CARE PLANNING PATIENT AND FAMILY EDUCATION

THE CLINICAL SETTING STEP BY STEP

WWW.DEARNURSES.NET

CHAPTER 16

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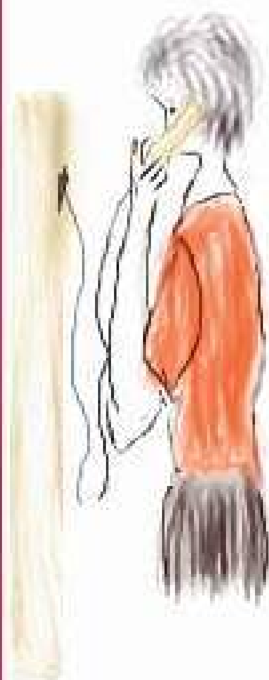
CARE PLAN

- ANXIETY RELATED TO HOSPITAL ADMISSION, EXPLAIN PROCEDURES
- DISCUSS WITH PATIENT AND FAMILY HIPPA

HIPAA



This nurse is giving information about a post-op patient. Does she know to whom she is giving the information?

H-EALTH
I- NSURANCE
P-ORTABILITY
A-CCOUNTABILITY
A-CT

CARE PLAN

- DISCUSS WITH PATIENT AND FAMILY HIPAA
- DISCUSS DURABLE POWER O OF ATTORNEY
- EXPLAIN YOUR INSTITUTION'S POLICIES AND PROCEDURES

TO LEARN MORE ABOUT HIPPA, PLEASE GO TO WWW.DEARNURSES.COM AND ENJOY READING - HIPPA.

WHAT IS HIPAA?

These are her patient's neighbors.

Mr. Swanson defies the nurse and calls his wife to bring him some food.

CARE PLAN

- FOLLOW MD ORDERS, HIPAA
- DISCUSS WITH PATIENT DIETARY ISSUES AND THE NEED TO FOLLOW MD ORDERS
- ENCOURAGE PATIENT TO VENTILATE CONCERNS

Honey I am really starving. I asked the nurse for a sandwich and she refused.Can you get over here quickly with my favorite treat?

PATIENT AND FAMILY EDUCATION

- DISCUSS WITH PATIENT AND FAMILY THE IMPORTANCE OF FOLLOWING A DIETARY REGIMEN
- ENCOURAGE THEM TO VENTILATE ANY CONCERNS
- ENCOURAGE DIABETIC TEACHING

FOR MORE INFORMATION VISIT:WWW. DEARNURSES. COM(DIABETES FOR THE LAYPERSON)

TAMMY IS HYPOGLYCEMIC!

INSULIN REACTION

ASSESSMENT

The nurse arrived and did an assessment. She noticed Tammy was anxious and shaky. She was also diaphoretic (sweating excessively).

INTERVENTION

The nurse checked the blood glucose by fingerstick and noted a result of 58. She checked the doctor's sliding scale orders and gave 4oz apple juice, as Tammy was able to swallow. She then notified the MD as ordered.

SLIDING SCALE (THIS IS ONLY A SAMPLE)
FINGERSTICK Q 6 HR , GIVE AS FOLLOWS:
BS < 80 = GIVE 4OZ JUICE AND CALL MD.
BS 81- 150= NO TREATMENT NECESSARY
BS 151-200= 3 UNITS REGULAR INSULIN SQ
BS 201-250= 6 UNITS REGULAR INSULIN SQ
BS 251-300 =9 UNITS REGULAR INSULIN SQ AND CALL MD.

Nurse, since you gave me that Insulin shot I feel weak and shaky.

SALLY WAS DIAGNOSED WITH TYPE 2 DIABETES ABOUT 4 WEEKS AGO. SHE HAS AN ORDER FOR 20 UNITS REGULAR INSULIN SQ, Q AM (0730). THIS MORNING BREAKFAST IS LATE. HER NURSE GAVE HER INSULIN AS SCHEDULED, BUT THRE WAS NO BREAKFAST TO FOLLOW. SALLY IS HAVING AN INSULIN REACTION. SHE IS HYPOGLYCEMIC!

