Medications

(see attached sheet)

Past Medical/Surgical History

- Left Cataract Surgery
- Right Thoracentesis

IV Site/Fluid Rate

- Left AC #20 Hep locked
- Left Arm #22 NS at 10cc/hr KVO

Monitoring: Invasive/ Non –invasive

- BP Cuff 119/60
- Pulse ox 99%

Student Name: Dan Laskey Client Initials: W.G_Date: 05/17/12 __Age: 65_

Gender: Male___Room 4406____Code Status: Full__

Allergies: No known allergies.___Diet: NPO

Activity: Bed rest Braden Score_12

- **Chief Complaint**: Trouble breathing after colonoscopy
- **Admitting Diagnosis:** Hypoxia, MI inferior lateral wall
- **Medical/Surgical/Past History Diagnosis**: Smoker, Left Cataract Surgery, Family history of Grandmother Diabetes, Sister Hypertension, Father MI at age of 80, Mother Colon Cancer, and paternal grandfather stroke.

Describe the patient's condition, including signs/symptoms that led to this admission.

- The PT was scheduled for a heart cauterization but started noticing blood in stool. A colonoscopy was scheduled and performed and polyps also collect for pathology. PT was having trouble coming out of anesthesia and was sating in the 80's and hypoxic. The PT was then admitted for Hypoxia/MI of the lateral inferior wall to the MICU. The colonoscopy was performed first instead of heart cath due to during the use of anticlotting agents being used and since PT was already had evidence of blood in stool the colonoscopy and stop

State Lab Values and Identify Trends

- Na: 138 (132-146) Normal Range
- K: 4.8 (3.5-5.1) Normal Range
- Cl: 97 (99-109) Low
- The CL is just slightly low which can be due to respiratory issues such as acid base imbalances along with CHF.
- C02: 29.3 (35-45) low (on my shift)
- The PT is on the lower side for Co2 now due to being on the vent and assuming receiving Bicarb in ED for the very High level in ED.
- Co2 in ED 138.5 (35-45) High
- The PT Co2 is high in ED

• Respirations 12-16 • Foley amber yellow to clear after Lasix given • Intubation tube • OG Tube • Vent • Ekg lead 5 lead **ECG Interpretation (See Attached Sheet)**	of bleeding needed to be done first. **Briefly describe the pathophysiology related to the pt's diagnosis and current medical/surgical condition.** • A **colonoscopy** uses a flexible scope to visually view the entire lining of the colon. Usually a colonoscopy is done in clients with diarrhea, constipation, rectal bleeding, and lower abdominal pain. It is also done in patients who have a risk of colon cancer. A colonoscopy is recommended every ten years for patients (especially males) after the age of fifty. • **Hypoxia** is oxygen deficiency in the body tissues and in the Pt's case is acute due to the onset and cased the body to have a drop in oxygen leading to ischemia in the heart. • **MI** also known as a heart attack usually follows a sudden or abrupt changed or cessation in blood flow and oxygen flow to the heart. This to necrotic tissue death in heart can be fatal to the PT. The PT had more specifically a lateral inferior MI which involves the right coronary artery and the effects the conduction system. The coronary artery perfuses the SA, and AV nodes. **Describe the patient's head to toe assessment findings and explain how they relate to the pathophysiology. Include vital signs Integrate the current laboratory data, diagnostic test results, hemodynamic parameters, medications, medical nursing interventions, and other treatments into the**	because of PT being hypoxic and not breathing adequately and retaining Co2. • Bun: 24 (9-23) High • The BUN is just slightly high and only one point above the normal range. But are seen after a recent MI, in CHF, and stressful situations which this pt had 2 out of 3 and may or could develop the third. • Cr: 1.0(0.7-1.3)Normal Range • Glu: 198 (70-100) High • High glucose can be just from stress in general but the pt is also receiving Solu Medrol which will make your glucose level rise. • Calcium: 8.5 (8.6-10.5) Low

