

<p align="center"><b>Medications</b> (see attached)</p>	<p>Student Name <u>Nicole Perretta</u> Client Initials <u>D.Y.</u> Date <u>2/13/12</u></p>	<p><b>State lab values and identify trends.</b></p>
<p align="center"><b>IV Sites/Fluids/Rate</b></p> <p>PICC line RIJ MAC II IV-Cefepime HCl 2 gm in sodium chloride 0.9 ml 100cc/hr IV-Linezolid (Zyvox) 300 ml at 150 ml/hr IV- NS @ KVO. Site intact and without redness or swelling</p>	<p>Age <u>68</u> Gender <u>Male</u> Room # <u>SCU07</u> Admit Date <u>2/08/12</u></p> <p>CODE Status <u>FULL</u> Allergies <u>Levaquin</u></p> <p>Diet <u>NPO till swallow eval.</u> Activity <u>bedrest</u> Braden Score <u>    </u></p>	<p>Sodium 143 Potassium 4.1 Chloride 106 Carbon Dioxide 31 Glucose Bld <b>108 H</b> Bun <b>29 H</b> Creatinine Bld 0.94 Bun/Creatinine ratio <b>31 H</b> Calcium <b>7.7 L</b> Magnesium 1.7 WBC <b>16.7 H</b> RBC <b>3.60 L</b> HGB <b>10.9 L</b> HCT <b>33.3 L</b> Platelet <b>70 L</b> pH 7.41 PCo2 36.2 PO2 <b>78 L</b> HCO3 22.5</p>
<p><b>Monitoring: Invasive/Non-Invasive State specific monitoring device and specific values with each device</b></p> <p>Art-Line (D/C'd when I arrived but being inserted when I left) Foley Chest Tubes (D/C'd when I arrived) 5 lead ECG monitoring continuously Ventilator (D/C'd 2/10) Pulse OX Blood pressure cuff Thermometer PICC line</p>	<p><b>Chief Complaint/Admitting Diagnosis(es):</b> Elective admit for outpatient heart catheterization and plans for aortic valve replacement</p> <p><b>Medical/Surgical Diagnosis(es):</b> Chronic atrial fibrillation Critical aortic stenosis</p>	

<p><b>ECG Interpretation</b> (see attached)</p>	<p>1. Describe the patient's condition, including signs/symptoms that led to this admission</p> <p>2. Briefly describe the pathophysiology related to the patient's diagnosis and current medical/surgical condition.</p> <p>3. Describe the patient's head to toe assessment findings and explain how they relate to the pathophysiology. Include the vital signs.</p>	
<p><b>Past Medical/Surgical History</b> <b>Relevant to this admission</b></p> <ul style="list-style-type: none"> <li>- Family history is negative for respiratory or chet-related disease</li> <li>- Former 1 pack per day smoker who quit 20 years ago</li> <li>- Obstructive sleep apnea for which he is noncompliant with NIPPB therapy</li> <li>- AFIB</li> <li>- Hyperlipidemia</li> <li>- Atonic bladder</li> <li>- DM</li> <li>- Bariatric Sugery</li> <li>- Cardiac Catheterization</li> </ul>	<p>4. Integrate the current laboratory, diagnostic test results, hemodynamic parameters medications, medical and nursing interventions, and other treatments into the pathophysiology and explain how it is affecting this patient's outcome/current condition.</p> <p>Complete this on a separate sheet of paper. Cite references.</p>	<p><b>Treatments/ Medical and Nursing Interventions</b></p> <ul style="list-style-type: none"> <li>- Vitals and output q h</li> <li>- Assessment q 2</li> <li>- BiPAP: 16/12 60-40%, aerosol face mask otherwise</li> <li>- Chest tubes for right middle and right lower lung atelectasis with a mild degree of left lower lobe atelectasis</li> <li>- Chest x-ray on 2/11 showed improved aeration in the right middle love but continued right lower lobe loss, and now increasing volume loss with a small pleural effusion on the left side</li> </ul>