CARE PLANNING - PATIENT/ FAMILY EDUCATION

THE DIABETIC PATIENT WHO RECEIVES INSULIN OR HYPO-GLYCEMIC AGENTS, IS AT RISK FOR HYPOGLYCEMIA.

- DISCUSS WITH PATIENT AND FAMILY WHAT TO DO AND THE SYMPTOMS OF HYPOGLYCEMIA. ALWAYS LEAVE SOME JUICE AT BEDSIDE, IN CASE MEALS ARRIVE LATE AFTER RECEIVING INSULIN. A PATIENT WHO HAS BEEN A DIABETIC FOR A LONG TIME, USUALLY KNOWS THE WARNING SIGNS.

Monitoring blood glucose is essential to maintain glucose within normal limits. Normal blood glucose is 60-120. Typically blood glucose is measured before mealtime. This will make for a more accurate reading. There are many different blood glucose meters on the market.

Follow the manufacturer's instructions for accurate meter reading. MD orders are usually written to follow a sliding scale for each patient.

Finger sticking for glucose monitoring is usually done off to the side of the finger. Rotation of sites is essential to allow healing .

MONITORING BLOOD GLUCOSE IS AN ESSENTIAL PART OF MANAGING THE DIABETIC PATIENT. HYPOGLYCEMIC AGENTS OR INSULIN, OR BOTH WILL BE ORDERED BY THE DOCTOR ,TO MEET THE PATIENT'S NEEDS.

EXAMPLE OF SLIDING SCALE

SLIDING SCALE INSULIN IS USUALLY ORDERED BY THE DOCTOR AND SHOULD BE DISCONTINUED WHEN ORDERED BY THE DOCTOR.

SAMPLE:

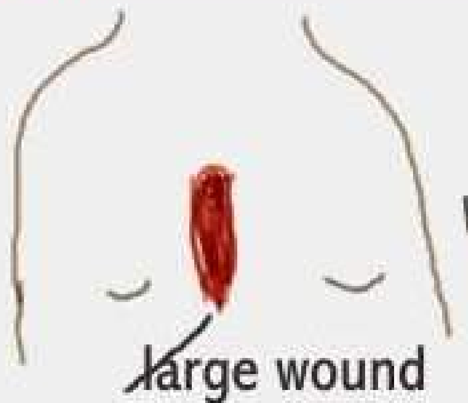
GIVE REGULAR INSULIN, SQ FOR BLOOD SUGAR
0-80 GIVE OJ AND CALL MD, 80-199 - 0 UNITS
200-250 = 3 UNITS
250-300 = 5 UNITS
300-351 = 8 UNITS
351-400 = 10 UNITS
> 400 GIVE 12 UNITS AND CALL MD.

PLEASE REMEMBER, THIS IS A SAMPLE AND SHOULD NOT BE ATTEMPTED IN THE CLINICAL SETTING.

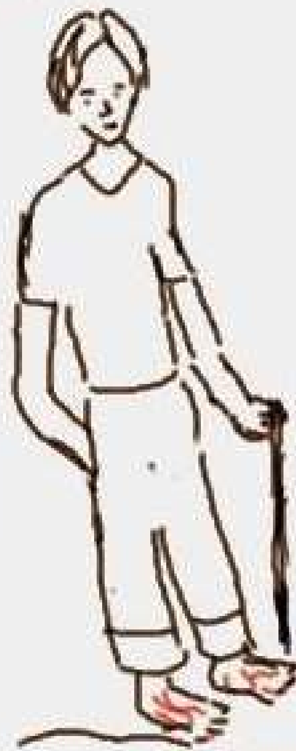
ASSESSMENT

OF CIRCULATION IN THE DIABETIC PATIENT

FOR MORE HELPFUL INFORMATION ON THIS TOPIC, PLEASE READ: DIABETIC CARE IN THE CLINICAL SETTING, VOLUMES 1 AND 2. WWW.DEARNURSES.COM



