N431 CARE PLAN #1

Erica Stevenson

Lakeview College of Nursing

N441: Adult Health III

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Demographics

Date of Admission	Client Initials	Age	Biological Gender
2/20/25	MH	58 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
African American/Black	Warehouse Operator at McLane Midwest	Married	NKDA
Code Status	**Height**	**Weight**	
Full Code	177.8cm (5’10”)	97kg (213lb 13.5oz)	

Medical History

Past Medical History: Coronary Artery Disease, Non-ST Elevation Myocardial Infarction, Peripheral Artery Disease, Hyperlipidemia, Heart Failure with Reduced Ejection Fraction, End-Stage Renal Disease, Obstructive Sleep Apnea, Diabetes Mellitus Type II, Chronic Kidney Disease Stage III

Past Surgical History: Percutaneous Coronary Intervention with Drug-Eluting Stent of the Left Anterior Descending Artery, Peritoneal Dialysis (PD) Catheter Placement

Family History: Brother – Atrial Fibrillation with Pacemaker Placement

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): No recorded use, unable to assess due to intubation.

Education: Unable to assess due to intubation.

Living Situation: Home with wife.

Assistive devices: None on file. Unable to assess due to intubation.

Admission History

Chief Complaint: Chest pain, sudden cardiac arrest.

History of Present Illness (HPI)– OLD CARTS

MH was at home on 2/19/25 when he reported to his wife that he was having sudden severe, crushing chest pain. His wife stated that he grabbed his chest and promptly fell to the ground, losing his pulse. After calling emergency medical services (EMS), 30 minutes of cardiopulmonary resuscitation (CPR) was performed at home by the patient's wife. Upon arrival of EMS, the patient was found to be in ventricular fibrillation (VF) and received 15 more minutes of CPR, eight total shocks, 400mg of amiodarone, and four doses of epinephrine, and a supraglottic airway device was placed for airway support. The patient's VF was resolved when a return of spontaneous circulation (ROSC) was achieved. The patient was transported to the emergency room and admitted to the Cardiovascular Intensive Care Unit on 2/20/25. The client had not received prior treatment as this was a sudden arrest. This HPI was collected from the provider notes and nurse report as the patient was unable to speak, report aggravating or relieving factors, or the severity of pain due to intubation.

Admission Diagnosis

Primary Diagnosis: Pulmonary Embolism

Secondary Diagnosis (if applicable): Cardiac Arrest

Pathophysiology

A pulmonary embolism (PE) is a type of blood clot that occurs in or travels to the arteries of the lungs (Capriotti, 2020). The clot typically originates in the veins of the lower extremities, called deep vein thrombosis (DVT), or on the right side of the heart (Capriotti, 2020). These clots occur when the platelets inappropriately coagulate (Hinkle et al., 2022). As the thrombus forms, it dislodges and travels through the venous system into the pulmonary arteries, where it lodges and causes infarction and hypoxemia of the lung tissue (Hinkle et al., 2022). This leads to

decreased blood flow and oxygenation of the lung tissue and, therefore, reduces the perfusion of oxygen to the rest of the body (Hinkle et al., 2022).

Signs and symptoms of a PE include shortness of breath, chest pain, palpitations, cough, anxiety, excessive sweating, tachypnea, and fainting (Capriotti, 2020). Symptoms vary depending on where the PE is located, and some people may not exhibit any or may have few symptoms (Hinkle et al., 2022). A PE can result in sudden death in some circumstances (Hinkle et al., 2022). This happens when the heart works harder to pump blood as a result of the increased pulmonary pressure, causing an overload of the heart and a weakened pumping ability (Hinkle et al., 2022). MH experienced sudden, severe chest pain before suddenly arresting. As he already had a weakened cardiovascular system and a history of heart failure, his heart was unable to compensate for the increased workload, which led to his sudden cardiac arrest.

Diagnosis of a PE includes lab work and imaging. A D-dimer is a blood test that looks for potential clots in the blood and is often the first test performed (Hinkle et al., 2022). Other blood tests, like a troponin or B-type natriuretic peptide, may be done to rule out other causes of the symptoms (Hinkle et al., 2022). Chest X-ray (CXR) is used to determine if any underlying pulmonary or cardiac issues are occurring (Hinkle et al., 2022). A CT angiography (CTA) of the chest will be performed to visualize any clots and determine their size and location (Hinkle et al., 2022). Additionally, an electrocardiogram (ECG) will be done to rule out cardiac issues (Hinkle et al., 2022). This patient had a CTA and CXR performed, which showed a PE of the subsegmental and segmental arteries of the right upper lobe. He also had an ECG that ruled out a myocardial infarction. A troponin was drawn, and a CT of the brain was performed to rule out other causes of the cardiac arrest.

Treatment for a PE includes anticoagulants and thrombolytic agents (Capriotti, 2020). Thrombolytic agents are typically only used for a PE that causes extreme hemodynamic changes or is severely life-threatening (Hinkle et al., 2022). Anticoagulants are the preferred treatment for a PE as they do not break up the clot but prevent further clotting from occurring (Hinkle et al., 2022). Surgical treatment may be needed to remove the clot if it is extensive (Hinkle et al., 2022). This client did not receive thrombolytic therapy as the risk of the clot dislodging and causing other issues was not greater than the risk of leaving the clot. He is receiving anticoagulants to prevent further clotting.

Pathophysiology References (2) (APA):

Capriotti, T. (2020, February 4). Chapter 21: Restrictive and Obstructive Pulmonary Disorders. In *Davis Advantage for pathophysiology: Introductory Concepts and Clinical Perspectives* (Second Edition, pp. 514). F.A. Davis Company.

