

Rubric: Care Plan

Category	Full Credit	Partial Credit	Needs Improvement	No credit (unacceptable)
Patient data	+3 All data complete.	+2 Most data complete.	+1.5 Some data omitted.	+0 Significant omissions.
Notes on patho	+10 Complete. Summary of physiologic processes that occurred leading to this hospitalization. Information is accurate.	+8 Somewhat Complete. Most of summary of physiologic processes that occurred leading to this hospitalization is evident. Information is somewhat accurate.	+5 Some data omitted. Unclear whether student understands physiology related to patient.	+0 Significant omissions. List of definitions. No connections made between concepts. Information inaccurate.
Labs & Tests	+20 Complete. Labs are defined. Abnormal values are identified. Student is able to articulate reasoning employed to determine significance. Appropriate relationships are identified among different labs through correlation of values and concepts.	+15 Somewhat complete. Most labs are defined. Abnormal values are identified. Student is somewhat able to articulate reasoning employed to determine significance. Most relationships are identified among different labs through correlation of values and concepts.	+10 Some data omitted. Labs are defined. Student demonstrates inaccurate understanding of foundational physiology related to some lab values. Abnormal values are identified. Student is unable to clearly articulate reasoning employed to determine significance (illogical).	+0 Significant omissions. Labs are not defined. Student demonstrates inaccurate understanding of foundational physiology related to all lab values. Student does not provide explanation of significance of some or all lab values.
Medications	+15 Complete. Plain language is used to explain action, purpose, and side effects. Information is accurate. Appropriate additional teaching included.	+13 Somewhat complete. Some plain language is used to explain action, purpose, and side effects. Information is somewhat accurate with some appropriate additional teaching included.	+7.5 Some data omitted. Medical jargon used to explain action, purpose, and/or side effects. Some additional teaching is missing, or is not appropriate for the patient.	+0 Significant omissions. Action, purpose, and/or side effects are in medical jargon only. There is no additional teaching, or it is not accurate.
NDs	+20 Complete. Appropriately prioritized. Data provided as evidence supports the chosen ND accurately. Variety of NDs demonstrate novice understanding of patient condition.	+15 Somewhat complete. Most data prioritized with some evidence to support the chosen ND accurately. Variety of NDs demonstrate some understanding of patient condition.	+10 Some data omitted. Not appropriately prioritized (out of order). Data provided as evidence does not accurately support the chosen ND. Lack of variety demonstrates limited understanding of patient condition.	+0 Significant omissions. Too little data to determine whether there is evidence to support ND. Limited NDs; total lack of understanding of patient condition.
NIC	+20 Complete. Student demonstrates use of ADPIE by discussing interventions, evaluating patient response, and determining whether additional interventions are needed.	+15 Somewhat complete. Student demonstrates some use of ADPIE by discussing interventions, evaluating patient response, and determining need for additional interventions.	+10 Some data omitted. Student's use of ADPIE unclear, i.e. not discussing evaluation of patient response and/or whether additional interventions are needed.	+0 Significant omissions. Unclear discussion of interventions. Total lack of evaluation of patient response to interventions.
Head to Toe Assessment	+7 Complete. Student demonstrates clear attempt to include appropriate assessment. Use of terms and abbreviations are accurate.	+5 Somewhat complete. Student demonstrates some attempt to include appropriate assessment. Use of terms and abbreviations are somewhat accurate.	+3.5 Some data omitted. Information include appropriate assessment. Terms or abbreviations in review of systems not accurate.	+0 Significant omissions.
Overall	+5 Complete. Evidence of incorporating instructor's feedback as applicable.	+3 Somewhat complete. Some evidence of incorporating instructor's feedback as applicable.	+2.5 Incomplete. Some data omitted. Discussions are lacking in one or more areas.	+0 Significant omissions. Includes mistakes previously corrected by instructor, as applicable.
Total: /100				

Student: Zarah Collins

Instructor: Prof Milly Gan

Care Plan ICU Day 1

Date of Care: 11/8/21

California State University, Stanislaus School of Nursing
NURS 2910, 4810
Plan of Care Evaluation

Patient Data

Demographics	Gender: M Age: 63 Height: 69 inches Weight: 65.6 Primary language: English Spirituality: Unknown			Code Status: Full Code
Vital signs (0800)	T: 37.0 HR: 77 RR: 22 BP:113/70 O2sat: 99% Pain: N/A (pt sedated and unresponsive) Pain scale type: N/A			
Admitting Dx	ARDS (moderate)			
PMHx	Non-occlusive bilateral DVT of the upper extremities; right-sided hemiparesis from MVA 50 years ago ; thrombocytopenia			
PSHx	None			
Surgery				
Allergies: NKMA Reaction: n/a	Advance directive: DPOA	Isolation: Yes droplet/contact initially for covid but was removed on 11/8/21, 16 days after quarantine	VS Frequency: q4hr	
Diet order: Enteral feeding	Activity order: Bedrest, PROM	Vascular access: PICC, left basilic vein	IVF: heparin drip	
Oxygen therapy: CMV 55-65 FiO2	Foley: Indwelling, 16F	Feeding tube: None	Glucose checks: q6hr	
VTE prophylaxis: heparin, SCD	Drains/tubes: ET 7.5, OG	Wounds/dressings: Optifoam on left cheekbone and upper nasal bridge for pressure injuries	Telemetry: Yes	
Restraints: None	Safety issues: risk for aspiration; tube dislodgement	Braden: 11- high-risk	D/C plan: LTCF that can manage tracheostomy care if hypoxemia is not resolved and long-term airway is deemed necessary, and if pt becomes more hemodynamically stable	

Pathophysiology: Required – evidence-based reference(s) and citation(s).