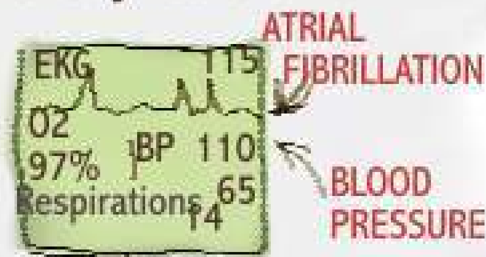
PVD



HELPFUL HINTS:

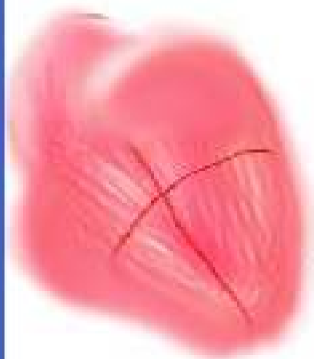
- PALPATE PERIPHERAL PULSES AND DOCUMENT WHETHER PRESENT AND BOUNDING OR WEAK
- ASSESS THE COLOR OF SKIN AND IF SIGNS OF DISCOLORATION OR GANGRENE ARE VISIBLE
- ASK PATIENT ABOUT ANY NUMBNESS, TINGLING OR LOSS OF SENSATION IN HANDS OR FEET
- ASSESS SKIN BREAKDOWN AND WHAT STAGE
- ASSESS WOUND HEALING
- DOCUMENT ALL FINDINGS

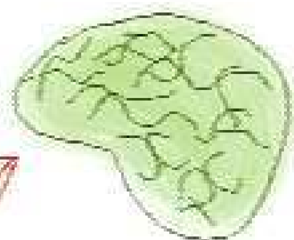
Mr.Henry was transferred to the Coronary Care Unit. He was connected to a cardiac monitor. His EKG showed Atrial Fibrillation.



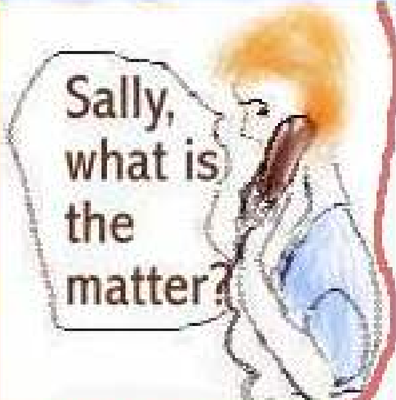
OXYGEN via nasal cannula - supplemental oxygen - saturation is 97%.

IV SITE -site is clear, no redness or swelling.





IN ATRIAL FIBRILLATION A BLOOD CLOT MAY FORM BECAUSE OF "QUIVERING" AND NOT EMPTYING OF THE ATRIA. A BLOOD CLOT MAY FORM AND TRAVEL TO THE BRAIN , THUS CAUSING A STROKE.



CARE PLAN

- POTENTIAL FOR STROKE RELATED TO ATRIAL FIBRILLATION
- CLOSELY MONITOR NEURO STATUS AND DOCUMENT FINDINGS. REPORT ANY SIGNIFICANT CHANGES TO MD(ARM WEAKNESS, SLURRED SPEECH OR BLURRED VISION)

PLEASE READ-STROKE SERIES (VOLUME1)
WWW.DEARNURSES.COM

HYPOKALEMIA (LOW POTASSIUM)

CARE PLAN

- POTENTIAL FOR CARDIAC ARRHYTHMIAS, MONITOR EKG
- DISCUSS WITH PATIENT AND FAMILY THE PLAN OF CARE

Mrs.C is a 65 year old female who has a historyof CHF (congestive Heart Failure). She receives Lasix twice daily. This morning she is having severe leg cramps. Her Potassium is 3.0. normal serum potasssium is = 3.5 - 5.0. Hypokalemia (low Potassium) may cause U waves on the EKG.

