N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 9/17/19	Patient Initials RC	Age 66	Gender Male
Race/Ethnicity Caucasian	Occupation Undetermined	Marital Status Separated	Allergies NKA
Code Status Full Code	Height 74 inches	Weight 143 Kg	

Medical History (5 Points)

Past Medical History: Patient has a BMI between 45.0-49.9, Dysphagia, Hyperglycemia, Hypertension, Morbid Obesity, Odynophagia, Sleep apnea, and Fasciitis.

Past Surgical History: The patient has a history of having these surgical procedures done: (EGD) Esophagogastroduodenoscopy Biopsy, Colonoscopy Screening, Hernia repair, Leg Surgery.

Family History: The patient has a daughter and grandson that are at the bedside for support. Patients father is deceased due to a stroke, mother due to colon cancer, brother due to other reasons not listed, sister also for reasons not listed.

Social History (tobacco/alcohol/drugs): Patient used to chew tobacco for many years, started around age 25 and quit at 58.

Occasional alcohol use but family denied evidence of substance abuse.

Assistive Devices: No assisted devices used at home.

Living Situation: Patient lives at home alone and is independent in ADLs.

Education Level: Unattainable due to family not wanting to talk about it and patient being on vent.

Admission Assessment

Chief Complaint (2 points): Scheduled Laryngoscopy

History of present Illness (10 points): Admitting physician was consulted after the patient was extubated after a procedure with Dr. Cudone. The patient was having an outpatient procedure done (laryngoscopy), and was going to be discharged later that day. Patient was extubated too early after the procedure and was found unable to protect his airway. He became hypoxic and bradycardic. It is unknown if the patient lost pulse but compressions were performed and the patient was given atropine. The patient was able to be re-intubated and sent to CCU. He is able to wake up but is sedated due to fighting the vent.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Compromised airway due to inflammation

Secondary Diagnosis (if applicable): Hypoxia and Bradycardia

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

Infections and inflammations are a common occurrence of people and can come out of nowhere. They typically make you feel weak and drained and can sometimes cause your body issues in breathing, cell development, and even organ dysfunction. "Inflammation is a protective, coordinated response of the body to an injurious agent(Capriotti, T. et al., p.157, 2016). During inflammation in the body, the bone marrow sends out white blood cells and can even send out stronger white blood cells like neutrophils, lymphocytes, eosinophils, basophils, and monocytes. When the body is damaged, inflammation occurs at the site of the injury. In the cellular phase of inflammation, an increase in white blood cells happens, which is called leukocytosis. Some signs and symptoms of inflammation include elevated temperature, increased white blood cell count,

swelling, and even pain is possible. The patient that I had to take care of had an increase in white blood cells, neutrophils, and monocytes which all point towards an inflammation. The patient was also taking the medication, Dexamethasone, which is known for its therapeutic effects on inflammation. Inflammation is common after a surgical procedure as well, and that is also a reason the patient has it. He had to go through a laryngoscopy and a biopsy of his salivary glands. Having such a procedure put the patient at risk for airway issues, which contributed to his collapsed airway. In the case of acute inflammation, blood vessels dilate, blood flow increases and white blood cells swarm the injured area to promote healing(Szalay, J., 2018). The patient had a CT and X-ray done to determine what was the main cause of his plight. The CT showed an in the mediastinum of the patient and the X-ray showed the placement of the OG tube that he had to have put in. For further care, the patient will be transferred to Carle Hospital.

Pathophysiology References (2) (APA):

Capriotti, T. Frizzle J.P. *Pathophysiology: introductory concepts and Clinical Perspective* p.157 Retrieved on September 21, 2019

Szalay, J. (2018, October 19). What Is Inflammation? Retrieved from https://www.livescience.com/52344-inflammation.html

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.80-5.41**	**5.18**	**5.17**	