Hinkle, J. L., Cheever, K. H., & Overbaugh, K. (2022). Chapter 26: Assessment and Management of Patients with Vascular Disorders and Problems of Peripheral Circulation. In *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (15th ed., pp. 850-851). Wolters Kluwer.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Glucose	356 mg/dL	141 mg/dL	74 – 100 mg/dL	MH is a type II diabetic. Diabetes leads to increased blood glucose

				levels. Increased glucose levels can also indicate acute stress (Pagana et al., 2023).
Sodium	135 mmol/L	131 mmol/L	136 – 145 mmol/L	Decreased sodium levels can be related to heart failure, chronic renal insufficiency, inadequate intake of sodium, or malabsorption (Pagana et al., 2023).
Carbon Dioxide	11.0 mmol/L	21.0 mmol/L	22.0 – 29.0 mmol/L	A decreased carbon dioxide reading may be related to shock, renal failure, diabetic ketoacidosis, or starvation (Pagana et al., 2023).
BUN	77 mg/dL	35 mg/dL	8 – 26 mg/dL	Elevated BUN levels may indicate congestive heart failure, myocardial infarction, shock, or renal failure or disease (Pagana et al., 2023). The client

				has a history of renal disease and cardiac related issues.
Creatinine	16.26 mg/dL	3.61 mg/dL	0.70 – 1.30 mg/dL	Elevated creatinine levels may indicate diabetic nephropathy, nephritis, or reduced renal blood flow (Pagana et al., 2023). The client has a history of renal disease, which leads to elevated creatinine levels over time.
Albumin	2.6 g/dL	2.3 g/dL	3.5 – 5.0 g/dL	Decreased albumin levels can be related to infection, stress, or malabsorption (Pagana et al., 2023).
AST	206 U/L	36 U/L	9 – 43 U/L	Elevated AST levels may be related to trauma to the skeletal muscles from cardiopulmonary resuscitation (CPR) or medication adverse effects (Pagana et al., 2023).

ALT	179 U/L	65 U/L	0 – 34 U/L	Increased ALT levels can be due to shock, trauma to the muscles from CPR, or myocardial injury (Pagana et al., 2023).
Troponin	2,230 ng/L	N/A	0 – 4 ng/L	Elevated troponin levels indicate myocardial injury, and increased levels are often seen after CPR (Pagana et al., 2023). It may also indication a myocardial infarction (Pagana et al., 2023).
Red Blood Cells	3.34 10^6 U/L	3.16 10^6 U/L	3.50 – 5.20 10^6 U/L	Reduced red blood cells can be caused by renal disease, blood thinner use, hemorrhage, anemia, iron deficiency, or hemolysis (Pagana et al., 2023). The client does not have a history of anemia and no known active hemorrhages, but is on

				heparin, aspirin, and Plavix, so frequent assessments should be performed. He also has a history of renal disease.
Hemoglobin	8.7 g/dL	8.3 g/dL	11.0 – 16.0 g/dL	Low levels of hemoglobin can indicate hemorrhage, anemia, or hemolysis (Pagana et al., 2023). As indicated above, the client is at risk for bleeding due to blood thinner use, so he should be assessed for bleeding. Additionally, decreased hemoglobin can be due to his renal disease (Pagana et al., 2023).
Hematocrit	27.4%	25.1%	34.0 – 47.0%	Decreased hematocrit levels can indicate hemorrhage, anemia, or hemolysis (Pagana et al., 2023). As indicated above, the client is at risk

				for bleeding due to blood thinner use. His renal disease may also cause these reduced levels (Pagana et al., 2023).
White Blood Cells	6.30 10^3 U/L	12.99 10^3 U/L	4.00 – 11.00 10^3 U/L	Increased white blood cell levels can be caused by inflammation, stress, or possible infection (Pagana et al., 2023). The client is at high risk of hospital acquired infections through his central venous catheter, foley catheter, CRRT site, and endotracheal tube, so he should be closely monitored for signs of infection.
Mean Corpuscular Hemoglobin Concentration (MCHC)	31.8 g/dL	33.1 g/dL	32.0 – 36.0 g/dL	Decreased MCHC levels may be related to the client's renal disease or can indicate bleeding

				(Pagana et al., 2023).
Mean Corpuscular Hemoglobin (MCH)	26.0 pg	26.3 pg	27.0 – 33.0 pg	Decreased MCH levels may be related to the client's renal disease or can indicate bleeding (Pagana et al., 2023).
Red Blood Cell Distribution Width (RDW)	20.6%	19.9%	12.0 – 15.0%	Increased RDWs may be related to the client's renal disease or can indicate bleeding (Pagana et al., 2023).
Absolute Lymphocytes	5.04 10^3 U/L	1.46 10^3 U/L	1.00 – 4.90 10^3 U/L	Increased absolute lymphocytes can indicate infection (Pagana et al., 2023). It may also indicate inflammation (Pagana et al., 2023).
Lactic Acid	10.1 mmol/L	0.50 mmol/L	0.5 – 2.0 mmol/L	Increased lactic acid levels are due to tissue hypoxia or ischemia, in this case caused by his 45-minute arrest period (Pagana et al., 2023).

Platelets	227	116	140 – 400 10^3 U/L	Reduced platelets when using heparin may indicate heparin induced thrombocytopenia (Pagana et al., 2023).
PCO_2	N/A	30.4 mmHg	35.0 – 45.0 mmHg	His decreased PCO_2 levels may be due to hyperventilation or renal insufficiency (Pagana et al., 2023).
PO_2	N/A	148.3 mmHg	80.0 – 100.0 mmHg	His increased PO_2 may be caused by hyperventilation, pain, or his pulmonary embolism (Pagana et al., 2023).
HCO_3	N/A	19.9 mmol/L	22.0 – 26.0 mmol/L	Decreased HCO_3 can be caused by renal disease, elevated lactic acid levels, or respiratory alkalosis (Pagana et al., 2023).

Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results**
2/19/25: Chest XR	The client experienced chest pain	Cardiomegaly with

A CXR allows for the tissue, organs, and bones of the chest to be visualized (Pagana et al., 2023). A CXR is utilized by the provider to diagnose fractures, visualize changes to organs, and show the presence of fluid, air, or infection in the chest (Pagana et al., 2023). A CXR shows the heart, lungs, blood vessels, and ribcage (Pagana et al., 2023). In this case, a CXR was needed to determine if there was any trauma to the lungs or heart and check the placement of the endotracheal tube and orogastric tube.	prior to his cardiac arrest. Due to this and his cardiac arrest, the CXR was needed to determine the cause. He also was intubated, so the CXR was sued to determine if the ET tube was in the correct location. Unable to assess for any other symptoms as the client is intubated.	poor inspiratory volume and airspace opacities in the bilateral lung bases. Endotracheal tube in place.
2/19/25: CT Brain A CT of the brain is done to visualize the structures of the brain, including the cerebrum	The client experienced a cardiac arrest. A CT of the brain was needed to determine the cause of the arrest. Unable to assess for any other	No abnormal findings.