	pathophysiology and explain how it is affecting this PT's outcome/current condition • The PT has a diagnosis of Acute MI of lateral inferior related to hypoxia. On initial assessment the PT was very drowsy and sleepy but did open eyes to voice and was alert to person and assuming more but not able to assess due to intubation tube and LOC of PT at current time. PT was able to follow commands and wiggle fingers and toes. Lungs were clear and decreased in all fields and was currently intubated on a vent with the settings of AC of 10, Fio2 40%, tidal of 500, and a peep of 5. Current measurement checked for correct position. Bowel sounds were present in all four quadrants, OG placement checked and measurement for correct position, and Foley was in place draining amber to clear yellow at time of assessment. Radial pluses +2 in both arms and pedal pluses +1 with edema in bilateral extremities at +2 with discoloration to lower shin leg area. No skin issues at this time coccyx intact with no redness present, PT was turned and repositioned throughout shift to prevent skin breakdown. Two Iv sites on left a #20 in AC hep locked and #22 in forearm running normal saline at KVO at 10CC per hour. PT had currently on previous day been on IV Ativan and at the start of my shift was still very drowsy but throughout the day the PT did wake up and became more alert to surroundings as day went on.	• The calcium level is really just under the low normal range by a tenth but is on the lower end of normal may be just because he has been npo and getting no nutrition other than fluids at KVO. • WBC: 11.3 (4.5-11) High • There is an increase in WBC which could mean infection but also since the pt's Neutrophils are elevated could mean tissue death which makes since since he had a MI. The solu Medrol my also be increasing the WBC level • RBC: 6.63 (3.80-5.8) High • The high RBC could be due to when the body cannot get enough oxygen it try's to compensate by

	Pressure support was attempt throughout the day and PT was able to be weaned off partially and was breathing partly on his own. At first this was difficult for the PT and had to be reminded to breathe and take big deep breaths especially in the beginning of weaning process. As the day progressed the PT was able to breathe at the level he was on fairly well even when resting with eyes closed as he had not been able to do earlier in the shift. Vitals signs 97.8, HR 74, 101/55 BP, 12 RR, 100% on Fi02 of 40%. On review of the PT's EKG strip PVC's were reported in report and the P waves were not typical and smaller but regular which since it was a lateral inferior affects the SA and AV nodes which would affect the p wave conduction and cause PVC's and indicates a recent MI along for ST would show new ischemia in leads 2,3 and avf on 12 lead ekg. The PT was retaining fluid and had a +2 bilateral lower edema and a Thoracentesis was performed to pull off some fluid off the right lung field due from having the MI and the backing up of fluid in the lungs from the heart not pumping efficiently due to MI and abnormal conduction and contractions. PT was also given Lasix on my shift to pull fluids off and decrease edema the PT currently had and prevent any fluid overload to stress the heart even more. PT is on Lisinopril which is an Ace Inhibitor that will decrease the H20 and NA retention by inhibiting angiotensin II and will Lisinopril also decreases preload and afterload. The Lopressor the PT is currently on is a beta blocker	producing more RBC's to carry the available oxygen and adapt. My pt was hypoxic so this is a good hypothesis to this lab level • HBG: 14.0 (12.5- 16.5) Normal Range • HCT: 45.6 (37-54) Normal Range • PLT: 163 (130-450) Normal Range • PH: 7.628 (7.35-7.45) High (on my shift) • PH: 7.143 (7.35-7.45) before my shift in ED • PT had a combination of respiratory and metabolic alkalosis. Which can be cause by interfere in oxygen exchange and also by overdose HCO3 is another possible cause. In ED PT's PH was very acidic

	that is selective only for Beta 1 and decreases afterload that decreases the workload of the heart, heart rate, and blood pressure. It relaxes the smooth muscles of the heart and slows the conduction of the heart. Mouth care and Foley care were performed to prevent infection and suctioning to prevent any fluid in the PT's mouth and prevent aspiration. Turning of the PT every two hours helps prevent any bed sores that the PT currently does not have and gives ou a chance to listen to lungs in the back of the chest on assessments. Encouragement was needed to help the PT in the beginning of the weaning phase of the Vent process due to the PT having to relearn to breathe on his own and take deeper breaths and feel safe doing so on his own. Encouragement was done by the nurses, respiratory, and family throughout the shift.	due to very high Co2 level and was given I assume Bicarb and placed on vent and over treated I assume since PT is now to basic. • HC03: 30.0 (22.0-26) High • Overdose of Bicarb is a option that could have happen to this pt because his HCO3 was originally low and metabolic alkalosis • Troponin I 0.41 (0.00-0.40) High • First Troponin is high which proves there was some ischemia and MI • Troponin II 0.24 (0.00-0.41) Normal • CK 159 (32-294) Normal • CK 118 (32-294) Normal • CK and Troponin are both resolving