Hgb	**11.3-15.2**	**15**	**15**	
Hct	**33.2-45.3%**	**46.7**	**45.7**	
Platelets	**149-493 K**	**189**	**206**	
WBC	**4-11.7 K**	**11.5**	**16.2**	Patient had an elevated WBC count upon admission due to the body trauma that they currently have. Older adult clients are at a higher risk for infection if they have improper nutrition status and even trauma can cause an elevated white cell count(RN Adult medical surgical nursing, 2016).
Neutrophils	**45.3-79**	**92.8**	**89.6**	When an infection is severe and the body is trying to fight it off quickly, patients produce neutrophils. Neutrophils help prevent infections by blocking, disabling, digesting, or warding off invading particles and microorganisms(Huizen, J., 2018)
Lymphocytes	**11.8-45.9**	**4.7**	**6.5**	With the body being under distress, the bone marrow produces lymphocytes to help fight off infection or inflammation. Lymphocytes are present when there is an elevation in inflammation(RN Adult medical surgical nursing, 2016)
Monocytes	**4.4-12.0**	**3.7**	**1.3**	Monocytes are also released when the person is fighting off inflammation or infection(RN Adult medical surgical nursing, 2016)
Eosinophils	**0.0-6.3**	**0.2**	**NA**	
Bands	**<1**	**0.5**	**1.1**	

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-	**135-145**	**139**	**138**	
K+	**3.5-5.1**	**4.4**	**4.3**	
Cl-	**98-107**	**101**	**100**	
CO2	**22-29**	**33**	**29**	The patient has an increase in CO2 due to being hypoxic when being admitted into the ER. Retention of CO2 happens when a person is unable to breath out for themselves. Due to the patient being coded and being put on a ventilator CO2 levels are elevated. Airway trauma and hypoventilation leads to respiratory acidosis(RN Adult medical surgical nursing, 2016)
Glucose	**70-99**	**197**	**162**	The patient's glucose levels are elevated due to the patient having a trauma to the body. With any type of issue to the body, patients can develop hyperglycemia. Patients can develop hyperglycemia due to poor eating habits, lack of exercise, or shock to the body system can cause a rise in glucose(RN Adult medical surgical nursing, 2016)
BUN	**6-20**	**23**	**29**	BUN and Creatinine are indicative of kidney function and are elevated when the patient's kidneys are not able to move products out of the body causing damage to the kidneys. Kidney disease increases serum creatinine levels while dehydration, infection, steroid therapy or reabsorption of blood in the liver damage the kidneys elevating BUN(RN Adult medical

				surgical nursing, 2016)
Creatinine	**0.5-0.9**	**1.05**	**1.17**	BUN and Creatinine are indicative of kidney function and are elevated when the patient's kidneys are not able to move products out of the body causing damage to the kidneys. Kidney disease increases serum creatinine levels while dehydration, infection, steroid therapy or reabsorption of blood in the liver damage the kidneys elevating BUN(RN Adult medical surgical nursing, 2016)
Albumin	**3.5-5.2**	**3.6**	**NA**	
Calcium	**8.6-10.4**	**9.5**	**9.7**	
Mag	**1.6-2.4**	**1.5**	**1.7**	
Phosphate	**0.8-1.5**	**NA**	**NA**	
Bilirubin	**0.1-1.2**	**0.6**	**NA**	
Alk Phos	**35-105**	**51**	**NA**	
AST	**0-32**	**25**	**NA**	
ALT	**0-33**	**25**	**NA**	
Amylase	**30-125**	**NA**	**NA**	
Lipase	**10-150**	**NA**	**NA**	
Lactic Acid	**0.5-1**	**NA**	**NA**	
Troponin	**<0.03**	**0.03**	**NA**	

CK-MB	**5-25**	**3.63**	**NA**	Cardiac enzymes are released into the bloodstream when the heart muscle suffers ischemia(RN Adult medical surgical nursing,2016) Any sort of damage to the heart releases myoglobin, Troponin I & T, and CKMB.
Total CK	**22-198**	**84**	**NA**	This enzyme is released when the heart has suffered damage. It is an indicator of ischemia. Cardiac enzymes are released into the bloodstream when the heart muscle suffers ischemia(RN Adult medical surgical nursing, 2016)