and cerebellum (Pagana et al., 2023). Aneurysms, ischemic and hemorrhagic strokes, masses, tumors, infection, and structural defects can all be found from a CT of the brain (Pagana et al., 2023). The CT brain was performed for this patient to determine if the cause of the patient's cardiac arrest was due to one of these abnormalities.	symptoms as the client is intubated.	
2/19/25: Electrocardiogram An ECG is a test done to show the electrical conduction of the heart (Pagana et al., 2023).	The client experienced chest pain prior to his cardiac arrest. Because of this and the subsequent arrest, an ECG was needed to determine if a myocardial infarction was the cause of his arrest. Unable to assess for any other symptoms as the client is intubated.	Atrial fibrillation with premature ventricular contractions, nonspecific intra-ventricular conduction block, and a nonspecific ST and T wave abnormality.
2/20/25: Chest XR	This CXR was done to visualize the	Right internal jugular

A CXR allows for the tissue, organs, and bones of the chest to be visualized (Pagana et al., 2023). A CXR is utilized by the provider to diagnose fractures, visualize changes to organs, and show the presence of fluid, air, or infection in the chest (Pagana et al., 2023). A CXR shows the heart, lungs, blood vessels, and ribcage (Pagana et al., 2023). This CXR was done to check for worsening pulmonary function as well as the placement of the internal jugular catheter.	placement of the CVC and check for any worsening pulmonary or cardiac issues. Unable to assess for any other symptoms as the client is intubated.	catheter with tip projecting at the mid superior vena ava level. Endotracheal tube in place.
2/20/25: CTA Chest/PE A CT/CTA of the chest is used to visualize the organs and blood vessels of the chest (Pagana et al., 2023). The CT of the chest visualizes the	The client experienced chest pain prior to his cardiac arrest, so a CTA was needed to determine the cause of his cardiac arrest. Unable to assess for any other symptoms as the client is intubated.	Acute subsegmental and segmental pulmonary embolism in the right upper lobe. Cardiomegaly present. Small

organs and bones of the chest while the CTA determines blood flow in the vessels (Pagana et al., 2023). The CT is done to determine if there is any damage to the organs of the chest (Pagana et al., 2023). The CTA is done to determine if there is a blood clot, called a pulmonary embolism, within the lung vessels (Pagana et al., 2023). This CTA was performed to assess for the cause of the client's cardiac arrest.		volume of free air in the upper abdomen. Dependent consolidation in the right upper lobe and bilateral lower lobes. Coronary artery disease with a stent in the left anterior descending artery.
2/20/25: CT Abdomen/Pelvis The purpose of a CT of the abdomen and pelvis is performed to visualize the tissue, bones, and organs within the abdominal and pelvic spaces (Pagana et al., 2023). The structures	The client's CTA showed free air in the abdomen. Unable to assess for any other symptoms as the client is intubated.	Small amount of free air present in the left upper quadrant, less than seen in the CTA. Small bilateral pleural effusions with dependent airspace opacities in the

visualized include the stomach, intestines, liver, pancreas, spleen, kidneys, adrenal glands, blood vessels, lymph nodes, spine, pelvic bones, bladder, and reproductive organs (Pagana et al., 2023). CT scans can show masses, fluid collection, inflammation, fractures, and other changes to the tissue and organs (Pagana et al., 2023). This CT was performed to determine the extent and possible source of the free air visualized in the CTA.		bilateral lower lobes. Atherosclerosis with coronary artery and peripheral artery disease. Enlarged prostate.
2/20/25: Echocardiogram An echo is a type of ultrasound that shows cardiac function. It looks at cardiac output, function of the heart	The client experienced a cardiac arrest. An echo was needed to determine if the cause of the arrest was related to his heart function and determine if his arrest caused any	Mild enlargement of the left ventricle and left atrium. Mild concentric left ventricular

and vessels, and the structure of the heart (Pagana et al., 2023).	worsening of his heart function. Unable to assess for any other symptoms as the client is intubated.	hypertrophy with a severely reduced systolic function and ejection fraction of 20-25%. Mitral valve mildly thickened with mild regurgitation.
2/20/25: Electrocardiogram An ECG is a test done to show the electrical conduction of the heart (Pagana et al., 2023).	The second ECG was done to determine if his condition was improving or worsening. Unable to assess for any other symptoms as the client is intubated.	Normal sinus rhythm with a prolonged QT interval and an ST and T wave abnormality, possibly due to previous inferior ischemia.
2/20/25: Electroencephalogram (EEG) An EEG is done using leads attached to the head and measures the electrical activity of the brain (Pagana et al., 2023). EEGs look for seizure activity, changes in the brain activity due to	An EEG was ordered to determine if he had any brain activity. Unable to assess for any other symptoms as the client is intubated.	No seizure activity noted.

tumors, sleep disorders, injuries to the brain, and brain death (Pagana et al., 2023). This EEG was performed to determine if any seizure activity was occurring, as well as determine if the client had any brain activity.		

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's Diagnostic and Laboratory Test Reference* (16th ed.). Elsevier.

Active Orders

Active Orders	Rationale
CRRT settings: • DNL (cc/hr) = 50mL/hr • Therapy mode = continuous venovenous hemodiafiltration (CVVHDF) • Blood pump speed = 200 mL/hour • Replacement fluid mode = pre and post dilution mode	This is necessary to maintain fluid balance and to remove waste as the client is unable to do so from a critical kidney injury. The settings are needed so that the nurse can adjust the CRRT machine.

