N441 Care Plan 1

Lakeview College of Nursing

Brianna Lilly

Demographics (3 points)

Date of Admission 3/19/2023	**Client Initials** A.W.	**Age** 60 years old	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Unemployed for about a year, formally a warehouse manager.	**Marital Status** Married	**Allergies** Codeine (hives)
Code Status DNR	**Height** 188 cm	**Weight** 92.1 kg	

Medical History (5 Points)

Past Medical History: Bipolar disorder I (no date), Depression (no date), Esophageal cancer (2/20/23).

Past Surgical History: Open cholecystectomy (1988), Upper gastrointestinal endoscopy (1/2023) and (3/2/2023), Central venous catheter; left (2/15/2023), gastrostomy tube placement (3/2/2023), Laparoscopy (3/2/2023).

Family History: Brother: cancer (unspecified type) age 56. Father: diabetes, Parkinson's disease, thyroid disease. Mother: no known problems.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): Patient-reported smoking cessation 1 month prior to hospitalization. The patient has a 45-pack-year history of cigarettes only. The patient denies current alcohol or recreational drug use.

Assistive Devices: The patient was using a walker/wheelchair at home, the patient uses glasses, and a bipap.

Living Situation: The patient lived at home with his wife. Home care was visiting to administer enteral feedings via J-tube.

Education Level: The highest level of education is 9th grade.

Admission Assessment

Chief Complaint (2 points): Acute respiratory failure

History of Present Illness – OLD CARTS (10 points): The patient reported difficulty swallowing sometime in November 2022. The patient also was experiencing shortness of breath and a sore throat. The patient went to primary care for the issue in January 2023 where an upper gastrointestinal endoscopy was performed (1/2023) and (2/15/2023). The patient was diagnosed with upper esophageal cancer (2/20/2023). A PET CT tumor imaging skull base to mid-thigh (2/11/2023) staged esophageal cancer (stage 4). Cancer lesions were found in both lungs bilaterally, preaortical, on the bones, and in multiple esophageal lymph nodes. The patient experienced shortness of breath on 3/19/2023 which worsened over 12 hours when his wife called an ambulance for the patient (3/19/2023). Oxygen via BiPAP was given in the ambulance which improved the shortness of breath. The patient arrived at OSF ER on 3/19/2023. A CBC, urine sample, arterial gases, and blood chemistry were ordered on 3/19/2023. A CT of the chest was ordered on 3/19/2023 showing bilateral pulmonary effusions with bilateral lower lung compressive atelectasis. Fentanyl was ordered to decrease dyspnea and workload on the heart. The patient was responsive until (3/20/2023), when the patient's wife placed him on comfort care and requested no CPR. The patient is actively dying and on comfort care (3/22/2023).

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute hypoxic respiratory failure secondary to metastatic esophageal carcinoma.

Secondary Diagnosis (if applicable): Metastatic esophageal carcinoma

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

Acute hypoxic respiratory failure or first, adult respiratory distress syndrome is caused due to a lack of pulmonary function (Capriotti, 2020). The lack of pulmonary function is characterized by diffuse alveolar injury, bilateral pulmonary infiltrates, and pulmonary capillary damage (Capriotti, 2020).

Risk factors for developing ARDS include cancers of the head and neck such as the patient having esophageal cancer (Capriotti, 2020). The main risk factor for developing cancers of the head and neck are tobacco and alcohol use (Capriotti, 2020). Critically ill patients with trauma, sepsis, drug overdose, massive transfusion, acute pancreatitis or aspiration are all risk factors for developing ARDS (Capriotti, 2020). The main symptom reported in ARDS is shortness of breath (Capriotti, 2020). Sudden pulmonary edema takes place as a result of an inflammatory trigger. The inflammatory trigger releases cellular and chemical mediators that cause damage to the alveolar-capillary membrane. The alveoli fill with fluid and the alveoli collapse (Capriotti, 2020). The lungs are compressed and the lung loses the ability to ventilate (Capriotti, 2020). This causes hypoxemia which causes a decreased level of consciousness, compensatory tachycardia, diminished peripheral circulation, diaphoresis, restlessness, and anxiety (Capriotti, 2020). As the lungs become stiff with dead air space the fluid in the lungs creates a crackle lung sound (Capriotti, 2020).