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**	**NA**	**NA**	
PT	**11-13.5**	**NA**	**NA**	
PTT	**30-40**	**NA**	**NA**	
D-Dimer	**<0.5**	**NA**	**NA**	
BNP	**<100**	**NA**	**NA**	
HDL	**>60**	**NA**	**NA**	
LDL	**<100**	**NA**	**NA**	
Cholesterol	**<200**	**NA**	**NA**	
Triglycerides	**<150**	**NA**	**NA**	

Hgb A1c	**<5**	**NA**	**NA**	
TSH		**NA**	**NA**	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow, Clear**	**NA**	**Amber**	Patient has a dark urine color due to dehydration. Dehydration can lead to dark-colored urine(RN Adult medical surgical nursing, 2016)
pH	**5.0-8.0**	**NA**	**5.0**	
Specific Gravity	**1.005-1.034**	**NA**	**1.027**	
Glucose	**Normal**	**NA**	**Normal**	
Protein	**Negative-Normal**	**NA**	**2+**	Presence of protein in the urine can indicate kidney damage(RN Adult medical surgical nursing, 2016) Protein in the urine is also indicative of kidney damage.
Ketones	**Negative**	**NA**	**Negative**	
WBC	**<5**	**NA**	**11**	White blood cells, bacteria, and sediment are positive in urinary tract infections(RN Adult medical surgical nursing, 2016) The patient also had an elevated white blood cell count which also caused WBC in the urine.
RBC	**0-3**	**NA**	**NA**	
Leukoesterase	**Negative**	**NA**	**Trace**	Positive leukocyte esterase and nitrates (68% to 88% positive results indicates UTI)(RN Adult medical surgical nursing, 2016)

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**	**7.38-7.50**	**7.47-7.50**	This patient has an increased pH level due to hypoventilation which causes alkalosis. A blood pH level greater than 7.45 reflects alkalosis(RN Adult medical surgical nursing, 2016)
PaO2	**80-100**	**57.1-77.7**	**60.6-70.1**	PaO2 is the partial pressure of oxygen(RN Adult medical surgical nursing, 2016)
PaCO2	**35-45**	**35-47.4**	**37.8-38.2**	PaCO2 is the partial pressure of carbon dioxide in the arterial blood(RN Adult medical surgical nursing, 2016).
HCO3	**21-28**	**26-28.5**	**28.0-29.8**	HCO3 is the concentration of bicarbonate in the arterial blood(RN Adult medical surgical nursing, 2016)
SaO2	**95-100**	**95**	**96**	

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	**Neg**	**NA**	**NA**	
Blood Culture	**Neg**	**NA**	**NA**	
Sputum Culture	**Neg**	**Neg**	**Neg**	
Stool Culture	**Neg**	**NA**	**NA**	

Lab Correlations Reference (APA):

RN Adult medical surgical nursing Ed. 10.0

RN Adult medical surgical nursing. (2016) Retrieved September 18th, 2019

Huizen, J. (2018, December 12). Neutrophils: Functions and count result meanings. Retrieved

from https://www.medicalnewstoday.com/articles/323982.php

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- X-ray of ET tube placement- This is a protocol that is followed to help determine the correct placement of the tube. The patient was ordered this test per physician due to an endotracheal tube having to be put in.
- EKG (Electrocardiogram)- This is used to determine any cardiac changes in the heart and determine the electrical activity of the heart. This is a noninvasive test used when any issues are about the heart or concern the heart and that is why the patient had this test done.
- Echocardiogram with contrast- This test measures the ejection fraction of the heart or how well the heart is pumping blood. Due to the size of the patent and sedation being used patient had this test done.
- CT of the chest with contrast- This test is used for determining any chest abnormalities and consolidations. This was done on the patient to look at the mediastinum and to see if patient had any atelectasis.