• Post replacement flow rate = 1000 mL/hour • Pre replacement flow rate = 1000 mL/hour • Dialysate flow rate = 1000 mL/hour	
Activity: bedrest	This order is placed due to the client being intubated and on CRRT.
Notify MD for: • Unplanned interruption in unfractionated heparin (UFH) delivery. • Anti-Xa lab result greater than or equal to 1.1 IU/mL. • Decrease in platelets to <100,000 or by more than 50% from the baseline. • Decrease in hemoglobin greater than or equal to 2 g/dL from the previous measurement. • Decrease in hematocrit greater than or equal to 6% from the previous measurement. • Significant changes in clinical condition (bleeding, signs or	This order is placed to inform nursing staff that communication with the provider is needed for changes to the client's status, labs, or heparin therapy plan.

symptoms of worsening ischemia, etc.). • Hemoccult/guaiac positive stool, urine, or emesis. • Patient falls or sustains other trauma. Therapeutic range not reached after 2 consecutive dose adjustments.	
Diet: NPO except for tube feed	This order is needed so the nurse is able to feed the client via his OG and prevents accidental ingestion my mouth and aspiration.
Place order for PTT 6 hours after starting/restarting heparin.	This order is placed to inform nursing staff that lab work is needed when starting or re-starting heparin therapy.
Place order for PTT per subsequent PTT measurement per dosing titration table.	This order is placed to inform nursing staff that lab work is needed during the client's heparin therapy to determine the dosage.
Wound care/dressing change: daily peritoneal catheter dressing change.	This order is placed so that the nurse knows to change the client's PD catheter dressing daily to prevent infection.
Oral care every 2 hours.	Intubated clients need oral care every 2 hours to prevent ventilator associated pneumonia.
Assess RASS score every 2 hours.	This order is placed so that the client's sedation and agitation levels can be

	monitored, as they should not be overly sedated but also need to be sedated enough to remain calm.
Peritoneal dialysis: 1 cycle via CAPD, total 1,500 mL over 20 minutes with 30 minutes dwell time, every Monday, Wednesday, and Friday.	This order is placed so that the client can attend dialysis.
Glucose level every 2 hours.	This is needed as he is diabetic and on continuous tube feeding.
Avoid intramuscular injections while on UFH infusion.	This order is placed to ensure IM injections are not being given due to the risk for bleeding and bruising on heparin therapy.
Use actual body weight for UFH dosing calculation up to 100kg.	This order is placed due to the client being on heparin therapy as it is a weight-based medication.
Notify MD for blood glucose levels less than 60 or signs of severe hypoglycemia.	This is necessary as the client is diabetic and unable to control their blood glucose level. They may have decreased glucose levels from insulin therapy.
Daily weight.	This is needed for heparin therapy and is standard on a critical care floor.
Maintain MAP of greater than 70 mmHg.	This order is placed so the nurse can maintain blood pressure control via medications and

	monitor for a decreased MAP.
Phase 3 TTM: rewarming and normothermia. Rewarm to 37°C, maintain for 48 hours, use Baer Hugger as needed.	This order is placed to warm the patient after the initial cooling period post-resuscitation.
Notify RT for ventilator adjustment.	This order is placed so that respiratory therapy will adjust the ventilator as needed.
Spontaneous breathing trial – notify RT.	This order is placed to assess the client's ability to breathe on their own.
Foley catheter placement and care.	This order is placed as the client is intubated and unable to void on their own.
Tube feed - Promote with Fiber at 55 mL per hour.	This order is needed as the client must maintain proper nutrition.
Vital signs every 15 minutes.	This client is a critical care patient. Protocol for vital signs on the critical care unit unless otherwise ordered is every 15 minutes.
Intake and output every hour.	This order is placed to watch the client's fluid balance while on CRRT and is standard for the ICU setting.

Medications

Home Medications (Must List ALL)

Medication	Reason for taking
Calcitriol (Rocaltrol) 0.25mcg by mouth once daily.	Prevention of low calcium related to his renal disease (Jones & Bartlett Learning, 2023).

Carvedilol (Coreg) 25mg by mouth twice daily.	Treatment of hypertension and heart failure (Jones & Bartlett Learning, 2023).
Cholecalciferol (Vitamin D3) 50,000 units by mouth once every 7 days.	Bone support due to reduced production of vitamin D in kidney disease (Jones & Bartlett Learning, 2023).
Clopidogrel (Plavix) 75mg by mouth once daily.	Blood clot prevention due to his cardiac history, including stent placement (Jones & Bartlett Learning, 2023).
Empagliflozin (Jardiance) 10mg by mouth once daily.	Treatment of his diabetes, kidney disease, and heart failure (Jones & Bartlett Learning, 2023).
Folic acid/Vitamin B complex with vitamin C once daily.	Supplementation to prevent deficiency and support heart health (Jones & Bartlett Learning, 2023).
Semaglutide (Ozempic) 2mg subcutaneously once every 7 days.	Treatment for his diabetes and reduce the risk of cardiac complications (Jones & Bartlett Learning, 2023).
Torsemide (Demadex) 100mg by mouth daily.	Reduce blood pressure and treat edema related to his heart failure and renal disease (Jones & Bartlett Learning, 2023).

Hospital Medications (Must List ALL)

Brand/ Generic	Aspirin (Bayer Aspirin)	Atorvastatin (Lipitor)	Carvedilol (Coreg)	Ceftriaxone (Rocephin)	Clopidogrel (Plavix)	Dextrose 50% (Abboject)
Classification	Pharmacologic class: Salicylate (Jones & Bartlett Learning, 2023). Therapeutic class: NSAID (Jones & Bartlett Learning, 2023).	Pharmacologic class: HMG-CoA reductase inhibitor (Jones & Bartlett Learning, 2023). Therapeutic class: Antihyperlipidemic (Jones & Bartlett Learning, 2023).	Pharmacologic class: Nonselective bet blocker and alpha-1 blocker (Jones & Bartlett Learning, 2023). Therapeutic class: Antihypertensive, heart failure treatment adjunct (Jones & Bartlett Learning, 2023).	Pharmacologic class: Third-generation cephalosporin (Jones & Bartlett Learning, 2023). Therapeutic class: Antibiotic (Jones & Bartlett Learning, 2023).	Pharmacologic class: $P2Y_{12}$ platelet inhibitor (Jones & Bartlett Learning, 2023). Therapeutic class: Platelet aggregation inhibitor (Jones & Bartlett Learning, 2023).	Pharmacologic class: Glucose elevating agent (Drugs.com, 2023). Therapeutic class: Glucose elevating agent (Drugs.com, 2023).
Reason Client Taking	The client is taking this as a blood thinner due to his cardiac history and current pulmonary embolism	The client is taking this medication to control lipid levels.	The client is taking this medication for blood pressure control and to treat his heart failure.	The client is taking this due to is increased white blood cell count and to prevent an HAI.	The client is being given this due to his previous NSTEMI, extensive cardiac history, stents and current PE to prevent	The client has this ordered as needed for hypoglycemia.