Diagnosis of ARDS requires arterial hypoxemia (Capriotti, 2020). The Berlin criteria list diagnostic conditions for ARDS (Capriotti, 2020). Conditions include; Respiratory symptoms beginning within a week, or new/worsening respiratory symptoms within a week (Capriotti, 2020). Bilateral opacities must be present on a chest x-ray or CT (Capriotti, 2020). A moderate to severe impairment of oxygenation must be present (Capriotti, 2020). Chest x-rays demonstrate pulmonary edema (Capriotti, 2020).

Supportive treatment for ARDS includes mechanical ventilation, sedation, and neuromuscular blockade (Capriotti, 2020). Nutritional support via enteral or TPN may be needed (Capriotti, 2020). Fluid management is conservative (Capriotti, 2020). Prone positioning is recommended as it relates to pressure from the heart and diaphramohn the lungs which are shown to improve oxygenation (Capriotti, 2020). There is no recommended “cure” (Capriotti, 2020).

The patient was diagnosed with metastatic esophageal cancer on 2/20/2023. The cancer was staged via a PET scan (2/11/2020) which showed metastasis to pre aortic regions, multiple areas of the esophagus lymph nodes, the lungs, and the bones. The chest CT scan 3/20/2023 showed bilateral lung compressive atelectasis which was caused by metastatic carcinoma. Chest X-Ray 3/20/2023 showed bilateral pulmonary opacities (cancerous lesions). The inflammatory response to the lungs caused bilateral lung compressive atelectasis as characterized in ARDS (Capriotti, 2020). The patient had worsening shortness of breath for 12 hours on 3/19/2023 and was admitted to OSF. The patient has not yet recovered and has been sedated and supplied oxygen as he actively dies.

Pathophysiology References (APA):

Capriotti, T. M. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F. A. Davis Company.
https://fadavisreader.vitalsource.com/books/9781719641470

Laboratory Data (15 points)

Lab	Normal Range	Admission Value (3/19/2023)	Today's Value (3/22/20	Reason for Abnormal Value

			23)	
RBC	4.40-5.80	3.70	Not done	Low RBC due to cancerous lesions affecting bones, malnutrition, smoking/dyspnea (Leeuwen & Bladh, 2019).
Hgb	13.0-16.5	11.3	Not done	Low HGB due to cancerous lesions affecting bones, malnutrition, smoking/dyspnea (Leeuwen & Bladh, 2019).
Hct	38.0-50.0	33.8	Not done	Low HCT due to cancerous lesions affecting bones, malnutrition, smoking/dyspnea (Leeuwen & Bladh, 2019).
Platelets	140-440	352	Not done	Within Normal Limits
WBC	4-12	6.10	Not done	Within Normal Limits
Neutrophils	40.0-68.0%	72.7	Not done	High due to inflammatory response to metastatic cancer (Leeuwen & Bladh, 2019).
Lymphocytes	19.0-49.0.%	15.4	Not done	Low due to current carcinoma, creating immunocompromised status (Leeuwen & Bladh, 2019).
Monocytes	3.0-13.0%	10.7	Not done	Within Normal Limits
Eosinophils	0.0-8.0%	0.6	Not done	Within Normal Limits
Bands	0.0-10	Not Done	Not done	N/A

Lab	**Normal Range**	**Admission Value (3/19/2023)**	**Today's Value (3/22/2023)**	**Reason For Abnormal**
Na-	136-145	124	Not done	Low Na- due to fluid retention caused by slowing of metabolism in the death process (Leeuwen & Bladh, 2019).