Diagnostic Test Correlation (5 points):

- An X-ray is used when the patient has an internal system that needs to be looked at. In this case, the patient has a ET tube that had to be put in due to patient needing additional breathing support. Per radiologist, the patient has the ET tube 5.8cm above the carina, which means that the tube is in correct placement to help facilitate breathing.
- The EKG or electrocardiogram showed the patient had a rhythm of sinus tachycardia while in the ER.
- An echocardiogram is an ultrasound of the heart. It is conducted to diagnose valve

disorders and cardiomyopathy(RN Adult medical surgical nursing, 2016). This was conducted on this patient due to the patient being post code blue. This test was ordered to determine the pumping efficiency of the heart. The sonographer used contrast to better see the heart. It was conducted by the sonographer and then interpreted by the doctor that the patient has an ejection fraction of 45% which is considered medium but not optimum.

- A CT of the chest was done using contrast to visualize the mediastinum. There was fat that was noted on the mediastinum but it was noted to be benign and not a cause of any other issue in the heart. The lungs showed that the patient had developed atelectasis secondary to hypoventilation. This test was interpreted by the doctor and conducted by the radiologist.

Diagnostic Test Reference (APA):

RN Adult medical surgical nursing Ed. 10.0

RN Adult medical surgical nursing. (2016) Retrieved September 18th, 2019

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

Home Medications (5 required)

Brand/Generic	Lisinopril Zestril	Lovastatin/ Altoprev	Pantoprazole protonix	Tamsulosin/ Flomax	Tylenol/ Acetaminophen
Dose	20mg	40mg	40mg	0.4mg	650mg/ 2tabs
Frequency	Daily	Daily	Daily	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Antihypertensive	Antihyperlipidemic	PPI	Alpha 1 Blocker	Antipyretic and Analgesic

Mechanism of Action	Causes decreased production of angiotensin II and suppression of the RAAS system.	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 the liver cells.	Interferes with gastric acid secretion by inhibiting the H+,K+, ATP enzyme system in gastric cells	Selectively blocks alpha receptors in the prostate, leading to relaxation of smooth muscle in the bladder neck and prostate, improving urine flow and reducing BPH	Inhibits the enzyme cyclooxygenase blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.
Reason Client Taking	Patient has a history of high blood pressure	Patient has a history of high cholesterol and is taking this to control it.	To prevent gastric stomach ulcers while in hospital	Patient has BPH	Patient is taking this for pain
Contraindications (2)	-Use cautiously in patients with impaired renal functions - Use caution in patients with hypotension	-Active hepatic disease -Breastfeeding women	-Hypersensitivity -patients taking Rabeprazole sodium	-hypersensitivity - patients who have had glaucoma surgery	-hepatic impairment -Hypersensitivity
Side Effects/Adverse Reactions (2)	-lightheadedness -abdominal pain	-Amnesia -Glaucoma	-Fatigue -Hypertonia	-Nausea, vomiting, and diarrhea could occur -Decreased libido	-Hepatotoxicity -Pancytopenia
Nursing Considerations (2)	-When using drug in acute MI, give pt. thrombolytics and beta blockers -patient should take medication with thiazide diuretic	-Know it can be used with colestipol for additive effects -Expect liver function tests to be performed before starting this medication	-Ensure the continuity of gastric acid suppression during transition from oral to IV -Know that PPIs should not be given longer than necessary.	-Monitor patients for orthostatic hypotension -Priapism can occur	-Use cautiously in patients with hepatic impairment. -Monitor renal function
Key Nursing Assessment(s) Prior to Administration	-Assess BP frequently	-Assess if the patient is taking any blood thinners	Assess blood pressure before administering (2018 Nurses drug handbook., 2017)	-Assess patient for prostate cancer before starting	-Assess for hepatic function before administering medication
Client Teaching needs (2)	-Advise patient to report signs of infection -Inform that a	-Tell patient to take drug at the same time each day.	-Longterm use may cause osteoporosis -Instruct to stop	-Instruct patients not to chew tablet -Teach patient	-Tell patient that tablets may be crushed or

	dry non productive cough may occur	-Advise patients with diabetes to monitor blood sugar very closely.	use if any adverse reactions occur	to take drug about 30 minutes after eating each day.	swallowed whole. -Caution patient to not exceed dosage limit.