References

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- Urden, L. D., Stacy, K. M., & Lough, M. E. (2010). *Critical care nursing diagnosis and management*. (6 ed.). St. Louis, Missouri: Mosby Elsevier.
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Treatments/Medical and Nursing Interventions

- Mouth care
- Turn/reposition pt
- Resp treatments
- Foley cath care
- Flush OG
- Assessment
- Rounding
- Vital Signs
- Pain management
- Monitoring labs
- Encouragement
- Suctioning
-

State Diagnosis Test results

- ECG see attached
- ABG's (results in lab data)
- CT of chest results Right pleural Effusion (had Thoracentesis)

		• Thaliiin Stress Test (showed large inferior lateral ischemic changes) • Polyps from colonoscopy sent and came back negative for cancer

Primary Nursing Diagnosis with Rational Statement	Short Term Goal	6 Nursing Diagnosis with relational Statement
• Impaired Gas Exchange related to altered oxygen supply and altered blood flow as evidence by hypoxia. **Definition (state definition and source)** • The state in which the individual experiences a deficit in oxygenation and/or carbon dioxide elimination at the alveolar capillary membrane, often producing subjective fatigue or anxiety. • (2005). *Taber's cyclopedic medical dictionary*. (20 ed., p. 855). Philadelphia: F.A Davis Company. **AEB: Defining characteristics specifically exhibited by your patient that support primary nursing diagnosis** • History of smoking • Increased level of Co2 on admission • MI to lateral inferior wall • EKG changes supporting MI due to hypoxia • Blood gases • Ischemia • Troponin level • Being placed on vent • Need for cardiac cauterization (was scheduled before all this happened) • Thoracentesis • Decreased lung sounds on assessment	• PT will be weaned off vent the pressure support by the end of the shift at 1630. **Outcome Criteria (must be specific and measurable)** • PT will Maintain a patent airway at all times • PT will demonstrate improved ventilation and adequate oxygenation within normal parameters as evidence by blood gas levels before end of shift • PT will show improvement in lung fields by end of shift • PT will take be take deeper and more breaths on own and continue to decrease on pressure support as shift continues • Participate in treatment regimen within level of ability or situation as in realizing the need to take deeper breaths and breath on own.	1. **Ineffective Breathing Pattern/impaired Spontaneous Ventilation** related to Alteration of client's usual O2/CO2 ratio, respiratory center depression and respiratory muscle weakness 2. **Risk for decreased Cardiac Output** related to Changes in rate, rhythm, electrical conduction and Infarcted/weakened muscle, altered electrical conduction, reduced myocardial contractility due to recent MI. 3. **Risk for dysfunctional Ventilatory weaning response** related to fear and anxiety of breathing on own and not being able to breath and SOB. 4. **Risk of fear**/anxiety related to weaning off ventilator and breathing on own 5. **Imbalanced Nutrition**: Less than Body Requirements related to PT's NPO Status. 6. **Risk for impaired Skin Integrity** related to prolonged bed rest edema, decreased tissue perfusion and immobility decrease nutrition.

Identify nursing interventions that you implemented with this patient and evaluate patient progress towards achieving outcome criteria as a result of nursing interventions
 	
• **T**urned PT every two hours to prevent tissue damage
  ➢ Patient did not develop any bed sore on this shift
• Mouth care performed on pt during shift
  ➢ Patients mouth was cleaned and remain cleaned during shift to prevent infection and sores
• Foley cath care provided to prevent infection and promote good hygiene
  ➢ Patient did not develop a temp or any s/s of infection this shift
• Suctioning of PT as needed
  ➢ PT did not aspirate or choke on this shift PT did not seem anxious or have anxiety since I kept the PT suctioned
• Encouragement of PT to take deep breaths and remember to breath to wean
		What I would do Differently
		• I would have spent more time being able to understand the ventilator functions more than I did and learned the EKG strips more along with being more familiar with the unit and staff but since it was really are first week this wasn't really possible at this point yet. I wish I could have been able to do my assessment and enter my data into the computer to be able to help my RN with the workload of this PT.

off ventilator ➢ PT was able to be weaned some on pressure support and was breathing easier by end of my shift and was able to rest with eyes closed and not have alarms go off as in beginning of shift.		