K+	3.5-5.1	3.9	Not done	Within Normal Limits
Cl-	98-107	90	Not done	Low Cl- due to lack of ventilation from the lungs (Leeuwen & Bladh, 2019).
CO2	22-30	22	Not done	Within Normal Limits
Glucose	70-99	110	Not done	High glucose due to stress response from hypoxemia (Leeuwen & Bladh, 2019).
BUN	8-26	13	Not done	Within Normal Limits
Creatinine	0.70-1.30	0.70	Not done	Within Normal Limits
Albumin	3.5-5.0	Not done	Not done	N/A
Calcium	8.7-10.5	9.3	Not done	Within Normal Limits
Mag	1.6-2.6	2.2	Not done	Within Normal Limits
Phosphate	40-150	Not done	Not done	N/A
Bilirubin	0.0-0.2	Not done	Not done	N/A
Alk Phos	40-150	Not done	Not done	N/A
AST	5-34	Not done	Not done	N/A
ALT	0-55	Not done	Not done	N/A
Amylase	25-125	Not done	Not done	N/A
Lipase	8-78	Not done	Not done	N/A
Lactic Acid	0.7-2.0	2.0	Not done	Within Normal Limits
Troponin	0-0.040	<0.030	Not done	Within Normal Limits
CK-MB	5-25	Not done	Not done	N/A
Total CK	55-170	Not done	Not done	N/A

Lab Test	Normal Range	Value on Admission (3/19/2023)	Today's Value (3/22/2023)	Reason for Abnormal
INR	0.8-1.1	Not Done	Not Done	N/A
PT	10-13.1	Not Done	Not Done	N/A
PTT	25-30	Not Done	Not Done	N/A
D-Dimer	0-622	Not Done	Not Done	N/A
BNP	0-100	49	Not done	Within normal limits
HDL	>40	Not Done	Not Done	N/A
LDL	<130	Not Done	Not Done	N/A
Cholesterol	<200	Not Done	Not Done	N/A
Triglycerides	<150	Not Done	Not Done	N/A
Hgb A1c	4-6%	Not Done	Not Done	N/A
TSH	0.270-4.205	Not Done	Not Done	N/A

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

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	Pale Yellow	Yellow	Not Done	Within normal limits
pH	5-9	6	Not Done	Within normal limits
Specific Gravity	1.003-1.030	1.010	Not Done	Within normal limits

Glucose	Negative	Negative	Not Done	Within normal limits
Protein	Negative	Negative	Not Done	Within normal limits
Ketones	Negative	Negative	Not Done	Within normal limits
WBC	0-5	0-5	Not Done	Within normal limits
RBC	0-2	6-10	Not Done	High RBC due to possible spread of cancer to the kidneys or urinary tract (Leeuwen & Bladh, 2019).
Leukoesterase	Negative	Negative	Not Done	Within normal limits

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	7.47	Not done	High PH due to respiratory alkalosis due to respiratory distress (Leeuwen & Bladh, 2019).
PaO2	85-105	77	Not done	Low PaO2 due to respiratory alkalosis due to respiratory distress (Leeuwen & Bladh, 2019).
PaCO2	35-45	32	Not done	Low PaCO2 sue to respiratory alkalosis due to respiratory distress (Leeuwen & Bladh, 2019).

HCO3	22.0-26	23.2	Not done	Within normal limits
SaO2	95-98%	93	Not done	Within normal limits

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	No growth	No growth	Not done	Within normal Limits
Blood Culture	No growth	No growth	Not done	Within normal limits
Sputum Culture	No growth	Not done	Not done	N/A
Stool Culture	No growth	Not done	Not done	N/A

Lab Correlations Reference (1) (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2019). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implication* (8th ed.). F. A. Davis Company

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT Chest with contrast (3/19/2023), Adult trans thoracic echo 2D complete (3/20/2023), Chest X-Ray (3/20/2023), PET CT Tumor imaging skull base to mid-thigh (2/11/2023).