	(PE).				further blood clots.	
List two teaching needs for the medication pertinent to the client	This client should be taught to report any signs of excessive bleeding, bruising, or dark tarry stools to their provider (Jones & Bartlett Learning, 2023). They should also be taught to take the medication with food to prevent GI issues (Jones & Bartlett Learning, 2023).	The client should be educated on the need to take the dose at the same time every day, and not to take double doses if the previous dose is missed (Jones & Bartlett Learning, 2023). They should also be educated to closely monitor their blood glucose levels as atorvastatin can alter the blood sugar of patients with diabetes (Jones & Bartlett Learning, 2023).	The client should be advised to monitor their blood sugar closely as they may experience very high or very low blood sugar levels (Jones & Bartlett Learning, 2023). They should also be educated to stand slowly as carvedilol can cause orthostatic hypotension and dizziness (Jones & Bartlett Learning, 2023).	The client should be educated on the need to inform the nurse or provider of watery stools as antibiotic treatment can lead to *Clostridium difficile* infection (Jones & Bartlett Learning, 2023). They should also be taught to report vaginal itchiness as antibiotics can lead to opportunistic fungal infections like a yeast infection (Jones & Bartlett Learning, 2023).	The client should be taught to stop taking nonprescription NSAIDs as it increases the risk for bleeding (Jones & Bartlett Learning, 2023). They should also be taught to report any easy bruising or bleeding (Jones & Bartlett Learning, 2023).	The client should be taught to report signs of low glucose levels (Drugs.com, 2023). They should also be instructed to closely monitor their blood glucose levels (Drugs.com, 2023).
Key nursing assessment(s) prior to administration	The nurse should assess for any signs of bleeding (Jones & Bartlett Learning, 2023). The nurse should ensure the client is well hydrated prior to giving as dehydration increases the risk for toxicity (Jones & Bartlett Learning, 2023).	The nurse should monitor the client's liver and kidney labs as well as glucose level as all of them can be altered from statin use (Jones & Bartlett Learning, 2023). They should also monitor signs of rhabdomyolysis (Jones & Bartlett Learning, 2023).	The nurse should monitor for signs of worsening peripheral artery disease as arterial insufficiency can be worsened (Jones & Bartlett Learning, 2023).	The nurse should monitor the client laboratory reports for signs of nephrotoxicity or liver damage (Jones & Bartlett Learning, 2023). They should also assess the client's stool for signs of *C. difficile* infection (Jones & Bartlett Learning, 2023).	The nurse should assess the client for signs or bleeding (Jones & Bartlett Learning, 2023). They should also assess the client's blood count to monitor for thrombocytopenia (Jones & Bartlett Learning, 2023).	The nurse should assess the client's blood glucose levels and level of consciousness (Drugs.com, 2023).
Brand/ Generic	Famotidine (Pepcid)	Heparin (Heparin sodium)	Hydralazine (Apresoline)	Insulin lispro (Humalog)	Insulin glargine (Lantus)	Labetolol (Trandate)
Classification	Pharmacologic class: Histamine-2 blocker (Jones &	Pharmacologic class: Anticoagulant (Jones & Bartlett Learning, 2023).	Pharmacologic class: Vasodilator (Jones & Bartlett	Pharmacologic class: Human insulin (Jones & Bartlett	Pharmacologic class: Human insulin (Jones & Bartlett Learning, 2023).	Pharmacologic class: Noncardioselective beta-blocker/alph

	Bartlett Learning, 2023). Therapeutic class: Antiulcer agent (Jones & Bartlett Learning, 2023).	Therapeutic class: Anticoagulant (Jones & Bartlett Learning, 2023).	Learning, 2023). Therapeutic class: Antihypertensive (Jones & Bartlett Learning, 2023).	Learning, 2023). Therapeutic class: Antidiabetic (Jones & Bartlett Learning, 2023).	Therapeutic class: Antidiabetic (Jones & Bartlett Learning, 2023).	a[1] blocker (Jones & Bartlett Learning, 2023). Therapeutic class: Antihypertensive (Jones & Bartlett Learning, 2023).
Reason Client Taking	The client is taking this to prevent ventilator associated ulceration.	The client is getting this medication for his pulmonary embolism.	The client is receiving this medication to treat his hypertension.	The client is taking this for blood sugar control due to his diabetes mellitus.	The client is taking this for blood sugar control due to his diabetes mellitus.	The client is taking this medication for blood pressure control.
List two teaching needs for the medication pertinent to the client	The client should be educated to report pain or tarry emesis (Jones & Bartlett Learning, 2023). They should also be instructed to avoid doing any hazardous actives as the CNS effects are unknown in patients with renal impairment (Jones & Bartlett Learning, 2023).	The client should be instructed to avoid overusing other blood thinning medications like aspirin while on heparin (Jones & Bartlett Learning, 2023). They should also be taught to monitor for signs of bleeding bright red or dark tarry stools and increased bruising (Jones & Bartlett Learning, 2023).	The client should be educated to take this medication on an empty stomach to avoid worsening side effects (Jones & Bartlett Learning, 2023). They should also be educated to notify the nurse or provider if they experience dizziness upon changing positions (Jones & Bartlett Learning, 2023).	The client should be educated on how to dose their insulin (Jones & Bartlett Learning, 2023). They should also be taught how to inject their insulin (Jones & Bartlett Learning, 2023).	The client should be taught proper blood glucose monitoring prior to insulin injections (Jones & Bartlett Learning, 2023). They should also be taught how to store their insulin (Jones & Bartlett Learning, 2023).	The client should be told to lay flat for 3 hours after receiving the medication via IV (Jones & Bartlett Learning, 2023). The client should also be taught to report any confusion, slow pulse, or swelling (Jones & Bartlett Learning, 2023).
Key nursing assessment(s) prior to administration	The nurse should assess the clients telemetry monitor as this medication can cause a prolonged QT, an AV block, or arrythmias (Jones & Bartlett Learning, 2023).	The nurse should assess the client's PTT level to determine the proper dose needed (Jones & Bartlett Learning, 2023). They should also keep protamine sulfate on hand so overdose can be treated quickly (Jones & Bartlett Learning, 2023).	The nurse should monitor the client's blood pressure for hypotension on this medication (Jones & Bartlett Learning, 2023).	The nurse must determine the client's blood glucose level to determine how many units are needed and prevent hypoglycemia (Jones & Bartlett Learning, 2023).	The nurse should monitor the clients blood glucose level prior to giving insulin to ensure it is needed (Jones & Bartlett Learning, 2023).	The nurse should assess the client's blood pressure and pulse prior to giving (Jones & Bartlett Learning, 2023). They should also be advised to not stop labetalol abruptly to avoid rebound hypertension and angina (Jones & Bartlett Learning, 2023).