Hospital Medications (5 required)

Brand/Generic	Dexamethasone/ Decadron	Diprivan/ Propofol	Furosemide/ Lasix	Zosyn/piperacillin and tazobactam	Famotidine/Pepcid
Dose	2ml	0.30mcg/kg	40mg	50ml	20mg 2ml
Frequency	q8hr	q8hr	Daily	q8hr	BID
Route	IV Push	IV Drip	IV Push	IV Push	IV Push
Classification	Corticosteroids	Hypnotics	Loop Diuretics	Penicillin	Gastric acid secretion inhibitor (H2 blocker)
Mechanism of Action	Decreases inflammation, mainly by stabilizing leukocyte lysosomal membranes	Rapid acting IV sedative	Inhibits sodium and chloride reabsorption at the proximal and distal tubules and the ascending loop of Henle	Inhibits cell-wall synthesis during bacterial multiplication	Famotidine is an H2 receptor antagonist that reduces the HCL formation by preventing histamine from binding with H2 receptors on the surface.
Reason Client Taking	Inflammation due to surgical procedure and intubation	-Patient is sedated while on the vent	Patient is taking this in order to have a more normal urine movement due to having a catheter.	Because the patient has an elevated WBC count, provider started this to combat infection	To prevent GERD
Contraindications (2)	-Do not give this medication to patients who have systemic infections	-Patients allergic to egg or egg products -Use cautiously in patients that	-Use cautiously in patients with hepatic cirrhosis -Patients who	- bleeding tendencies	-Hypersensitivity -Other H2 antagonists

	- Use cautiously in patients with GI issues	are hemodynamically unstable	have renal impairment should not take this medication	- Use caution in patients with uremia	
Side Effects/Adverse Reactions (2)	-Can lead to osteoporosis -hypoglycemia can occur	-Respiratory acidosis can occur -burning or stinging at iv site	-Vertigo may occur -May cause orthostatic hypotension	-Arrhythmias can develop -Nausea, vomiting and diarrhea are common side effects	-Agitation -Arrhythmias
Nursing Considerations (2)	-Watch for depression in patients taking this medication -Inspect skin for petechiae	-If used for prolonged periods urine may turn green -stop drug gradually and not abruptly	-Monitor intake and output -Monitor electrolytes especially potassium	-Monitor patient for any skin reactions that could occur -May increase serum sodium levels due to sodium in drug	-Don't give to patients who have phenylketonuria -Shake solution vigorously.
Key Nursing Assessment(s) Prior to Administration	Monitor BP, weight and electrolyte levels	Assess patient for allergy to eggs	Monitor blood pressure and pulse before administering	Assess patients heart rhythm before starting and continue monitoring after	Assess patients for H-Pylori before starting this medication
Client Teaching needs (2)	-Do not stop drug abruptly -Warn patients about easy bruising.	-Advise patients that abnormal dreams may occur -Assess client's mental status before discontinuing	-Advise to take drug in morning due to having to go pee often -discourage client from storing multiple drugs in the same container.	-Tell patient to report discomfort at the IV site. -Advise patients to report any adverse reactions to the provider	-Wait 30 min to 60 mins to take an antacid after famotidine -Advise patient to seek medical help if they notice blood in stool.

Medications Reference (APA):

2018 nurses drug handbook. (2017). Burlington: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was AxO times 0 but did respond to stimuli. Patient moved his head when being worked with or when given a bath. Patient has an appropriate color and not hypoxic.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score: 14** **Drains present: Y☐ N ☐** **Type:**	Patient is a caucasian male and skin color is appropriate for him. No cyanosis is noted. Patient has a temporal temperature of 36.7 and has good skin turgor. Patient has no rashes or bruises. Patient has a braden score of 14 No drains are present
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patients head and neck did not have any skin breaks. Ears were intact and free of pressure injuries, patients eyes were able to do PERRLA.
CARDIOVASCULAR (2 points): **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:**	Patient has normal S1 and S2 heart sounds were auscultated at the mitral valve. A heart strip was read and interpreted. The patient has sinus arrhythmia. Patient also has good peripheral pulses and were graded to be 2+. The dorsalis pedis were the pulses graded. Patient has a capillary refill of 2-3 seconds and was not hypoxic. No neck vein distention was noted and no edema was seen on the patient.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Tidal volume (TV):**	Patient did not use accessory muscles to breathe. Lung sounds were auscultated in all lobes but patient is on a ventilator with an FiO2 of 100%. Patient has an ET Tube with 6.5 size Placement is 24cm Respiration rate is 20 FiO2 is 100% Tidal volume is 500 PEEP is 14 for patient VAP prevention measures included assessment of

