Medications

(see attached)

IV Sites/Fluids/Rate

RIJ TLC
Arterial Line
IV #20 RH

0.9% NS BRNT CVP @ 10ml/hr
Propofol WT TLC @ 4ml/hr
-increased to 5ml/hr @1230
0.9% NS BT TLC @ 65ml/hr
0.9% NS PIV @ 35ml/hr

Student Name Chelsea Youngman Client Initials LK Date 10/24/2012

Age 58 Gender F Room # 125

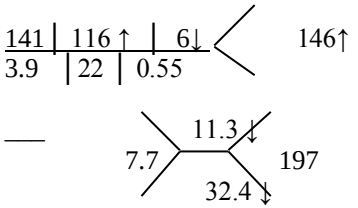
Admit Date 10/23/2012

CODE Status FULL Allergies Percocet

Diet NPO/OG tube Activity Sedated/Bedrest Braden Score

LK is a 58 year old white female with a history of COPD, GERD, and high cholesterol admitted to a health care facility to remove hardware placed in her tibia and fibula. During the procedure the patient became hypotensive and started to experience SOB. The patient continued to deteriorate after being placed on a nonrebreather mask and was transferred to an acute care facility CCU. A chest x-ray was performed an bilateral infiltrates were found. The patient was intubated and an arterial line was placed. The patient was also placed on IV antibiotics for possible pneumonia.

State lab values and identify trends.



State other appropriate lab results

Pt has a decreased H&H which is secondary to her surgery that she had performed.

CA+ = 8.3↓ - could be due to patient taking folic acid.
Blood glucose could be elevated due to patient taking folic acid

ABGs

PH- 7.47↑(B)
PCO_2- 25.6 ↓ (B)
HCO_3- 18.5↓(A)
PO_2 90.9
Pulse ox 99%

Interpretation:

Uncompensated Respiratory Alkalosis

State diagnostic test results

Chest X-ray – bilateral infiltrates in lungs

Monitoring: Invasive/Non-Invasive

-Right IJ triple lumen catheter (fluids, CVP measurement)
-6 lead ECG (heart rate and rhythm)
-SaO_2 (oxygen saturation)
-Right radial arterial line (arterial blood pressure)
-Foley (hourly urine output)
-CVP (preload)

Chief Complaint/Admitting Diagnosis(es):

Shortness of breath, hypotension

Medical/Surgical Diagnosis(es):

COPD exacerbation, possible pneumonia, shock

EKG Interpretation **(See Attached Weekly EKG sheet)**		
Past Medical/Surgical History Relevant to this admission COPD GERD Hyperlipidemia RLE fracture – hardware placed in tibia/fibula Motorcycle accident 14 months ago		**Treatments/ Medical and Nursing Interventions** Ventilator-settings Tidal Volume: 480; Rate: 12 A/C; Peep: 12; FIO2: 50%, decreased to 40% @ 1230. ETT size 7.5, 23 at the lips Foley for strict I & O Turn q2h Oral gastric tube Respiratory treatments Suction at bedside Sedation restraints Vitals q hour IV bolus to increase BP Antibiotics for possible pneumonia

Primary Nursing Diagnosis with Relational Statement	Short Term Goal Relevant to Nursing Diagnosis	**6 Nursing Diagnosis with Relational Statement**
Ineffective airway clearance r/t respiratory insufficiency secondary to COPD and bilateral infiltrates in lungs	**The patient will demonstrate improved airway clearance by being able to sustain O_2 stats above 95% during the clinical shift** *Met – LK Sa02 remained between 98-99%.	1. **Ineffective breathing pattern** r/t artificial airway, OG tube placement, and impaired respiratory function 2. **Dysfunctional ventilator weaning response** r/t sedation and patient being agitated when stimulated