Acute respiratory distress syndrome (ARDS) is a sudden and progressive form of acute respiratory failure in which the alveolar-capillary membrane becomes damaged and more permeable to intravascular fluid. In ARDS, the alveoli and the capillaries that surround them - the site of gas exchange in the lungs - are damaged by an inflammatory process like pneumonia or sepsis (Harding et.al., 2020). As a result of this inflammation, blood becomes more likely to clot (as some inflammatory molecules are procoagulant, and which may explain why some thrombi were found in the pt's upper extremities). The endothelium also becomes leaky, allowing fluid to seep into the interstitium, causing pulmonary edema, and the fluid then seeps into the alveoli—causing an infiltrate to show up on a chest Xray, as was the case in R.H.'s CXR labs. Further, the alveoli themselves get injured and they are not able to do a good job with facilitating gas exchange and produce less surfactant. Without surfactant, there's more surface tension within the alveoli and that makes them more likely to collapse. Hence, R.H. was placed positive pressure mechanical ventilation with PEEP settings so alveoli are kept open upon expiration.

ARDS is generally a severe and often life-threatening situation that starts with shortness of breath hours after the initial alveolar injury occurs and then rapidly worsens to the point of respiratory failure. A diagnosis of ARDS is typically made when a person in respiratory distress meets four criteria. First, the symptoms have to be “acute” meaning an onset of one week or less. Second, a chest X-Ray or CT scan shows opacities—or “white out”—in both lungs, which is due to massive pulmonary edema. In R.H.'s CXR, they were described as “patchy infiltrates”. The third relates to what's called the PF ratio, which is the partial pressure of oxygen in the arterial blood—PaO₂—divided by the percent of oxygen in the inspired air, also called the fraction of inspired oxygen or FiO₂ (Harding et.al., 2020). In ARDS the PF ratio is below 300 mmHg, and the lower this ratio gets, the more severe the ARDS is. R.H.'s P/F ratio had been progressively low and so they tried the prone position but after a few days of no improvement, The P/F ratio was still dropping however, so the provider lifted the proning order. The fourth criterion is that the respiratory distress must not be explained by heart failure, which R.H. apparently did not have any history of as per medical records.

Reference:

Harding, M., Reinisch, C., Hagler, D., Roberts, D., & Kwong, J. (2019). *Lewis's medical-surgical nursing: Assessment and management of clinical problems* (11th ed.). Elsevier.

Lab and Diagnostic Test Data

LABS	Normal Range (Fill in Hospital Norms)	RESULT 1 11/06/21 @0718	RESULT 2 11/07/21 @0644	RESULT 3 11/08/21 @1008	Reason for abnormal lab values related to patient care & nursing implications
CBC					
• WBC	4-10	18.9 (↑)	21.2 (↑)	17.7 (↑)	<p>The elevated WBC count indicate that there is presence of growing infection, which is validated by the pt's diagnosis of pneumonia and sepsis. As per records, pt was given azithromycin and ceftriaxone but these were no longer in his scheduled meds. He is still on corticosteroids but no longer on abx.</p> <p>Nurse should continue to monitor the WBC count and report to HCP to verify if another course of abx may be needed.</p>
• RBC	4.3-5.9	3.71 (↓)	3.83 (↓)	3.42 (↓)	<p>RBC indicates the amount of red blood cells in the blood. This value is important because RBCs carry oxygen around the body.</p> <p>Decreased blood cell production can be caused by folic acid deficiency, vitamin B₁₂ deficiency, iron deficiency, or chronic disease. This pt's low RBC could most likely be from nutritional deficit. Pt has been on enteral feeding for weeks.</p> <p>Although not critically low, nurse should continue to monitor and ensure adequate O2.</p>

Hemoglobin (Hgb)	13.6-17	10.7 (↓)	10.9 (↓)	9.8 (↓)	This is low as it correlates to the low RBC count. Nurse should continue to monitor
Hematocrit (Hct)	39-49	33.1 (↓)	33.8 (↓)	30.3 (↓)	This is low as it correlates to the low RBC count. Nurse should continue to monitor
• RDW	11.4-14.6	15.4 (↑)	15.7 (↑)	15.4 (↑)	The RDW is a measurement of cell size distribution Decrease in RBCs cause RDW to increase. Nurse should continue to monitor.
PLT COUNT	15-400	Pt has hx of thrombocytopenia, but platelet count has been normal			
WBC DIFF					
ABS NEUTROPHIL	1-7	18.3 (↑)	15.5 (↑)	17.8 (↑)	Neutrophils are the first WBCs to be released during tissue injury, migrating to the inflamed site. The pt's elevated neutrophil count is explained by pneumonia and may also be indicative of ongoing sepsis. Nurses should continue to monitor BS neutrophil numbers during therapy.
CHEMISTRY					
Sodium					These ions are within normal range. Nurse should continuously monitor lab values for indications of electrolyte imbalance.
Potassium					
Chloride					
BUN	8.4-25.7	30.5 (↑)	27.2 (↑)	27.2 (↑)	The slight increase from normal BUN levels may suggest that the kidneys are hypo-perfusing as a result of the systemic hypotension caused by ARDS.
Creatinine	0.7-1.3	0.6 (↓)	0.5 (↓)	0.5 (↓)	The lower-than-normal creatinine was an unexpected finding because it is normally proportional to BUN. The decrease may be attributed to decrease in muscle mass from the pt being chronically ill.