THE CARDIAC PATIENT IS AT RISK FOR ELECTROLYTE IMBALANCES DUE TO DIURETIC THERAPY. MEDICATIONS SUCH AS LASIX DOES NOT SPEAR POTASSIUM. HYPOKALEMIA MAY RESULT. MONITOR LAB VALUES AND REPORT ABNORMAL VALUES TO MD.

SEIZURE ACTIVITY

CARE PLANNING FOR THE SEIZURE PATIENT

Mrs.S was involved in a car accident a week ago and has no prior history of seizures.
She now has generalized seizures about twice a day.

HERE IS A SAMPLE OF A CARE PLAN FOR THE SEIZURE PATIENT:
- POTENTIAL FOR SEIZURES
- ASSESS AND MAINTAIN A PATENT AIRWAY,
- O2, SUCTION
- SIGN OVER BED
- PADDED BED RAILS

SEIZURE PRECAUTIONS

FOR MORE INFORMATION ON SEIZURES, PLEASE READ: SIMPLIFYING SEIZURES.

- BED RAILS UP AT ALL TIMES
- HOB OF BED UP 30 DEGREES OR AS ORDERED BY MD
- ROOM CLOSE TO DESK
- PATIENT AND FAMILY EDUCATION ABOUT SEIZURES

TRANSPHENODIAL SURGERY

DIABETES INSIPIDUS (DI)

PATIENTS WHO HAVE SURGERY DONE TO THE PITUITARY GLAND MAY DEVELOP DIABETES INSIPIDUS. ANTIDIURETIC HORMONE (ADH) WHICH IS SECRETED BY THIS GLAND MAY BE DISRUPTED, THUS RESULTING IN DI. PATIENTS WHO DEVELOP DI, DUMP LARGE VOLUMES OF PALE, ALMOST COLORLESS URINE. THEY MAY BECOME DEHYDRATED.

LARGE QUANTITY OF PALE ,YELLOW URINE.

DDAVP IS THE DRUG USED TO CORRECT THE LACK OF ADH. IT MAY BE USED IN NASAL SPRAY, IV OR SQ.

PATIENT AND EDUCATION

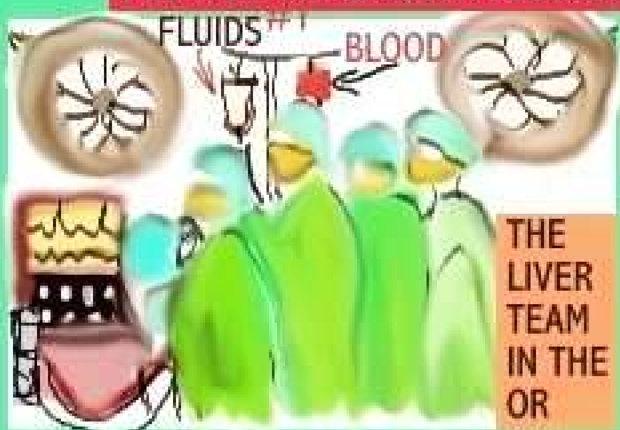
- DISCUSS WITH PATIENT AND FAMILY THE NEED FOR REST TO DECREASE HEADACHES

ENCOURAGE PATIENT AND FAMILY TO VERB-ALIZE FEARS. ADDRESS SOCIAL SERVICES IF NEEDED.

CARE PLAN

- FOLLOW MD ORDERS
- MONITOR AND RECORD URINARY OUTPUT
- MONITOR NEURO STATUS
- GIVE MEDS AS ORDERED FOR DI
- NOTIFY MD OF SIGNIFICANT CHANGES

HELPFUL INFORMATION REGARDING ORGAN TRANSPLANTATION



CARE PLANNING

THE ORGAN TRANSPLANT PATIENT IS AT RISK FOR:

- REJECTION OF THE ORGAN
- INFECTION OF THE SURGICAL SITE
- PNEUMONIA AND SKIN BREAKDOWN DUE TO SURGERY AND BEING IN BED.
- BLEEDING DUE TO CLOTTING PROBLEMS
- DVT- SCDs/TEDS SHOULD BE IN USE

DONOR- THE PERSON WHO GIVES THE ORGAN.
RECIPIENT- THE PERSON WHO RECEIVES THE ORGAN
MATCH -THE DONOR AND THE RECIPIENT MUST HAVE BLOOD COMPATIBILITY.
REJECTION- SHOULD BE DISCUSSED BY THE TRANSPLANTATION TEAM , AS THIS MAY POSSIBLY HAPPEN.