Prioritize Three Hospital Medications

Medications	Why this medication was	List 2 side effects. These

	chosen	must correlate to your client
1. Heparin	This medication was chosen because it a blood thinner used to treat pulmonary embolism and prevent further clots (Jones & Bartlett Learning, 2023). It has major risks and requires the nurse to assess the patient frequently and perform medication calculations based on laboratory values to prevent overdose and undertreatment (Jones & Bartlett Learning, 2023).	**1.** Excessive bleeding (Jones & Bartlett Learning, 2023). **2.** Chest pain (Jones & Bartlett Learning, 2023).
2. Labetalol	This medication was chosen because it is a rapid acting blood pressure control agent that is used in critical care (Jones & Bartlett Learning, 2023). This patient needs intense blood pressure control due to his renal disease, but	**1.** Bradycardia (Jones & Bartlett Learning, 2023). **2.** Ventricular arrythmias (Jones & Bartlett Learning, 2023).

	labetalol should be used carefully as he had a ventricular arrythmia (ventricular fibrillation) and this can be an adverse effect of this medication (Jones & Bartlett Learning, 2023).	
3. Ceftriaxone (Rocephin)	This medication was chosen as the patient has multiple sites at risk of infection and has increased white blood cells, which can indicate a developing infection (Jones & Bartlett Learning, 2023). The patient has an endotracheal tube, which places him at risk for ventilator associated pneumonia. He has a central venous catheter which increases the risk of a bloodstream infection and septic shock. He has a PD catheter, which can lead to	**1.** Acute renal failure (Jones & Bartlett Learning, 2023). **2.** *C. difficile* infection (Jones & Bartlett Learning, 2023).

	peritonitis. He also has a foley catheter, which can cause a urinary tract, kidney, or bladder infection.	

Medications Reference (1) (APA)

Dextrose 50% injection: Package insert. Drugs.com. (2023). https://www.drugs.com/pro/dextrose-50-injection.html

Jones & Bartlett Learning (2023). *NDH: Nurse's Drug Handbook (23rd ed.)*. Jones & Bartlett Learning.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** Semi-comatose **Orientation:** Unable to assess due to intubation. **Distress:** No signs of acute distress, unable to ask patient due to intubation. **Overall appearance:** Appears calm, occasionally grimaces. **Infection Control precautions:** None. **Client Complaints or Concerns:** Unable to assess due to intubation.	MH is a 58-year-old male. He is semi-comatose, and orientation is unable to be obtained due to intubation. He appears to be in no acute distress. He appears calm but occasionally grimaces. He is not on isolation precautions. He is unable to answer if he has any complaints or concerns due to intubation.
VITAL SIGNS: **Temp:** 98.8 F (37.1 C), temperature sensing foley **Resp rate:** 18 bpm **Pulse:** 76 bpm **B/P:** 116/55 (MAP 78) **Oxygen:** 98% **Delivery Method:** Mechanical ventilator	The client's vital signs at 12:00 are within normal limits and are as follows: temperature is 98.8 F (37.1 C) via temperature sensing foley ; respirations are 18 breathes per minute; pulse is 76 beats per minute; blood pressure is 116/55 with a mean arterial pressure of 78; oxygen saturation is 98% on 40% FiO2 via mechanical ventilation.
PAIN ASSESSMENT: **Time:** 1200 **Scale:** Critical Pain Observation Tool	The patient is unable to be asked about pain, so the CPOT pain scale was used, with scoring as follows:

(CPOT) **Location:** Unable to assess due to intubation. **Severity:** 3 **Characteristics:** Unable to assess due to intubation. **Interventions:** Repositioned, provided calming environment.	Compliance with ventilator: coughing but tolerating = 1 Facial expression: grimacing = 2 Body movements: absent = 0 Muscle tension: relaxed = 0 This pain scale gives the patient a score of 3. Unable to assess the location and characteristics of pain due to intubation. The patient was repositioned, lights were turned off, and calming music was turned on for pain management.
IV ASSESSMENT: **IV 1** **Size of IV:** 18 gauge **Location of IV:** Left antecubital **Date on IV:** 2/19/25 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Clean, dry, intact **Fluid Type/Rate or Saline Lock:** Saline locked **Central venous catheter – triple lumen** **Size of IV:** 8 French – three lumens **Location of IV:** Right internal jugular (IJ) vein **Date on IV:** 2/20/25 **Patency of IV:** All lumens patent **Signs of erythema, drainage, etc.:** None **IV dressing assessment:** Clean, dry, intact **Fluid Type/Rate or Saline Lock:** Proximal: saline locked; mid: saline locked; distal: heparin at 11.6 mL/hour	The client has two intravenous lines, a peripheral IV (PIV) and a central venous catheter (CVC). An 18-gauge IPV is present in his left antecubital. It was placed on 2/19/25. The line is patent and flushes with ease. No bruising, bleeding, or drainage is present. It is dressed with a transparent Tegaderm and is clean, dry, and intact. It is saline locked. An 8 French triple lumen CVC is present in the right IJ. The line was placed on 2/20/25. All lumens are patent and flush with ease. No bruising, bleeding, or drainage is present. It is dressed with a large chlorhexidine gluconate Tegaderm and is clean, dry, and intact. The proximal and mid lumens are saline locked. The distal lumen has heparin running at 11.6 mL/hour.
INTEGUMENTARY: **Skin color:** Brown, appropriate for ethnicity **Character:** Dry **Temperature:** Warm **Turgor:** Slow **Rashes:** None **Bruises:** Scattered throughout arms, chest **Wounds:** None **Braden Score:** 13 **Drains present: Y☒ N ☐** **Type:** Peritoneal dialysis catheter, foley catheter, continuous renal replacement therapy	MH's skin is brown and appropriate for his ethnicity. He is warm and dry with slow to return skin turgor. No rashes or wounds are present, bruising is present on his arms and chest. His Braden score is 13, placing him at a moderate risk for impaired skin integrity. He has a peritoneal dialysis catheter, foley catheter, and tubes for continuous renal replacement therapy present.