					Nurse should continue to monitor.	
GFR	>60	>60 (N)	>60 (N)	>60 (N)	It is extremely important for nurse to monitor this because decreased perfusion to the kidneys may quickly lead to AKI which is indicative of MODS. So far, pt's GFR is normal.	
Glucose	70-105 mg/dL	126 (↑)	129 (↑)	112 (↑)	This level of BG is desired to counter the pt's hypermetabolic state. It is a little elevated most likely because of the steroids he is on. Nurse should continue to monitor.	
Calcium	8.5-10.2	8.1 (↓)	8.4 (↓)	8.3 (↓)		
LIVER PANEL						
Total protein	6.5-8.4	5.6 (↓)	5.8 (↓)	56 (↓)	Total protein includes albumin and globulins. The pt's low albumin level corresponds to the low albumin level, being that albumin is the protein present in highest concentrations. Nurse should continue to monitor.	
Albumin	3.5-5	2.0 (↓)	2.0 (↓)	2.0 (↓)	Albumin is the main transport protein in the body. Albumin also significantly affects plasma oncotic pressure, which regulates the distribution of body fluid between blood vessels, tissues, and cells. Pt's low total protein may be caused by prolonged immobilization that leads to muscle wasting. Nurse should continue to monitor.	
AST	5-34	38 (↑)	33 (N)	70 (↑)	AST is released from any damaged cell in which it is stored. The sudden spike to 2x the normal level may indicate pulmonary infarction. Also, this pt has been on a lot of	

					<p>routine hepatotoxic medications which cumulatively may have been damaging the liver.</p> <p>Nurse should report to HCP immediately.</p>	
ALT	0-55	34 (N)	33 (N)	67 (↑)	<p>The increase in ASL is proportional to AST.</p> <p>Nurse should report the spike in this value as well to the HCP.</p>	
Triglycerides		958 (↑) (11/4/21 @0310)			<p>Pt has no hx of hyperlipidemia. This isolated spike in TG may be attributed to the use of propofol which is used commonly in the ICU and when intubating pts. There were no tests that followed to make sure this has gone down though.</p> <p>Nurse should verify with HCP of ff-up lab tests are indicated.</p>	
Lactate	Not ordered but should have been. For patients with ARDS, hypoxemia cause buildup of lactic acid in the system and should be closely monitored.					
CARDIAC PANEL (CPK, BNP)	Not ordered. These values should be monitored as well because HF and other CV complications are common with ARDS.					
COAGULATION						
PTT	25-35 sec	28.3 (N) (11/6/21, 0033)			Because the pt is on heparin therapy, it's important for the nurse to closely monitor these values to check for therapeutic ranges.	
Anti Factor Xa	0.3-0.7 units/mL (Non-ACS)	0.26 (N)	0.39 (N)	0.38 (N)		
Ventilator settings						

ABG(FiO₂ + device)	CMV, <40-50	70	50	85	<p>The FiO₂ settings are adjusted by the RT based on the current SpO₂. An FiO₂ higher than 50 means that the pt has decreased O₂ perfusion and so his O₂ supply should be increased.</p> <p>Nurse should ask RT to adjust as necessary or let them know of any changes done with the settings.</p>	
PEEP	>5-8	10	10	10	This is the pressure delivered to the pt to keep the alveoli open during expiration. This value should be gradually titrated so as to prevent complications from constant intrathoracic pressure.	
pH	7.35-7.45	7.51 (↑)	7.54 (↑)	7.40 (N)	Respiratory acidosis with compensatory metabolic alkalosis.	
PO₂	83-108	159 (↑)	199 (↑)	94 (↑)	This value should be closely monitored because too much O ₂ may lead to O ₂ toxicity.	
PCO₂	35-45	47 (↑)	45 (N)	65 (↑)	CO ₂ retention in the system, which is likely from permissive hypercapnia brought on by the mechanical ventilation.	
Bicarbonate	22-26	37.5 (↑)	38.5 (↑)	40.3 (↑)	Kidneys are retaining HCO ₃ which leads to compensate for the CO ₂ retention.	
Oxygen Saturation	95-100	95 (N)	95 (N)	99 (N)	Nurse should constantly monitor and make sure the alarms are set when this value goes down the limit.	
DIAGNOSTIC TESTS (ALL DIAGNOSTIC TESTS SHOULD BE HERE)						
ECG					(see ECG strip)	