Diagnostic Test Correlation (5 points):

CT Chest with Contrast (3/19/2023): The patient came into the ED experiencing dyspnea and shortness of breath. A CT chest with contrast was ordered to view the lungs. There was no CT evidence of pulmonary embolism. There was effusion with bilateral lung compressive atelectasis which was caused by metastatic carcinoma. Multiple enlarged paratracheal lymph nodes were

seen. 3cm anterior epicardial metastatic lymph node and 6.5 cm ap window metastatic lymph node mass were detected.

Adult Trans Thoracic Echo 2D Complete (3/20/2023): Test used to visualize the muscular workings of the heart after the patient arrived on 3/19/2023 with respiratory distress. The test used to assess heart function and rule out heart failure. Pleural effusion detected on the left, left ventricular hypertrophy, small-moderate pericardial effusion present, grade I diastolic dysfunction with an ejection fraction of 55-60%.

Chest X-Ray (3/20/2023): A test was ordered to visualize the heart and lungs after the patient arrived on 3/19/2023 in respiratory distress. No pneumothorax was noted on the left, pleural effusion was noted on the left infiltrates, and nodular opacities were noted bilaterally.

PET CT Tumor Imaging Skull Base to Mid Thigh (2/11/2023):

Test ordered to stage esophageal carcinoma. The findings were compatible with metastatic disease (stage 4). There was a large area of enlarged lymph nodes with extensive metabolic activity, and cancerous lesions located preaortically and on the bones.

Diagnostic Test Reference (1) (APA):

Van Leeuwen, A. M., & Bladh, M. L. (2019). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implication* (8th ed.). F. A. Davis Company

Current Medications (10 points, 1 point per completed med)

Brand/Generic	Norco/ hydrocodone-acetaminophen	Paxil/ paroxetine suspension	Albuterol/ aerosol solution	Augmentin/ amoxicillin-clauulanate	Zithromax/ azithromycin
Dose	5-325mg tablet	10mg/5mL suspension	108 mcg/Act 2 puffs	875-125 mg tablet	500mg tablet
Frequency	PRN q 4	Daily	PRN q 4	BID (for 5	BID (for 5

	hours		hours	days)	days)
Route	PO	J-tube	Inhalation	PO	PO
Classification	Opioid	SSRI	Adriennergic bronchodilators	Penicillin antibiotic	Macrolide antibiotic
Mechanism of Action	Binds to and activates opioid receptors to produce pain relief (Jones & Bartlett, 2020).	Potentiates serotonin activity and inhibits serotonin reuptake to increase serotonin levels to reduce anxiety/depression (Jones & Bartlett, 2020).	Albuterol attaches to beta 2 receptors to stimulate ATP, increase intercellular levels of cAMP which relaxes bronchial smooth muscle cells and inhibits histamine release (Jones & Bartlett, 2020).	Kills bacteria by binding to penicillin-binding proteins inner cell wall and causing lysis (Jones & Bartlett, 2020).	Binds to the ribosomal subunit of the bacteria and blocks protein synthesis (Jones & Bartlett, 2020).
Reason Client Taking	Moderate to more severe pain	Depression/ anxiety	Shortness of breath	Prevention of pneumonia	Prevention of pneumonia
Contraindications (2)	Acute or severe bronchial asthma, and significant respiratory depression (Jones & Bartlett, 2020).	Hypersensitivity to paroxetine, use within 14 days of a MAO inhibitor (Jones & Bartlett, 2020).	Hypersensitivity to albuterol or any of its components (Jones & Bartlett, 2020).	Hypersensitivity or reaction to other beta-lactam antibiotics (Jones & Bartlett, 2020).	History of cholestatic jaundice or hepatic disfunction (Jones & Bartlett, 2020).