PEEP: **VAP prevention measures:**	the device, routine mouth care and wearing gloves. Patient also has an OG tube to prevent pneumonia. Ventilator was free from debris and the patient was routinely suctioned.
GASTROINTESTINAL (2 points): **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:**	Patients current diet is NPO due to ventilator Patients diet at home is regular The patient has a height of 74 inches and 143 kg. Patients last BM was on the 17th Bowel sounds were present in all four quadrants The patient also has an OG tube to suction out secretions. Abdomen was soft and free from skin breaks. No abdominal distension was noted. No scars, drains, or wounds.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** Clean and no skin breakdown **Catheter: Y ☐ N ☐** **Type:** Foley **Size:** 14 **CAUTI prevention measures:** Catheter wipes were used to clean the patient's genitals	Patients catheter had an output of 350ml and had amber-colored urine. Due to 14 french foley catheter insertion, patient has no pain upon urination. No skin breakdown or redness noted upon inspection. Catheter cleaning wipes were used to help prevent CAUTI.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM: Not performed** **Supportive devices: None needed** **Strength:** **ADL Assistance: Y ☐ N ☐** **Fall Risk: Y ☐ N ☐**	Patient has a response to touch and painful stimuli. Patient was told all the procedures that will be done on him even though he was on the vent due to the assumption that patient can hear still. Patient has not been able to do ROM due to sedation Patients family states that patient doesn't need

Fall Score: **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	assistive devices Due to patient being sedated he does need assistance with ADLs. Morse fall score of 50 noted Patient does have a secondary diagnosis, needs aid due to bedrest, has an IV giving him a fall score of 50.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N ☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is under sedation and is unable to do any exercises. PERLA was performed by doctor and pupils were equal, round, reactive to light and accommodation. AxO times zero Patient is able to respond to stimuli.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Unattainable from family or patient. All that's known is that family consists of daughter and grandson who are both currently at bedside.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	90	140/72	20	Not taken	100% FiO2 95%
1100	94	154/80	20	36.7	100% FiO2 97%

Vital Sign Trends/Correlation:

- The patient is on hypertensive medication due to having high blood pressure. Also due to the body having distress on it with ventilation and also with having multiple medications being pushed in, it is causing hypertension.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

Pain Assessments not done due to not being able to determine level of pain. Nurse was asked about assessing and she states it's not a necessity due to the ventilator.

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:**	Patient has two IV catheters in both right and left arms. A 16 in the right wrist and an 18 in the left wrist Both were dated on 9/17/19 and both flush easily IV was used for medications Patients dressing is free from debris and erythema
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	No other lines were present but Curos caps are on all IV tubing

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/A due to the patient being on vent	Urinary catheter output was 350ml

Nursing Care

Summary of Care (2 points)

Overview of care: Patient care was primarily based on assessments due to patient being on the vent. Full body assessment was conducted along with the nurse after getting report. Patients family was cooperative with the nurse and I but was not willing to talk too much. Patient was given a bath and a new gown. Heart monitor patches were also changed.

Procedures/testing done: Patient had phlegm so suction was performed on the patient with the help of the nurse.

Complaints/Issues: Patient did not have any issues and neither did the family while nurse was in the room.

Vital signs (stable/unstable): Vital signs are stable and only hypertension was noted.

Tolerating diet, activity, etc.: Patient did not have a BM while I was there and patient has a 14 french catheter inserted to drain urine.

Physician notifications: Physician recommends to transfer patient to Carle for higher level care.

Future plans for patient: Patient will be transferred to Carle for higher level of care per family wishes and also advise of the doctor.

