway.**	**1.Maintain elevation of the head. Assess the patient for swallow reflex.** **2. Keep suction equipment available at all times, especially when feeding the patient to ensure ability to keep the airway clear.**	**1. The patient will not experience aspiration and will maintain patency of airways.**	**The patient will exhibit an ability to swallow without difficulty. The patient and their family will understand measures to avoid aspiration.**
3. Risk for injury related to confusion as evidenced by reduced alertness and disorientation	**The patient was only oriented to self earlier, which could contribute to anxiety and a lack of**	**1.Assess the patient's level of consciousness .** **2. Improve environmenta l safety as**	**1. The patient's neurological status will remain stable. The patient will be safe from harm due to injury.**	**The patient will be fully alert and oriented. The patient and their family will know about safety measures to prevent injury**

	awareness of their limitations that could cause injury or fall.	**needed. Orient the patient to the environment and keep bed at the lowest level.**		**during episodes of confusion.**
4. Risk for impaired skin integrity related to limited mobility as evidenced by irritated skin on right arm and legs	**The patient has limited mobility and increased BUN that indicates dehydration that could make them subject to impaired skin integrity.**	**1. Change the patient's position at least every 2 hours. Protect bony prominence with foam padding or pillows.** **2. Monitor nutritional intake and maintain adequate hydration.**	**1. The patient will not show signs of skin breakdown.**	**The patient will be protected from impaired skin integrity. Patient and their family will understand preventive skin care.**
5. Acute pain related to extubation as evidenced by reported pain in throat	**The patient reported pain in their throat from being intubated. This could cause complicatio ns with nutrition if they are unwilling to eat/drink and also could increase emotional stress.**	**1.Provide ice water to minimize pain.** **2.Administer prescribed analgesics when alternative methods of pain control are inadequate.**	**1. Patient will report none or lessened pain.**	**The patient will verbalize a relief of pain. The patient and their family will understand the options in which the patient can use in their care to reduce pain.**

Other References (APA):

Phelps, L.L. (2020). ***Sparks and Taylor's Nursing Diagnosis Reference Manual*** **(11th ed.)**

Concept Map (20 Points):


Subjective Data
- Allergic to clarithromycin, duloxetine, propoxyphene
- No acute distress
- Social history with former use of tobacco and no alcohol or drugs
- Reports pain in throat from being intubated
Nursing Diagnosis/Outcomes
-Risk for impaired gas exchange related to extubation as evidenced by intermittent wheezing
-Risk for aspiration related to extubation as evidenced by dysphagia when eating/drinking
-Risk for injury related to confusion as evidenced by reduced alertness and disorientation
-Risk for impaired skin integrity related to limited mobility as evidenced by irritated skin on right arm and legs
-Acute pain related to extubation as evidenced by reported pain in throat
-The patient will have normal breath sounds and have ABG levels in their expected ranges.
-The patient will not experience aspiration and will maintain patency of airways.
-The patient's neurological status will remain stable. The patient will be safe from harm due to injury.
-The patient will not show signs of skin breakdown.
-Patient will report none or lessened pain.
Objective Data
- 162.6 cm
- 101.6 kg
- Pulse: 73 bpm
- Respiratory rate: 16/min
- Temperature: 97.8 degree F
- O2 saturation: 100%
Client Information
P.R.
Female
74 years old
CC: Vomiting, neck pain
Diagnosed with sepsis with UTI as origin
Married
Lives with husband and step-daughter with arrangements for facilitation of mobility
Nursing Interventions
-Assess and record pulmonary status frequently if the patient's condition worsens.
-Assist the patient with ADLs to decrease tissue oxygen demand.
-Maintain elevation of the head. Assess the patient for swallow reflex.
-Keep suction equipment available at all times, especially when feeding the patient to ensure ability to keep the airway clear.
-Assess the patient's level of consciousness.
-Improve environmental safety as needed. Orient the patient to the environment and keep bed at the lowest level.
-Change the patient's position at least every 2 hours. Protect bony prominence with foam padding or pillows.
-Monitor nutritional intake and maintain adequate hydration.
-Provide ice water to minimize pain.
-Administer prescribed analgesics when alternative methods of pain control are inadequate.