Definition (State definition and source) **The state in which the individual experiences a threat to respiratory status related to the inability to cough effectively** Source: Carpenito-Moyet, L. (2009). *Nursing diagnosis: Application to clinical practice.* (13 ed.). Philadelphia: Lippincott Williams & Wilkins. **AEB**: Defining characteristics specifically exhibited by your patient that support primary nursing diagnosis A/C mechanical ventilation Failure to maintain spontaneous ventilation on weaning attempt(RR out of normal range) Pulse ox ranges from 93-95% Chest x-ray showing bilateral infiltrates	**Outcome Criteria (Must be specific and measurable) & evaluation of patient progress towards meeting outcome criteria** **Patient will have SaO_2 levels WNL during the clinical shift** *Met-Pt had SaO2 levels between 98-99% during shift. **Patient will have RR of 20 or below during the clinical shift** *Met – pt had respiratory rate between 12-16 during clinical shift. **Patient will have ABGs within normal levels during the hospital stay** *Not Met- patient's ABG indicated elevated pH and decreased C02 and HCO3. **Patient will be able to be D/C from propofol without agitation(thrashing/pulling at tube) during the clinical shift** *Not Met- patient did show agitation(thrashing, pulling at tube) when her propofol was reduced requiring an increase in dosage to maintain sedation and prevent the patient from dislodging the tube during the clinical shift **Patient will have lung sounds free of crackles and rhonchi by the end of the clinical shift** *Met- Pt lungs were CTA during each assessment.	3. **Impaired tissue integrity** r/t mechanical ventilation, oral gastric tube, bowel incontinence and NPO status 4. **Bowel incontinence** r/t sedation and bed rest 5. **Risk for infection** r/t bilateral infiltrates in lungs, foley catheter in place, arterial line in place, and RIJ TLC in place. 6. **Anxiety** r/t SOB and difficulty breathing OR Anxiety r/t ETT and ventilator.

Identify nursing interventions that you implemented with this patient.

Check tube placement and that ties are secure q assessment to ensure proper positioning
---Ensures that the ETT tube is in the correct placement of the lungs

Check restraints and circulation to extremities every time in patient's room
--- Restraints can break down the skin and if they are too tight they can cause decreased circulation in the extremities

Ensure HOB elevated 30 degrees at all times
--- HOB elevated 30 degrees helps the patient breathe better

Assess patient q4h
---Ensures that there have been no negative changes in the patient

Provide mouth care q2h
--- Mouth care prevents breakdown of the skin around the mouth while ETT is in place

Provide mouth suctioning as needed
---Suctioning the mouth as needed helps prevent the patient from aspirating

Check mouth and mucous membranes for breakdown during mouth care
--- ETT and ties to keep the ETT in place can lead to bleeding in the mouth

Assess patient's need for endotracheal suctioning frequently
--- ETT and ties to keep the ETT in place can lead to bleeding in the mouth

Monitor urine output q hour
--- Decreased urine output could indication there is a problem with perfusion to the kidneys or indicate the kidneys are not functioning properly

Apply sensi care to coccyx frequently and prn
---Helps prevent skin breakdown

Monitor temperature q 4 hrs
---helps monitor for possible infection

References:

Black, J. & Hawks, J. (2009). *Medical-Surgical nursing: clinical management for positive outcomes.* 8th ed.-volumes 1&2. St. Louis: Sanders.

Carpenito-Moyet, L. (2009). *Nursing diagnosis: Application to clinical practice* . (13 ed.). Philadelphia: Lippincott Williams & Wilkins.

Deglin, J., Vallerand, A., & Sanoski, C. (2011). *Davis's drug guide for nurses.* 12th ed. Philadelphia: F.A. Davis.

Administer medications as ordered ---Administering medications as order helps to improve the patients condition Maintain vent settings as ordered --- Vent settings need to be maintained in order to help the patient breathe and get the proper oxygen needed Monitor BP and other vital signs qh and prn to ensure patient not hypotensive --- Vital signs helps to evaluate what is going on with the patient, BP is especially important d/t patient being hypotensive when admitted Monitor ABGs as needed ---ABGs need to be monitored to ensure the patient is recovering from respiratory alkalosis Monitor patient's response to changes in medications frequently --- Ensures the patient is receiving the correct medications for the diagnosis Assess bowel sounds q assessment --- Ensures the patients bowels are working properly Turned patient q2h ---Turning the patient frequently helps to prevent skin breakdown. Provided low stimuli to limit patient agitation ---When stimulated, the patient became very agitated (try to take restraints off, tried to pull at tube)	