Discharge Planning (2 points)

Discharge location: Patient will not be discharged but rather transferred by helicopter to Carle Hospital in Urbana, IL

Home health needs (if applicable): Patient will not be discharged home so this is not needed.

Equipment needs (if applicable): No equipment needs due to patient being transferred

Follow up plan: No follow up plan due to patient being transferred, physician will

follow up after recovery.

Education needs: No education due to patient on vent

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	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. At risk for impaired spontaneous ventilation related to respiratory failure as evidenced by diminished lung sounds	The patient is on a ventilator, which is one of the biggest causes for need in respiratory support.	1. Client will maintain spontaneous gas exchange with adequate SPO2 2. Client will demonstrate absence of complications from ventilator	No response necessary for the patient. Patient was assessed and was able to maintain an adequate O2 level
2. Ineffective airway clearance related to	When lung sounds were auscultated on patient, they	1. Client will be suctioned when breath sounds sound diminished	The patient has no response to this due to being on a ventilator. But client was suctioned and peak

endotracheal intubation, as evidenced by abnormal breath sounds	sounded diminished and only adequate ventilation was being provided by the ventilator.	2. Peak pressures will be monitored on the patient.	pressures were monitored during shift
3. At risk for anxiety related to inability to breathe as evidenced by patient had soft restraints in place.	This was chosen for this patient due to patient being able to hear and respond to certain stimuli.	1. Client will be monitored every hour for redness at restraint site 2. Client capillary refill will be assessed and it will be around 2-3 seconds	Patient was assessed and there was no redness noted at the wrists where the restraints were tied off at. Client did have good capillary refill of 2-3 seconds
4. Patient at risk for respiratory distress related to decreased respiratory status as evidenced by setting of 20 RR on the ventilator	This was chosen for this client because, if the patient was taken off the ventilator then his airway would collapse and he would have lower respirations	1. Assess patient for signs of pneumonia by listening to lung sounds twice per shift. 2. Assess patients CO2 level for measure of adequate ventilation.	Patient was assessed for pneumonia twice in the shift and both times, lungs were diminished yet had adequate ventilation due to having a vent setting of 20RR per minute.
5. Patient at risk for deficient knowledge related to unfamiliar with the care as evidenced by fighting the ventilator during initial set up	The patient was fighting the ventilator because he was scared as to what was going on so he kept trying to pull out the ET tube.	1. Patients respiratory status will be monitored due to being on diprivan drip 2. Patient will be monitored for adventitious lung sounds	The patient was monitored and had good respiratory outcome. The patient was sedated with diprivan but was not having any respiratory issues while on it.

Other References (APA):

Concept Map (20 Points):

Subjective Data

No subjective data was obtained

Nursing Diagnosis/Outcomes

1. At risk for impaired spontaneous ventilation related to respirat
diminished lung sounds
The patient was constantly assessed and O2 saturation was monit
2. Ineffective airway clearance related to endotracheal intubation
breath sounds
Client was suctioned and peak flow was assessed.
3. At risk for anxiety related to inability to breathe as evidenced b
place.
Patient was assessed for good capillary refill with measured to be
patient had no redness at site of restraint.
4. Patient at risk for respiratory distress related to decreased respi
setting of 20 RR on the ventilator
Patient was assessed for adequate CO2 levels and assessed twice
5. Patient at risk for deficient knowledge related to unfamiliar wi
fighting the ventilator during initial set up
Patient was monitored for respiratory distress

Objective Data

-Elevated WBC count indicted inflammation
-Patient was on a ventilator indicating ineffective airway clearance
- Patient had a high blood pressure indicating increased anxiety

Patient Information

Admitting physician was consulted after the patient was extubated after a procedure with Dr. Cudone. The patient was having an outpatient procedure done (laryngoscopy), and was going to be discharged later that day. Patient was extubated too early after the procedure and was found unable to protect his airway. He became hypoxic and bradycardic. It is unknown if the patient lost pulse but compressions were performed and the patient was given atropine. The patient was able to be re-intubated and sent to CCU. He is able to wake up but is sedated due to fighting the vent.

Nursing Interventions

Nursing outcome for thi
to regain control of his b
Another outcome would