Side Effects/Adverse Reactions (2)	Hypotension, and respiratory depression (Jones & Bartlett, 2020).	Suicidal ideation, blurred vision (Jones & Bartlett, 2020).	Anxiety, arrhythmias (Jones & Bartlett, 2020).	Agitation, Anxiety (Jones & Bartlett, 2020).	Hypotension, arrhythmias (Jones & Bartlett, 2020).
Nursing Considerations (2)	Be careful administrating to clients with preexisting respiratory depression as hydrocodone may cause respiratory drive to decrease to the point of apnea(Jones & Bartlett, 2020). Hydrocodone may cause hypotension especially in patients whose blood pressure is already compromised (Jones & Bartlett, 2020).	Do not give enteric-coated form with antacids, monitor for GI bleeding (Jones & Bartlett, 2020).	Monitor serum potassium levels, and blood glucose levels (Jones & Bartlett, 2020).	Patients with mononucleosis shouldn't receive amoxicillin, expect to administer therapy before culture and sensitivity results are known (Jones & Bartlett, 2020).	Should not be used in patients with known QT prolongation, or significant bradycardia (Jones & Bartlett, 2020).

Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess respiratory status and vitals, assess pain before administration (Jones & Bartlett, 2020).	Assess for suicidal tendencies and psychomotor agitation (Jones & Bartlett, 2020).	Assess Blood pressure and cardiac status prior to administration (Jones & Bartlett, 2020).	Monitor patient closely for diarrhea, monitor patient for a superinfection (Jones & Bartlett, 2020).	Monitor culture and sensitivity results prior to administration if possible, monitor liver enzymes prior to administration (Jones & Bartlett, 2020).
Client Teaching needs (2)	Instruct patients to avoid ingesting alcohol with this medication, tablets should never be crushed or chewed (Jones & Bartlett, 2020).	Advise patient to take medication in the morning to minimize insomnia, swallow pills whole (Jones & Bartlett, 2020).	Teach patient to shake inhaler before use, patient should wash the mouthpiece once a week and let airdrop (Jones & Bartlett, 2020).	Do not chew or crush tablets, take the full length of antibiotics for the full length of time (Jones & Bartlett, 2020).	Take capsule 1 hour before or 2 to 3 hours after food, take 1 hour before or 2 to 3 hours after an antacid (Jones & Bartlett, 2020).

***10 <u>different</u> medications must be completed*Home Medications (5 required)**

Hospital Medications (5 required)

Brand/Generic	Precedex/ dexmedetomidine	Fentanyl citrate	Ativan/ lorazepm	Seroquel/ quetiapine	Morphine
Dose	400mcg/ 100mL 4.6-27.6 mL/hr	50mcg	1mg	50mg	2-4 mg

Frequency	Continuous	PRN q 4 hours	PRN q 1 hour	BID	Every 15 mins PRN
Route	IV infusion	Subcutaneous	IV	PO	IV
Classification	Glucocorticoid	Opioid	Benzodiazepine	Antipsychotic	Opioid
Mechanism of Action	Binds to intracellular glucorticoid receptors and suppresses inflammatory and immune responses (Jones & Bartlett, 2020).	Binds to the opioid receptor site and alters the perception of pain (Jones & Bartlett, 2020).	May potentiate the effects of GABA and other inhibitory neuro transmitters (Jones & Bartlett, 2020).	May produce antipsychotic effects by binding to dopamine type 2 receptor sites and antagonizing serotonin (Jones & Bartlett, 2020).	Binds with and activates opiod receptors to produce analgesia (Jones & Bartlett, 2020).
Reason Client Taking	Sedation	Severe pain	Anxiety	Bipolar Disorder I	Severe pain
Contraindications (2)	Administration of live-virus vaccine, systemic fungal infections (Jones & Bartlett, 2020).	Hypersensitivity, significant respiratory depression (Jones & Bartlett, 2020).	Hypersensitivity, severe respiratory insufficiency (Jones & Bartlett, 2020).	Hypersensitivity to quetiapine or its components (Jones & Bartlett, 2020).	Bronchial asthma, gastrointestinal obstruction (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Increased intracranial pressure, bronchospasm (Jones & Bartlett, 2020).	Bradycardia, hypotension (Jones & Bartlett, 2020).	Coma, seizures (Jones & Bartlett, 2020).	Hypothermia, flu-like symptoms (Jones & Bartlett, 2020).	Increased intracranial pressure (Jones & Bartlett, 2020).