HEENT: **Head/Neck:** Midline, symmetrical **Ears:** Equal, no drainage **Eyes:** Bilateral scleral edema, 2mm, corneal reflex present **Nose:** Midline, no deviation or drainage **Teeth:** Slight decay	Head and face are symmetrical. Trachea is midline without deviation, thyroid and lymph nodes are not palpable and are without pain. Ears are symmetrical, no redness, drainage, or lumps are present. The patient opens eyes to voices, but does not follow commands. Pupils are equal, round, and reactive to light, but not accommodating. Pupil size 2mm bilaterally, corneal reflex is present. Bilateral scleral edema is noted, sclera is pink. Conjunctiva pink and cornea clear. Nose is midline and without deviation. No drainage, redness, or lumps are present, mucus membranes are pale, dry, and cracked. Lips are dry and pale. Endotracheal tube is present, 23cm at the lips. Dentition shows mild decay.
CARDIOVASCULAR: **Heart sounds:** S1 and S2 present, no adventitious heart sounds **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** 1+ throughout **Capillary refill:** 4 seconds **Neck Vein Distention:** **Y** ☐ **N** ☒ **Edema Y** ☒ **N** ☐ **Location of Edema:** Scleral, pedal	Normal sinus rhythm on monitor. S1 and S2 are present. No gallops, murmurs, or rubs. Peripheral pulses are diminished, 1+ throughout. Capillary refill is slow, 4 seconds. No jugular vein distension is noted. Edema is noted in the feet and sclera.
RESPIRATORY: **Accessory muscle use:** **Y**☐ **N** ☒ **Breath Sounds:** Course crackles throughout	Normal rate, rhythm, and depth of respirations. No accessory muscle use or retractions. Patient is breathing via mechanical ventilation, with FiO2 at 40%. Patient was on a spontaneous breathing trial at the time of assessment. Lung sounds are course crackles throughout.
GASTROINTESTINAL: **Diet at home:** Unable to assess due to intubation. **Current Diet:** Tube feed via OG **Is Client Tolerating Diet?** Yes **Height:** 177.8cm (5'10") **Weight:** 97kg (213lb 13.5oz) **Auscultation Bowel sounds:** Normoactive **Last BM:** 2/22/25 **Palpation: Pain, Mass etc.:** Soft, no organomegaly noted, unable to assess pain due to intubation.	Patient is currently on a tube feed only diet. He is 177.8 cm and 97 kg. Bowel sounds are normoactive, last bowel movement was 2/22/25. There are no signs of pain on light or deep palpation, but unable to ask patient due to intubation. No organomegaly or masses are noted. No distention, wounds, or incisions, peritoneal catheter is present. No ostomy is present. Patient has a 16 French orogastric tube.

Inspection: **Distention:** None **Incisions:** None **Scars:** None **Drains:** Peritoneal dialysis catheter **Wounds:** None **Ostomy:** **Y** ☐ **N** ☒ **Nasogastric:** **Y** ☒ **N** ☐ **Size:** 16 French **Feeding tubes/PEG tube** **Y** ☒ **N** ☐ **Type:** Orogastric, listed above.	
GENITOURINARY: **Color:** Unable to assess due to intubation. **Character:** Unable to assess due to intubation. **Quantity of urine:** 0 mL **Pain with urination:** Unable to assess due to intubation. **Dialysis:** **Y** ☒ **N** ☐ **Inspection of genitals:** Dry, intact **Catheter:** **Y** ☒ **N** ☐ **Type:** Temperature sensing foley **Size:** 16 French	The client has not had any urine output over the past 24 hours, unable to assess color and character. Unable to assess for pain with urination due to the client being intubated. The client is currently on continuous renal replacement therapy (CRRT) for dialysis, and receives peritoneal dialysis on Monday, Wednesday, and Friday. His genitals are dry, intact, and without sores or redness. He has a 16 French temperature sensing foley, without signs of infection or trauma to the area.
Intake (in mLs) Heparin drip: 11.6 mL/hour x 11 hours = 127.6 mL Tube feed: 55mL/hour x 11 hours = 605 mL Ceftriaxone IV push: 10 mL Flushes: 20 mL Total intake = 762.6 mL during this 11-hour shift. **Output (in mLs)** CRRT: 70, 70, 70, 88, 121, 120, 120, 124, 130, 128, 130 Total output = 1,171 mL during this 11-hour shift.	The client is on a strict tube feed only diet and fluid restriction. He received 127.6 mL of heparin, 605 mL of tube feed, 10mL IVP of ceftriaxone, and 20 mL of saline flushes. His total intake during this shift was 762.6 mLs. The client does not have any urinary output at this time. He is on continuous renal replacement therapy (CRRT) to remove waste. His initial CRRT plan was to remove the exact mLs as he was taking in, however nephrology changed his orders through the day to have 50 mLs extra per hour removed than his intake. His total output from CRRT for the shift was 1,171 mLs.
MUSCULOSKELETAL: **Neurovascular status:** No cyanosis or clubbing noted, skin is warm and dry. **ROM:** Diminished. Upper extremities	Patient has no cyanosis or clubbingnof the nailbeds. Extremities are warm and dry. Patient unable to perform range of motion, but responds to pain in his lower extremities by

without response to pain, small movements. Lower extremities respond to pain, small movements. **Supportive devices:** None **Strength:** Diminished, absent pedal pushes/pulls, absent hand grips. **ADL Assistance:** **Y☒ N ☐** **Fall Risk:** **Y ☒ N☐** **Fall Score:** 14, high **Activity/Mobility Status:** bedrest **Activity Tolerance:** Tolerates bedrest with passive ROM exercises	withdrawling. He has diminished strength throughout, unable to perform pedal pushes and pulls or hand grips when prompted. Requires assistance with ADL's. He is a fall risk and is on bedrest.
NEUROLOGICAL: **MAEW: Y ☐ N☒** **PERLA: Y ☐ N☒** **Strength Equal: Y ☐ N ☒ if no - Legs ☐ Arms ☐ Both ☒** **Orientation:** Unable to assess due to intubation. **Mental Status:** Semi-comatose **Speech:** Unable to assess due to intubation. **Sensory:** Responds to pain, unable to assess further due to intubation. **LOC:** Unable to assess due to intubation.	Patient only able to make small movements with his extremities, responds to pain in this lower extremities only. Pupils are equal, round, and reactive to light, but not accommodating. Patient is semi-comatose, orientation is unable to be assessed due to intubation. Speech unable to be assessed due to intubation. GCS of 9.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** Unable to assess due to intubation. **Developmental level:** Unable to assess due to intubation. **Religion & what it means to pt.:** Muslim, unable to assess meaning due to intubation. **Personal/Family Data (Think about home environment, family structure, and available family support):** Lives at home with wife, has multiple family members visiting throughout the day. Unable to ask patient due to intubation.	Coping methods and developmental level were unable to be assessed due to the patient being intubated. The patient is Muslim, but meaning was unable to be assessed due to intubation. MH lives at home with his wife. He has had many family and friends visit through the day, but further evaluation of his personal and family data is unable to be assessed due to intubation.