<table>
<tr>
<td>Secondary Nursing Diagnosis with Relational Statement

Ineffective Breathing Pattern r/t post surgical status, sedation, and failure to wean from artificial ventilation support.</td>
<td>Short Term Goal Relevant to Nursing Diagnosis

The patient will demonstrate an effective breathing pattern by successfully weaning from vent during clinical shift

LK was unable to successfully wean off the vent completely but was able to decrease her FiO2 from 50% to 40% but we had to increase her propofol to settle her agitation.</td>
<td rowspan="4">What I Would Do Differently

I wish that I would have asked more questions about her ventilator and the medications she was receiving. I also wish I would have asked more about what happened during surgery and post op at the health care facility her surgery was being performed.</td>
</tr>
<tr>
<td>Definition (State definition and source)

The state in which the individual experiences a threat to respiratory status related to the inability to cough effectively
Source: Carpenito-Moyet, L. (2009). Nursing diagnosis: Application to clinical practice . (13 ed.). Philadelphia: Lippincott Williams & Wilkins.</td>
<td>Outcome Criteria (Must be specific and measurable)

Patient will have ABGs within normal levels during weaning process
*Not Met- patient’s ABG indicated elevated pH and decreased HCO3 and PCO2

Patient will be able to be D/C from propofol without agitation
*Met- patient did not show agitation when propofol decreased

Patient will maintain O_2 stats of above 93% during the shift
*Met-patient maintained stats ranging from 98-99% during the clinical shift

Patient will maintain respiratory rate lower than 20 during clinical shift.
*Met- patient maintained RR between 12-16 during clinical shift.</td>
</tr>
<tr>
<td>AEB: Defining characteristics specifically exhibited by your patient that support primary nursing diagnosis

A/C mechanical ventilation
Failure to maintain spontaneous ventilation on weaning attempt
Patient on propofol for sedation
Post-op status on RLE
Agitation when propofol was decreased</td>
</tr>
<tr>
<td colspan="2">Identify nursing interventions that you implemented with this patient.
Evaluate patient progress towards achieving outcome criteria as a result of nursing interventions.</td>
</tr>
</table>

Check restraints and circulation to extremities every time in patient's room ---Restraints can break down the skin and if they are too tight they can cause decreased circulation in the extremities Ensure HOB elevated 30 degrees at all times ---HOB elevated 30 degrees helps the patient breathe better Provide mouth care q2h ---Mouth care prevents breakdown of the skin around the mouth while ETT is in place Provide mouth suctioning as needed ---Suctioning the mouth as needed helps prevent the patient from aspirating Check mouth and mucous membranes for bleeding during mouth care ---ETT and ties to keep the ETT in place can lead to bleeding in the mouth Assess patient's need for endotracheal suctioning frequently ---Suctioning the patient frequently helps to remove the secretions from the lungs Monitor urine output q hour ---Decreased urine output could indication there is a problem with perfusion to the kidneys or indicate the kidneys are not functioning properly Assess edema q assessment ---Patient had RLE edema d/t post op surgery Administer medications as ordered ---Administering medications as order helps to improve the patients condition Maintain vent settings as ordered ---Vent settings need to be maintained in order to help the patient breathe and get the proper oxygen needed Obtain BS levels through arterial line qh ---The patient had a decreased BP when transferred – need to make sure BP stays normal to provide adequate oxygenation to the organs Assess placement of art line transducer to ensure accurate readings as needed ---Arterial line needs to be placed in the proper position (in line with the heart) in order to provide accurate readings	

Assess vitals frequently, especially BP ---Vital signs helps to evaluate what is going on with the patient, BP is especially important d/t patient being hypotensive when admitted Monitor ABGs as needed ---ABGs need to be monitored to ensure the patient is recovering from respiratory alkalosis Monitor patient's response to changes in medications frequently ---Ensures the patient is receiving the correct medications for the diagnosis Assess bowel sounds q assessment ---Ensures the patients bowels are working properly Assess skin for breakdown q assessment ---Due to the patient being sedated and on bed rest, the patient is at risk for skin break down. Turn the patient q2h ---Turning the patient frequently helps to prevent skin breakdown.	