Nursing Considerations (2)	Use cautiously in patients with renal insufficiency can cause renal retention, give in the morning with food (Jones & Bartlett, 2020).	Use in extreme precaution in patients with respiratory depression, or increased intracranial pressure (Jones & Bartlett, 2020).	Before starting in patient with depression ensure they already take an antidepressant, use extreme caution in elderly patients due to respiratory depression (Jones & Bartlett, 2020).	Should not be given to patients with a history of Brady cardia or hypokalemia (Jones & Bartlett, 2020).	Be aware that morphine can lead to abuse, use in extreme caution in patients who may be at risk for carbon dioxide retention (Jones & Bartlett, 2020).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor intake and output, test stool for occult blood (Jones & Bartlett, 2020).	Monitor respiratory rate, and pain levels (Jones & Bartlett, 2020).	Assess respiratory status, and alcohol/drug use (Jones & Bartlett, 2020).	Assess magnesium levels and signs of tar dive dyskinesia (Jones & Bartlett, 2020).	Respiratory and cardiac status (Jones & Bartlett, 2020).
Client Teaching needs (2)	Do not consume with alcohol, follow a low-sodium high potassium diet (Jones & Bartlett, 2020).	Take medication exactly as prescribed as there is a risk for addiction, monitor heart rate (know how to count pulse) (Jones & Bartlett, 2020).	Instruct to report excessive drowsiness and nausea (Jones & Bartlett, 2020).	Instruct to take with food and do not stop taking suddenly (Jones & Bartlett, 2020).	Do not drink alcohol with medication, avoid benzodiazepines during therapy (Jones & Bartlett, 2020).

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2021 nurse's drug handbook* (20th ed.). Jones & Bartlett Learning.

Assessment

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient was A&O 0. Unresponsive to voice, and touch. Patient did not appear to be in distress. Patient was in a hospital gown with disheveled male pattern baldness hair. Eyes were slightly open.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y** **Type:**	The patient's skin was pale and yellow tinged. Generalized bruising from several previous falls as reported by the patient's wife. Patient's skin was slightly cool to the touch, dry and intact apart from his G-tube site and gastrostomy/enterostomy drain site. No rashes present. Skin turgor brisk <3 secs. Braden scale of 13 which indicates a high risk of pressure ulcers.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head is normocephalic neck is asymmetrical with the right side protruding with a large >3cm fixed mass. Trachea displaced to the left. Ears are symmetrical with no drainage. Hearing unable to assess due to patient's unresponsive state. Patient wears glasses at home, eyes were red and dry from being open. PERRLA extremely sluggish equal response, 2mm pupils. Nose midline with no apparent obstructions, drainage, polyps or deviations. Nares symmetrical. Dentition intact, stained from chronic tobacco use. .

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	S1 and S2 heart sounds audible no S3 or S4 sounds auscultated. Cardiac rhythm regular, tachycardic at times (108 BPM). Peripheral pulses radial, post tibial, dorsalis pedis palpable 2+. Capillary refill < 3secs. No neck vein distention noted. Generalized slight non pitting edema due to slowing of metabolism in death process.
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:**	Rhonci breath sounds auscultated bilaterally in both the upper and lower lungs. Respiratory rate was low (9 RR) and irregular, accessory muscles were utilized in the breathing effort. O2 on 2L nasal canula. No ET tube in place. No chest deformities noted. Patient doesn't cough.

GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Enteral feeding through G-tube at home. Currently NPO. IV 0.9% NACL running at 25 mL/hr. 188cm tall and 92.1kg. Extremely hypoactive bowel sounds auscultated. 3/19/2023 was the patient's last BM. Patient did not show signs of pain upon abdominal palpation, abdomen distended. No abdominal masses palpated. G-tube incision leaking yellow fluid, previously physically pulled out by patient and then replaced. The G-tube is not being used as of now. Gastrostomy/enterostomy ballon LUQ. NO NG tube. Implanted single lumen port left chest (3/19/2023), incision left chest (2/15/2023).
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:**	No urinary output throughout the student nurse's clinical time. Unable to assess pain due to semi comatose condition of the patient. Patient is not on dialysis. Inspection of genitals deferred. Patient doesn't have a catheter in place.

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**	Unable to fully assess neuromuscular status and ROM due to semi comatose state of patient. Patient used a walker, wheelchair, and glasses at home. Unable to access strength due to unresponsiveness of patient. Patient requires total assist care. The patient is a fall risk score of 13 which is a moderate fall risk. The patient is heavily sedated and movement was not seen. Patient would be a full assist with a Hoyer to transfer and can not stand or walk.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Unable to assess MAEW due to sedated nature of the patient. Extremely sluggish and equal PERLA. Unable to assess strength due to sedation. 7 gloscow coma scale rating. Unable to assess sensory status. Patient does not orientate to voice or touch. A&O 0.
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 not religious reported by the wife. Wife reports that the family and the patient has tried to stay positive and stay together. Another family member also has cancer at this time. The family has each other for support at this time.

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

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400	78 BPM right radial	86/63 Right arm laying	10 RR	95.5F temporally	100% on 2L O2 via nasal canula

1600	103 BPM right radial	99/62 Right arm lying	9 RR	97.7F temporally	96% on 2L O2 via nasal canula

Vital Sign Trends/Correlation: Blood pressure and respiratory rate are low as a result of morphine, fentanyl, and lorazepam. Heart rate increased as a result of increased workload on the heart due to low BP. Circulation is focusing on major organs causing a low temperature.

Time	Scale	Location	Severity	Characteristics	Interventions
1400	Nonverbal indicators of pain	N/A	N/A	N/A	Fentanyl administration
1600	Nonverbal indicators of pain	N/A	N/A	N/A	Fentanyl administration

Pain Assessment, 2 sets (2 points)

Absence of non-verbal indicators of pain however unable to accurately access it due to sedated nature of the patient.

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 IV present
Other Lines (PICC, Port, central line, etc.)	Port

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:**	Implantable single lumen port left chest implanted 3/19/2023, patent, dressing dry without drainage. No erythema, warmth, phlebitis, infection or occlusion. Dressing doesn't have a date. 25mL/hr saline continuously running no caps in place. Port is thoroughly disinfected before access. CHG wipes used for bed baths. Hand hygiene and gloves utilized before port access.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
187.5 mL of saline 375 mcg fentanyl	No significant output throughout clinical time.

Nursing Care

Summary of Care (2 points)

Overview of care: The patient is actively dying and on comfort-based care only. Fentanyl, morphine, and Ativan are administered regularly to keep the patient comfortable. The patient is sedated and non-responsive to voice or touch. Turns, and oral suctioning has been deferred by the patient the nurse states, "it would possibly irritate the patient and he is comfortable". The patient will die in the hospital.

Procedures/testing done: No procedures or testing was done throughout the clinical day.

Complaints/Issues: No complaints or issues from the patient or family.

Vital signs (stable/unstable): Vitals are currently stable.

Tolerating diet, activity, etc.: diet is NPO and the patient is sedated and bed-bound

Physician notifications: The physician was not notified throughout the clinical day.

Future plans for the client: The client will be kept comfortable as he dies in the hospital.

Discharge Planning (2 points)

Discharge location: The patient will not be discharged, the funeral home, and the coroner will need to be notified upon the death of the patient.

Home health needs (if applicable): The patient will not be going home.

Equipment needs (if applicable): The patient will not need equipment at home.

Follow-up plan: Emotionally support the family through the death process of their family member and answer any questions that they have. Provide postmortem care when necessary.