Discharge Planning

Discharge location:

MH's current discharge location is unknown. His discharge location will be dependent on the extent of his deficits. If he is eventually able to downgrade to rehab within the hospital, he may be able to be discharged home. If his deficits are severe, he will be discharged to a skilled nursing facility. He is currently being evaluated and followed by Gift of Hope for organ donation as well.

Home health needs:

His current home health needs are unknown and will be determined based on his deficits. If able to be discharged home, he will need to be followed by home health for therapy and rehabilitation.

Equipment needs:

His current equipment needs are unknown and will depend on his level of deficit. He may need supplies such as a wheelchair, walker, shower chair, hospital bed, ventilator, ramp, and more.

Follow-up plan:

MH is to be followed by critical care, cardiology, endocrinology, and nephrology to determine a plan of care and follow-up plan if discharged. He may also be followed by neurology and home health after discharge if he exhibits severe deficits. He is also currently followed by Gift of Hope for possible organ donation. His follow-up plan will be determined after his MRI on 2/24/25, which will determine if he has experienced an anoxic brain injury.

Education needs:

If discharged, he will need education on medications, diet, exercise, cardiac rehabilitation, and prevention of further cardiovascular, respiratory, and

neurological damage or disease. If discharged, his family will need education on environmental safety, home care, and diet. If determined to be a candidate for organ donation, his family will need to be educated on the process of organ donation.

Nursing Process
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	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**
1. Ineffective cardiac tissue perfusion related to cardiac disorder, pulmonary embolism, and hypoventilation as evidenced by chest pain prior to cardiac arrest, arrythmias, capillary refill greater than 3 seconds, respiratory alterations, abnormal	This nursing diagnosis was chosen as the client experienced cardiac arrest and has severe complications related to his cardiac tissue perfusion as a result.	The patient will maintain cardiopulmonary perfusion as evidenced by normal sinus heart rhythm, heart rate within normal limits, and a normal oxygen saturation (Phelps, 2023).	**1.** Vital signs and cardiac rhythm will be monitored for changes (Phelps, 2023). **2.** Medications to increase perfusion and reduce blockages will be given as ordered and the client will be given oxygen via ventilator as ordered (Phelps, 2023).	The client did not exhibit any signs of worsening tissue perfusion. Interventions to increased cardiac perfusion will continue.

ABGs, decreased peripheral pulses, edema, and unstable blood pressure readings (Phelps, 2023).				
2. Impaired gas exchange related to ineffective breathing pattern and neurologic status post-resuscitation as evidenced by level of consciousness, breath sounds, ABG levels, altered respirations prior to intubation, need for intubation, and decreased CO2 levels (Phelps, 2023).	This diagnosis was chosen as the client is unable to breath on his own and therefore has impaired gas exchange. He suffered from severe hypoxia during his arrest.	The patient will maintain adequate ventilation and show signs of over breathing the endotracheal tube within 5 days (Phelps, 2023).	**1.** The client will be closely monitored for signs of hypoxia and worsening respiratory status, and respiratory therapy will be consulted to change ventilator settings as needed (Phelps, 2023). **2.** The client's ABG levels will be monitored for changes and treated as needed (Phelps, 2023).	The client showed signs during the shift of trying to breath over the ET tube. He was given a spontaneous breathing trial (SBT). During his SBT, the client was able to breath on his own for some time until he tired and was placed back on the ventilator. His oxygen saturation remained stable during this time.
3. Decreased cardiac output related to history of cardiac disease as evidenced by echocardiogram results,	This nursing diagnosis was chosen as the client's echocardiogram showed decreased cardiac output and the client had an	The client will show no decrease in cardiac output over the next 7 days (Phelps, 2023).	**1.** Monitor for changes to the client's heart rhythm and blood pressure and give medications as needed for these changes (Phelps, 2023).	The client was monitored closely for arrythmias and I/O's were carefully recorded. The client

decreased ejection fraction of 20-25%, adventitious breath sounds, coughing, and restlessness (Phelps, 2023).	extensive history of cardiac disease.		**2.** Measure and record intake and output every hour to prevent fluid overload and worsening cardiac output (Phelps, 2023).	did not exhibit any signs of worsening cardiac output during this time.
4. Excess fluid volume related to kidney disease and heart failure as evidenced by scleral and pedal edema, course crackles on auscultation, decreased hemoglobin and hematocrit levels, and oliguria (Phelps, 2023).	This diagnosis was chosen based on the client's breath sounds, oliguria, and edema. The client exhibited many signs of fluid volume overload, in addition to his history of kidney disease and heart failure.	The patient's blood pressure will remain within normal limits over the course of the shift (Phelps, 2023).	**1.** The client's vital signs will be monitored for indications of increasing fluid volume (Phelps, 2023). **2.** The client will be given antihypertensives and dialysis as ordered to prevent fluid buildup (Phelps, 2023).	The client began having worsened edema, elevated blood pressure and coughing. The provider ordered extra fluid to be removed from their CRRT to reduce the fluid volume.
5. Risk for infection related to presence of invasive devices, including an endotracheal tube, central venous catheter, foley catheter, and peritoneal catheter (Phelps, 2023).	This diagnosis was chosen as the patient is at high risk for a hospital acquired infection and sepsis.	The client will not show any signs of infection during their hospitalization (Phelps, 2023).	**1**. Infection control measures, such as hand hygiene and sterile dressing changes, will be followed (Phelps, 2023). **2**. White blood cell count will be closely monitored for signs of infection (Phelps, 2023).	The client began to have a slightly elevated white blood cell count. Due to this, he was placed on ceftriaxone to prevent worsening infection and sepsis.

Other References (APA):

Phelps, L. L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.