X ray		<p>CXR 11/06</p> <p>ET tube placement Enteric tube placement Left PICC terminate in the SVC</p>	<p>CXR 11/07</p> <p>ET tube placement verification, ok</p> <p>Bilateral patchy infiltrates are noted which may reflect bilateral pneumonia, pneumonitis particularly of the right lower lobe with pulmonary edema</p>		<p>Nurse should always check CXR to make sure ET, PICC line and OG tubes are in place.</p>	
Angiography		<p>US by Doppler, vascular, bilateral extremities, 11/5/21</p> <p>Impression: mostly non-occlusive DVT involving bilateral upper extremities</p>			<p>An angiogram should be done again after the heparin therapy to evaluate effectiveness of medication.</p>	
CT Scans		<p>CT Head w/o contrast 10/21/21 @0825</p> <p>Findings: -Volume loss pronounced in the cerebellum and pons, raising concerns for</p>			<p>The findings imply neuronal degeneration which may be taken into account when developing a discharge plan for the pt.</p>	

		olivopontocerebellar degeneration - mild-to-moderate volume loss with mild small vessel chronic ischemic disease				
--	--	---	--	--	--	--

Medications: Scheduled Meds

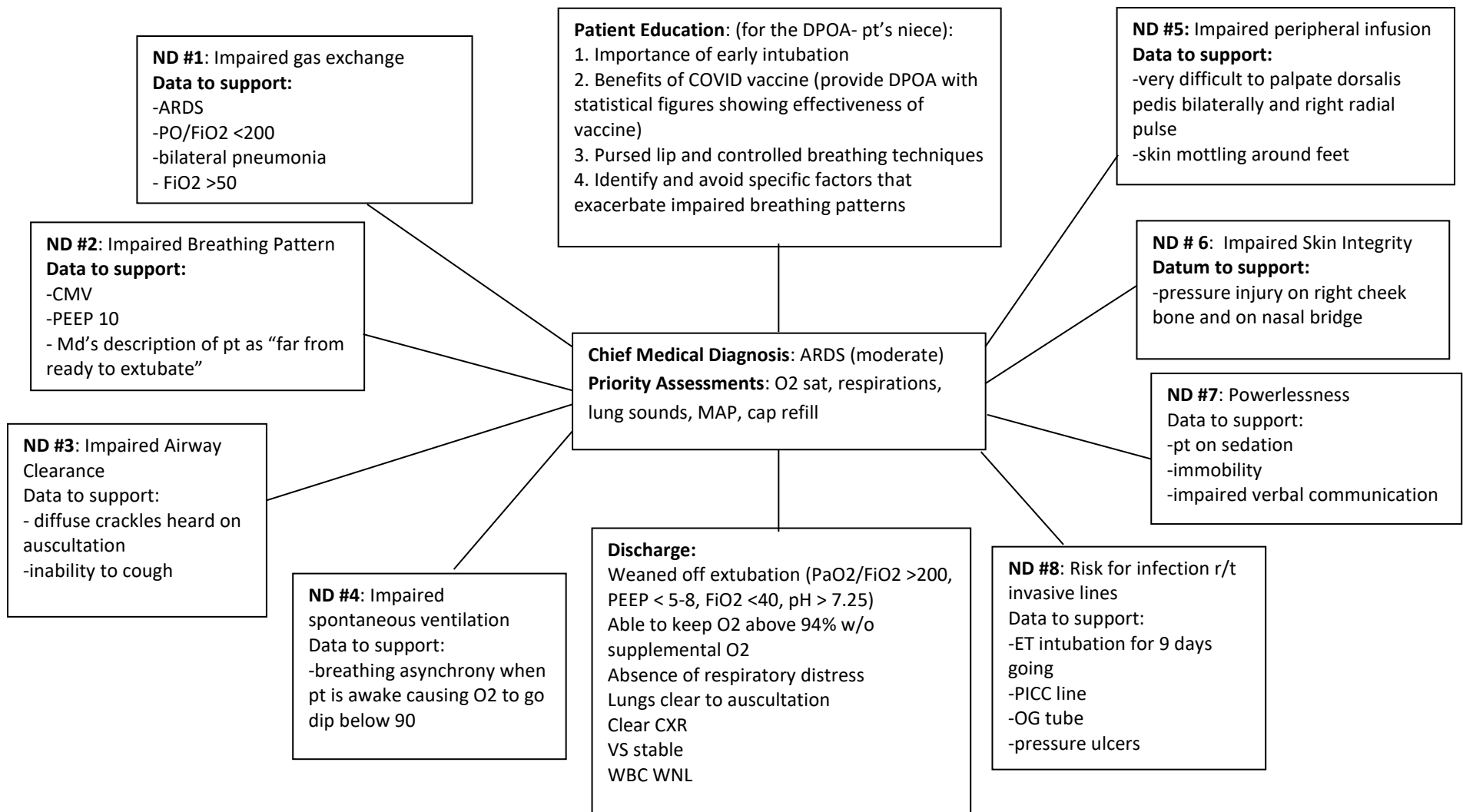
***add PRN meds if need to administer

Generic Trade Name Drug classification (<i>Therapeutic & Pharmacologic</i>)	Dose/Route Frequency Rate of Administration (if needed)	Action of Drug Purpose (specific to Pt)	Possible Side Effects	Nursing Considerations related to patient care and teaching (What to assess, when to hold, what to teach, etc. Anything other than the side effects that the hospitalized patient needs to know.)
G: dexmedetomidine T: Precedex Th: sedative/hypnotic Ph: sedatives	400 mcg + 0.9% NaCl 100 mL, IV, 6.5 mL/hr	Purpose: ICU sedation, specifically for initial intubation Action: acts as a relatively selective alpha-adrenergic agonist with sedative properties	Adverse: Bradycardia, sinus arrest Mild: hypotension, dry mouth	<ul style="list-style-type: none"> Nurse should continuously assess pt's LOC every 2 hours, when repositioning as titration of the drug is based on RASS score Nurse should monitor ECG and BP as this drug may cause hypotension, bradycardia, and sinus arrest. Nurse should make sure electrodes are in place all the time Nurse should be ready to administer IV atropine as an antidote in case of toxicity
G: alteplase T: Activase Th: thrombolytics Ph: plasminogen activators	2mg, IV inj. once	Purpose: given to the patient for the DVT found in bilateral upper extremities	Adverse: Intracranial hemorrhage, GI bleeding, retroperitoneal bleeding, GU tract bleeding Mild: epistaxis, gingival bleeding, flushing	<ul style="list-style-type: none"> Assess for patient carefully for bleeding every 15 mins during the 1st hour of therapy, every 15-30 mins for the next 4 hrs, and then every 4 hrs for the duration of the therapy

		Action: directly converts plasminogen to plasmin, which then degrades clot-bound fibrin		<ul style="list-style-type: none"> Assess neurologic status throughout therapy; sudden changes in neurologic status may indicate intracranial bleeding Observe extremities and palpate pulses of affected extremities every hour. Aminocaproic acid is the antidote for overdose