Education needs: Family was educated on the rapid nature of esophageal carcinoma. Education on the importance of quickly receiving health care upon difficulty swallowing or breathing was given, especially due to the 2nd hand smoke they have received.

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. Impaired gas exchange related to pulmonary function as evidenced by chest CT scan.	The patient is actively dying and impaired gas exchange will likely be the cause of death.	**1.** Provide O2 2 L by nasal cannula as ordered 2. Administer morphine as ordered	**1.** Ensure adequate oxygenation throughout clinical time.	Patient and family were accepting of treatment and the client remained above 95% O2 throughout clinical day - goal met.

2. Ineffective airway clearance related to esophageal carcinoma as evidenced by Chest CT	Carcinoma has spread to lesions in the lungs obstructing airway clearance.	1. Administer morphine as ordered. 2. Intubation is deferred as comfort care measures without intubation are in place.	**1**. Patient remains adequately oxygenated (O2 SAT above 90%) throughout clinical time.	Patient and family was accepting of plan of care. Patient remained O2 above 90% throughout clinical time goal was met.
3. Decreased cardiac output related to increased workload on the heart as evidenced by ejection fraction	The heart is working harder to maintain hemostatic balance which is why heart rate was increased.	**1.** Administer oxygen as prescribed to decreased cardiac workload. **2**. Administer morphine as ordered to decrease workload on the heart.	**1.** Patient remains regular rate and rhythm throughout clinical day.	Patient and family were accepting of plan of care. The client was tachycardic at times throughout the clinical day therefore goal not met, however no modifications to be done at this time as he is comfort care.
4. Readiness for enhanced coping related to death of the patient as evidenced by verbal statements of shock.	The patient will eventually die as a result of his condition, however it is our job as nurses to emotionally aid the family as well.	**1.** Allow the family to vent their feelings to the student nurse thought clinical time. **2.** Allow the family to ask any questions they have to the student nurse throughout clinical time**.**	1. The family will feel comfortable verbalizing feelings and questions to the student nurse throughout clinical day.	The family were accepting of the plan of care and verbalized feelings regarding death and condition of family member, goal met.

5. Grieving related to progressive condition of patient as evidenced by crying by family members	The family was visually upset and crying knowing their family member would soon inevitably pass.	1. Be present and empathetic to the family. 2. Ask the family how they are coping with the grief.	1. Family will express feelings of Grieg to the student nurse throughout the clinical day.	Family was accepting of the care plan and verbalized feelings of grief, goal met.

Other References (APA):

Phelps, L. L. (2020). *Sparks and Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Family statements of shock due to patient's condition rapid progression. Crying and visually upset family. Patient was unemployed due to mental issues he was having related to bipolar disorder

Nursing Diagnosis/Outcomes

2. Ineffective airway clearance related to esophageal carcinoma as evidenced by Chest CT **Impaired gas exchange related to pulmonary function as evidenced by chest CT scan.** Decreased cardiac output related to increased workload on the heart as evidenced by ejection fraction

5. Grieving related to progressive condition of patient as evidenced by crying by family members

4. Readiness for enhanced copin related to death of the patient evidenced by verbal statemen of shock.

Objective Data

Patient has metastatic esophageal cancer, spread to the lungs, and bones. Patient has ARDS as a result of the cancer. Vitals remain stable 9 RR, 103 BP, 86/62 BP .

Client Information

60 yr old male patient, unemployed. History of smoking, bipolar disorder I, married

Nursing Interventions

1. Allow the family to vent their feelings to the student nurse thought clinical time.

2. Allow the family to ask any questions they have to the student nurse throughout clinical time.

1. Administer morphine as ordered.

2. Intubation is deferred as comfort care measures without intubation are in place.

1. Provide O2 2 L by nasal cannula as ordered

2. Administer morphine as ordered

1. Be present and empathetic to the family.

2. Ask the family how they are coping with the grief.

1. Administer oxygen as prescribed to decreased cardiac workload.

2. Administer morphine as ordered to decrease workload on the heart.