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NUR392C
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Medical Diagnosis (admitting): Chronic Hypercapnic Respiratory Failure

Diagnostic Tests and Results: No diagnostic tests available

Past Medical History:

-Spina Bifida   -Failure to thrive
-Scoliosis   -Generalized Anxiety Disorder
-Total Body Weakness   -tethered cord
-Muscular Dystrophy   -normocytic anemia
-dysphagia
-gastrostomy
-neurogenic bladder
-urinary retention

Medications:
-Acetaminophen- 600mg GT Q6H PRN for pain
-Albuterol Sulfate- 2.5mg IH Q4H PRN for respiratory distress
-Albuterol sulfate- 2.5mg IH BIDR8 SCH
-Ferrous Sulfate- 300mg GT BID
-Fluticasone Propionate Flovent- 110mcg IH BID SCH
-Melatonin- 3mg GT bedtime PRN for insomnia
-Polyethylene Glycol- 17 mg FT daily PRN
-Sertraline HCL(zoloft)- 50 mg GT daily SCH
-Silver Nitrate- 1 each TP daily PRN for granuloma
-Terazosin HCL (hytrin)- 5mg GT bedtime SCH

Assessment:
Patient is A&Ox4, Vitals: 97.5, 109, 24, 123/70, 98%, pain 0/10. PERRLA. RRR, normal s1 and s2, Pedal Pulse 2+ and equal bilaterally, Cap. refill <3 seconds. Patient on Mechanical ventilation: tracheostomy 7.0 uncuffed, Rate:12, FIO2:21%, lung sounds clear and equal bilaterally, equal rise and fall of chest. GT Tube in place for medication administration. Soft, normoactive bowel, no tenderness. Patient on regular diet. Musculoskeletal weakness present, 1+. All skin intact, no breakdown. Patient is incontinent, voids into diaper.

Nursing Diagnosis: Risk for skin breakdown related to muscular dystrophy as evidenced by immobility, incontinence, and dehydration.
Expected Outcome: At the end of an 8 hour shift patient will have no signs of skin breakdown.
Interventions:
1.Ensure diaper is clean and dry.

2.Use pillows to keep bony prominences off of hard surfaces.

3.Adjust patient in bed regularly to help with high pressure areas.

4.Reassess patient every 2 hours to check for signs of skin breakdown and to reposition if needed.

Evaluation: After an 8 hour shift patient showed no signs of skin breakdown.

Nursing Diagnosis: Risk for decreased perfusion related to chronic respiratory distress as evidenced by tracheostomy, ventilator, and PMH with respiratory distress.

Expected Outcome: Patient will show no signs of decreased perfusion in an 8 hour shift.

Interventions:

1.Check ventilator settings regularly.

2.Continuous pulse oximetry monitoring.

3.Monitor secretion and suction PRN to ensure good flow of oxygen.

4.Reassess pulses regularly and check for any signs of cyanosis or cool skin.

Evaluation: After an 8 hour shift patient showed no signs of decreased perfusion.

Nursing Diagnosis: Risk for infection related to tracheostomy as evidenced by opening in trachea, long-term hospital stay,

Expected Outcome: Patient will show no signs of infection after an 8 hour shift.

Interventions:

1.Check color of respiratory secretions

2.Temperature should be taken regularly

3.Suction regularly to keep any bacteria from lingering.

4.assess the skin around the tracheostomy site for any redness or swelling which could indicate infection.

Evaluation: Patient showed no signs of infection after an 8 hour shift.

Nursing Diagnosis: Risk for anxiety related to generalized anxiety disorder as evidenced by anxiety attacks, lots of time alone, chronic illnesses.

Expected Outcome: Patient will show no signs of increased anxiety during an 8 hour shift.

Interventions:

1.Ensure patient has distractions such as phone and T.V.

2.Give patient the opportunity to express concerns about procedures and daily cares.

3.Educate caregivers at home on how to reduce patients' anxiety.

4.Allow patient to make decisions regarding their care when it is possible.

Evaluation: Patient showed no signs of increased anxiety during an 8 hour shift.