G: heparin T: heparin Th: <i>anticoagulants</i> Ph: <i>anticoagulants</i>	25,000 units, 15 units/kg/hr	Purpose: Part pt's DVT treatment Action: Higher doses neutralize thrombin, preventing the conversion of fibrinogen to fibrin	Bleeding, heparin-induced thrombocytopenia, rash, urticaria, pain at injection site, fever, hypersensitivity reactions	<ul style="list-style-type: none"> Assess for signs of bleeding and hemorrhage (bleeding gums; nosebleed; unusual bruising; black, tarry stools; hematuria; fall in hematocrit or BP; guaiac-positive stools). Notify health care professional if these occur. Monitor activated partial thromboplastin time (aPTT) and hematocrit prior to and periodically during therapy. Monitor heparin levels periodically and titrate per facility protocol as needed.
G: dexamethasone T: DexPak Th: <i>anti-inflammatories</i> Ph: <i>steroids</i>	6 mg, IV push, qDay	Purpose: given to as part of pt's pneumonia/sepsis treatment Action: suppresses inflammation and	Adverse: peptic ulceration, thromboembolism, adrenal insufficiency Common: hypertension, hyperglycemia, cushingoid appearance	<ul style="list-style-type: none"> Nurse should assess for signs of adrenal insufficiency (hypotension and weight loss for this pt). Monitor intake and output and daily weights. Observe for peripheral edema, steady weight gain, rales, crackles and notify HCP of these occur.

		the normal immune response		
G: midazolam T: Versed Th: sedative/hypnotics Ph: benzodiazepines	2 mg, IV, 50 mg/mL in 0.9% NaCl	Purpose: given to pt PRN when his breathing became asynchronous with the ventilator Action: effects may be mediated by GABA, an inhibitory neurotransmitter	Adverse: apnea, laryngospasm, respiratory depression Common: phlebitis at IV site (this pt has CVS) though, rash; other s/e will not be observed in a sedated pt (nausea, headache, blurred vision)	<ul style="list-style-type: none"> • Have a second RN verify the dose • Monitor BP, pulse, and respirations continually during administration. O2 and resuscitative equipment should be readily available. • Flumazenil is the antidote for overdose.
G: pantoprazole T: Protonix Th: anti-ulcer agents Ph: proton pump inhibitors	40 mg, IV push, qDay	Purpose: prevention of stress ulcers that may develop in hypoxemic patients due to lack of O2 that supplies the GI membranes Action: binds to enzymes in the presence of acidic gastric pH, preventing the final transport of H ⁺ into the gastric lumen	Adverse: CDAD, hypersensitivity reactions Common: vit B 12 deficiency, hyperglycemia	<ul style="list-style-type: none"> • Nurse should administer cyanocobalamin as prescribed to counter potential B12 deficiency and administer other vitamins as indicated • Monitor bowel movement- diarrhea, bloody stool should be immediately reported to HCP as possible signs of CDAD

Concept Mapping



Nursing Diagnosis (ND) & Nursing Interventions Classifications/Evaluation (NIC)