<p><b>Primary Nursing Diagnosis with Relational Statement</b></p> <p>Impaired comfort r/t acute pain r/t AVR and MAZE 2/9</p>	<p>Short Term Goal Relevant to Nursing Diagnosis</p> <p>The patient will report a decrease in their pain as evident by the patient rating their pain at a 5 or below during my shift from 0700-1200</p>	<p><b>6 Nursing Diagnosis with Relational Statement</b></p> <p>Impaired Urinary Elimination r/t atonic bladder</p> <p>Nutrition, Imbalanced: Less than body requirements r/t NPO till swallow eval and no TPN</p> <p>Impaired Verbal Communication r/t BiPAP and aerosol mask being constantly on the patient</p> <p>Impaired physical mobility r/t decreased oxygen saturation, being attached to BiPAP or aerosol mask continuously, 316 lbs</p> <p>Impaired Gas exchange r/t decrease ventilation</p> <p>Impaired airway clearance r/t thick mucus and having a weak cough</p>
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<p><b>Definition (State definition and source)</b></p> <p>The state in which a person experiences and reports severe discomfort or an uncomfortable sensation, lasting 1 s to less than 6 months</p> <p>Source: Carpenito-Moyet, L.J. (2006). Nursing Diagnosis Application to Clinical Practice. Philadelphia, PA: Lippincott, Williams &amp; Wilkins</p>	<p><b>Identify</b> nursing interventions that you implemented with this patient.  <b>Evaluate</b> patient progress towards achieving outcome criteria as a result of nursing interventions.</p> <p><b><u>Nursing Interventions</u></b></p> <ul style="list-style-type: none"> <li>- Medicate patient when patient states pain is present <ul style="list-style-type: none"> <li>-DY was medicated with 2 mg morphine IV when patient stated their pain was an 8/10</li> </ul> </li> <li>- Assess patient for pain q assessment/vital signs <ul style="list-style-type: none"> <li>- Patient's pain rating started at an 8 and dropped to a 6 when I reevaluated him after medicating him</li> </ul> </li> <li>- Monitor the patient's respiratory rate and heart rate after administration of any pain medication <ul style="list-style-type: none"> <li>- Patient's respiratory rate never went below 20 HR did decrease to the 90s</li> </ul> </li> <li>- Reposition the patient to a more comfortable position to help decrease his pain <ul style="list-style-type: none"> <li>- Even though my patient couldn't roll on either of his sides he still preferred not laying completely on his back and also liked getting out of bed to sit in the chair</li> </ul> </li> </ul>	
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<p><b>AEB: Defining characteristics specifically exhibited by your patient that support primary nursing diagnoses</b></p> <p>Pain rating of 8/10 in his belly, described as stabbing and constant, abdomen is red and warm  Maze and AVR on 2/9  HR 102  Respiratory rate 28</p>	<p><b><u>Outcomes/Evaluations</u></b></p> <ul style="list-style-type: none"> <li>- Patient will be able to express a decrease in his pain by rating it a 5 or below on a scale out of 10 by the end of my shift <ul style="list-style-type: none"> <li>- Outcome met. Patient's pain at the end of my shift was a 2/10</li> </ul> </li> <li>- During my shift my patient's HR will decrease in response to a decrease in his pain <ul style="list-style-type: none"> <li>- Outcome met. Patient's HR decreased to the high 80s low 90s at the end of my shift</li> </ul> </li> <li>- Patient's abdomen will decrease it's redness by the end of my shift. <ul style="list-style-type: none"> <li>- Outcome not met. The patient's abdomen stayed red during my shift</li> </ul> </li> <li>- Patient's respiratory rate will not go below 12 breaths per minute during my shift <ul style="list-style-type: none"> <li>- Outcome met. Patient's respiratory rate stayed between 19-26 during my shift</li> </ul> </li> </ul>	<p><b>What I Would Do Differently?</b></p> <p>I would definitely have sat in with the patient and just talked with him for a longer period of time then I did. I would use other forms of ways to communicate with the patient such as paper and pen or dry erase board to better understand what the patient's needs are.</p>
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