ND	Interventions	Evaluation of Response
<i>Impaired Gas Exchange r/t hypoxemia from ARDS AEB the need for supplemental O2 delivered by CMV to sustain SpO2 above 94%</i>	<p>Closely monitor O2 and ABGs. Nurse should make sure tube is patent and not kinked and settings are correct.</p> <p>Monitor VS, closely noting any changes.</p> <p>Auscultate lung sounds q4hr when taking VS</p> <p>Use continuous pulse oximetry.</p>	<p>Pt maintains optimal gas exchange AEB ABGs w/in the pt's usual range, O2 sat above 94%, alert response mentation and continued relaxed breathing and maintained baseline HR which is 70-85 bpm.</p> <p>Bilateral crackles heard in the morning which was relieved by suctioning; none heard in the noon and afternoon assessments.</p>
<i>Impaired breathing pattern r/t decreased lung compliance from ARDS AEB the need to intubate</i>	<p>Place pt semi-Fowler's position and observe breathing after each reposition. Report use of accessory muscles to HCP.</p> <p>Evaluate pt's nutritional status and coordinate with HCP and dietitian to improve pt nutrition.</p>	<p>Pt appears to tolerate semi-Fowler's but not position changes AEB O2 drop when repositioning.</p> <p>Serum protein is low. After planning with HCP and dietitian, protein level with improve and will help increase inspiratory muscle function.'</p>
<i>Impaired airway clearance r/t endotracheal intubation AEB excessive secretions and increased peak airway pressure</i>	<p>Assess the lungs for the presence of normal or adventitious breath sounds</p> <p>Suction when crackles are heard</p> <p>Ensure continuous IV fluids to maintain thinness of secretions</p> <p>Observe the quantity, color, consistency, and odor of the sputum</p> <p>Assess ABG for oxygenation and acid-base balances.</p>	<p>Goal is for the pt to maintain clear, open airways.</p> <p>In the morning, there were bilateral crackles heard so suctioned and re-auscultated. Crackles were diminished.</p> <p>Pt secretions were clear, thin, and odorless.</p> <p>ABG remains "normal" based on the ventilatory permissive hypercapnia.</p>

<p><i>Impaired spontaneous ventilation r/t acute respiratory failure AEB fluctuations in SpO2 especially when repositioning</i></p>	<p>Assess for correct ET placement by:</p> <ul style="list-style-type: none"> -auscultating bilateral breath sounds q2hr - observation of a symmetrical rise of both sides of the chest q2hr -x-ray confirmation (after Et tube is re-positioned and taped q24hr) -end-tidal CO2 monitor <p>Check the ventilator settings and alarm system q4hr</p> <p>Administer sedatives as prescribed to allow for ventilator synchrony</p>	<p>Goal is for the pt to maintain spontaneous gas exchange resulting in normal ABG that is within parameters and return to normal SpO2. Pt will also demonstrate no complications from mechanical ventilation.</p> <p>Pt ET placement confirmed by X-ray and further assessment of tube marking by the RN.</p> <p>Ventilator alarms verified are within the recommended settings.</p> <p>Pt continued breathing synchrony with ventilator and SpO2 rose to 94% from 88% after administration of midazolam.</p>
<p><i>Impaired peripheral perfusion r/t PEEP of 10 AEB diminished palpability of pedal pulses</i></p>	<p>Assess peripheral perfusion by checking cap refill q4hr.</p> <p>Use Doppler device to track pedal pulse.</p> <p>Assess skin around the extremities frequently.</p> <p>Place pulse oximetry on nose or ear for accurate SpO2 reading.</p> <p>Place the pt in a semi-Fowler's position as indicated and tolerated.</p> <p>Re-apply SCD after each assessment.</p>	<p>Pt's cap refill was less than 3 seconds.</p> <p>Pt pedal pulse bilaterally using Doppler. Marked site and palpated. It was 1+ in both.</p> <p>No signs of pressure injury formation on skin around extremities.</p> <p>Pt's pulse oximetry is placed on nose.</p> <p>Pt appears to be tolerating semi-Fowler's after order for proning was retracted AEB SpO2 of 94%.</p>

<p><i>Impaired skin integrity r/t proning AEB pressure injuries on the right cheekbone and upper nasal bridge</i></p>	<p>Determine the cause of the damage.</p> <p>Assess the characteristics of the wound including color, size, drainage, and odor and then document and submit to wound nurse.</p> <p>Maintain sterile dressing technique during wound care and used prescribed dressing.</p> <p>Position head of pt so that there is as little pressure as possible on the affected areas.</p>	<p>Pt's pressure injuries were from prolonged proning.</p> <p>Pt's pressure wounds will be assessed and treated by a wound nurse.</p> <p>Pt's pressure injuries were cleaned and covered with Opti-foam. No signs of infection present.</p> <p>Pt appears to tolerate head being tilted at angles where there is no pressure on right cheek and nose.</p>
<p><i>Powerlessness r/t illness and complex treatment AEB inability to perform activities that the pt was able to do without or with minimal assistance</i></p>	<p>Explain any procedure to patient – suctioning, repositioning, dressing- as even though they are sedated, they can still hear.</p> <p>Titrate sedatives to provide sedation PRN at the lowest dose possible and initiate sedation holidays everyday .</p> <p>Frequently assess pt's LOC and assess readiness for extubation once every shift.</p>	<p>Pt will have a more positive experience and psychological trauma from critical care will be minimized if not prevented altogether.</p> <p>Pt will have periods where he is awake and can be reoriented.</p>
<p><i>Risk for infection r/t invasive lines: ET, PICC, OG</i></p>	<p>Implement ventilator bundle protocol by the facility which includes but is not limited to:</p> <ul style="list-style-type: none"> -elevation of the head of the bed to 30-45 degrees -‘sedation vacation’ -daily assessment of readiness to extubate 	<p>Pt will not develop infection AEB the absence of fever, progressive pneumonia shown in later CXR's, and sustained O2 sat of 94 +.</p> <p>Pt's insertion lines are intact, dressings around them are dry and clean, so drainage noted. No swelling, discoloration, pallor of skin around insertion.</p>

	<p>-peptic ulcer disease prophylaxis</p> <p>Chest line insertions site. Report fever, purulent drainage from the insertion site, reddened wound edges</p> <p>Monitor WBC and liver enzymes and discuss with HCP about another abx course.</p>	<p>WBC and liver enzymes will decrease as infection is controlled by appropriate treatment ordered by HCP.</p>
--	---	--

HEAD TO TOE NURSING ASSESSMENT (11/8/21 @ 0800)

- <u>HEAD / NEURO</u>	-
- L.O.C.	- Pt is sedated on eval; RASS: -5 (no response to verbal and physical stimulation, no pain reflex).
- Optical	- No corneal reflex; sluggish pupil reaction to light, size 3mm bilaterally; scleral and periorbital edema
- Head and neck	- Normocephalic head; bald, scalp is smooth and with no lesions, supple neck, no JVD, no bruit on auscultation
- Nose and Throat	- Nostrils are patent, trachea midline unable to check gag reflex as pt was prone
- Gross and Fine Motor	- No movement- RASS -5
- <u>RESPIRATORY</u>	- Mechanically ventilated: Mode: CMV, respirations delivered: 22, tidal volume: 450, PEEP: 10, ETCO2: 32
- Pulmonary	- Bilateral crackles
- Breast and back	- No observed use of accessory muscles during respirations
- <u>CARDIO-VASCULAR</u>	
- Cardiac	- RRR, normal S1/S2, no extra heart sounds
- Central	- Left radial pulse 2+ reg, right radial pulse 1+ reg, bilateral pedal pulses 1+ and thready, difficult to palpate
- Peripheral	- Cap refill <3 seconds, No cyanosis, clubbing or edema in all 4 extremities; noted pallor and coldness

- <u>GASTROINTESTINAL</u>	-
- Abdominal	- Hypoactive bowel sounds on the 4 quadrants; got 10 mL residual
- Nutritional	- Enteral nutrition OG
- <u>GENITOURINARY</u>	- Indwelling catheter; urine output 107 mL/hr (EOD 11/7/21)
- Pelvic and rectal	- Skin around pelvic are intact. No fractures. Last BM 10/19.
- <u>MUSCULOSKELETAL</u>	- 0/5 neuromuscular strength; no movement; rigid tone of right extremities r/t hx of hemiparesis
- <u>INTEGUMENTARY</u>	-
- Skin / Hair	- Pressure injury on right cheek, right earlobe and on upper nasal bridge(non-stageable); overall skin pale and dry; mottling on soles and dorsum of both feet

SBAR:

S: Pt is a 63-year-old Caucasian male who was BIBA on 10/14 for further evaluation after having had an unwitnessed fall from the bed and altered mental status. On arrival to the ED, pt was afebrile and hemodynamically stable but Lab showed thrombocytopenia and hypokalemia and he was Covid + so they admitted him to med-surg where his breathing progressively deteriorated despite BIPAP. He was transferred to the ICU on 10/21 and was intubated on 10/29. The delay in intubation was due to initial refusal of DPOA to intubate believing that that once intubated, it is a “death sentence.” Pt is on CMV and provider ordered proning on 10/25 but he was weaned off that today so he’s back to just semi-Fowler’s starting today. Current FiO2 is 65.

B: Pt is single with no children. He has his niece as his DPOA. He has a hx of right-sided hemiparesis due to an MVA when he was 13 yrs old, so he was wheelchair bound. He lived alone and had caregivers that come by to help him with ADLs. He is still unvaccinated for covid and he refused remdesivir.

A: Pt has been doing well on supine so far, but his PaO₂/FiO₂ is still below 200. His O₂ dropped to low 70's at around 4pm when he was repositioned which woke him up and so he started holding his breath and was going out of sync with the ventilator. He was given midazolam 1g and his FiO₂ was increased to 65 from 60 and RT was informed of the change. His O₂ is back up to 94. ET is at 53' and CXR verified placement. No residual from OG. Urine output is about 100 mL/hr. He has not had a BM since 10/19 and he was given lactulose around noontime but so far there's nothing. Already informed HCP. He has pressure injuries on his right cheekbone and on the upper nasal bridge which appears to be caused by the proning. Took pics of that and opened a request for wound nurse to assess. Applied Opti-foam on those. Last VS taken @1600: T: 36.6 C, HR: 77, RR: 22, BP: 97/67, O₂sat: 94.

R: F/u with RT to check if FiO₂ needs to be adjusted back down because it looks like his O₂ is going up now. F/u HCP to order labs for tomorrow because his WBC is still high, and he is not on any abx right now. Also suggest for lactate value. He hasn't had any insulin coverage since last night but check it q4hrs. Try keeping him off sedation and see if he can be reoriented.

ECG Documentation

Rhythm: Atrial rhythm: Regular Irregular _____ Ventricular rhythm: Regular Irregular _____

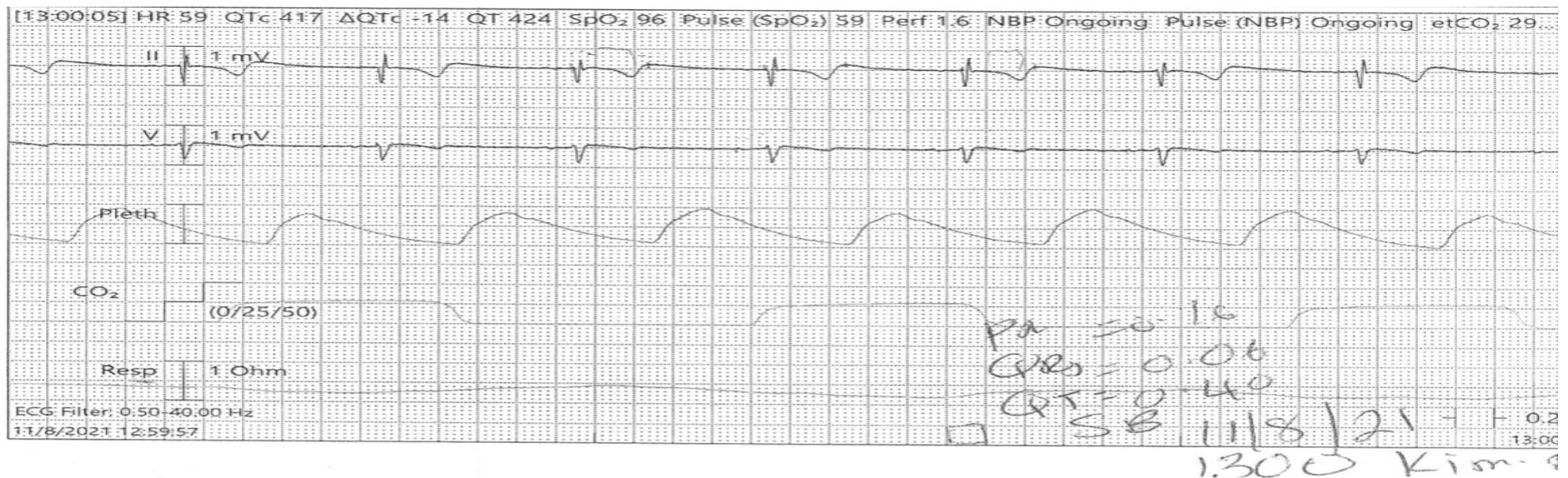
Rate: Atrial Rate: **59** Ventricular rate: **59** PR interval: **0.16** QRS interval: **0.06** QT interval: **0.40**

Conduction: Is AV conduction normal? (Y/N) **Y** If not, why is it abnormal? N/A

P wave normal? (Y/N) **Y** QRS complex normal? (Y/N) **Y** Are all of the QRS complexes the same? (Y/N) **Y**

Are there premature beats? (Y/N) **N** Atrial _____ Ventricular _____ Interpretation of rhythm: **sinus brady**

Potential hemodynamic consequences of this rhythm and interventions for this rhythm: The pt is on Levophed which may explain the bradycardia. If this continues to drop, the pt's CO will be affected and will exacerbate the already poor O₂ tissue perfusion, plus the high PEEP setting. Nurse should continue to monitor EKG and report to HCP if there is progressive decrease in HR.



Student Clinical Self-Appraisal
Weekly (turn in with Care Plan/Map)

STUDENT: ZARAH COLLINS

COURSE: NURS4810-120

INSTRUCTOR: PROF MILLY GAN

Instructions: Please evaluate your performance during clinical today using the following concepts:

Patient Advocate	Professional Demeanor	Flexible
Critical Thinking	Communication/rapport	Peer Support
Self-Initiated	Team Player	Skill Acquisition
Safety	Organized	Educator
Leadership	Well-prepared	Dependable
Nursing Process	Knowledgeable	

<p>Areas of Strength Today (Date): 11/8/21</p> <p>Knowledgeable Ability to apply concepts learned in theory to actual clinical setting</p> <p>Communication/rapport I was able to work with my nurse with no problem and the communication between us was free flowing, She said I ask a lot of questions and "that's good"</p> <p>Team Player Asking other nurses besides mine if they need help.</p> <p>Flexibility</p>	<p>Areas Needing Growth-Include plan of improvement</p> <p>Skill acquisition Be more assertive in doing more skills. I should ask the nurse to let me do as many skills as I can be allowed</p> <p>Safety Brought my water bottle in the nursing station and later found out that it was not allowed. I should ask first what the policy is on bringing personal items.</p>
---	---

Recognized learning opportunities and prioritizing them over documenting on care plan which can be done later.	
Instructor Comments:	