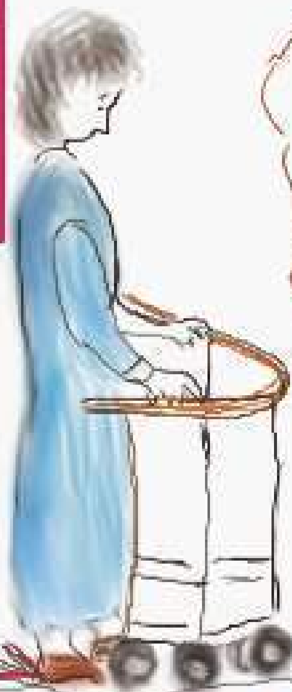
THE NUTRITIONAL NEEDS AND ANY OTHER LIFE-STYLE CHANGES WILL BE EVALUATED BY THE TRANSPLANTATION TEAM.

SURGEONS, ANESTHEOLOGIST, SOCIAL WORKER, PSYCHIATRIST, RN (COORDINATOR) AND THERAPISTS ARE ALL PART OF THIS TEAM.

IMMUNOSUPPRESSANT DRUGS -SUCH AS PROGRAF, STEROIDS, CELLCEPT AND IMURAN ARE USED TO PREVENT REJECT -ION. DISCUSSING WITH THE PATIENT AND FAMILY THE NEED TO TAKE THESE DRUGS WITHOUT FAIL, FOR THE REST OF THE PATIENT'S LIFE IS VERY IMPORTANT. SIDE EFFECTS SUCH AS HAIRLOSS, INFECTION, OBESITY, DIABETES MELLITUS AND GASTROINTESTINAL UPSET MAY OCCUR.

FALL PREVENTION

CARE PLAN SHOULD INCLUDE FALL PRECAU-TIONS.



BOTH PATIENTS HAVE SOMETHING IN COMMON. THEY ARE BOTH UNSTABLE ON THEIR FEET AND WILL NEED TO BE CLOSELY WATCHED.

STROKE SYMPTOMS LIKE ARM OR LEG WEAK-NESS MAY RESULT FROM A TRAUMATIC BRAIN INJURY.

THIS PATIENT WAS INVOLVED IN AN ACCIDENT A MONTH AGO. SHE IS RECEIVING PHYSICAL THERAPY TO LEARN TO WALK AGAIN.
SHE IS A FALL RISK, AS SHE IS UNSTABLE ON HER LEGS. HER RIGHT LEG IS WEAKER THAN HER LEFT.

THIS PATIENT HAS A PROSTHETIC LEG ON THE LEFT SIDE.
SHE HAD AN ABOVE KNEE AMPUTATION FOLLOWING A CAR ACCIDENT.
SHE IS LEARNING TO WALK AGAIN AND IS UNSTABLE ON HER LEGS.

FALLS CAN BE PREVENTED. INCLUDE FALL PREVENTION IN THE PLAN OF CARE.

FALLS

Mr.H seemed okay when he was put to bed. He was given a sleeping pill and 2 hours later, his nurse finds him on the floor.

HELPFUL HINTS TO AVOID FALLS

THE INFORMATION BELOW MAY BE USEFUL TOOLS IN FALL PREVENTION.

A LOW LIGHT IN A PATIENT'S ROOM, MAY HELP TO PREVENT DISORIENTATION AND FALLING.

BED RAILS UP FOR SAFETY. ADVISE PATIENT OF THE REASON WHY.

PATIENTS MAY BE AT RISK FOR FALLS FOR VARIOUS REASONS. CARDIAC, SLEEPING , ANTI-ANXIETY AND BLOOD PRESSURE MEDICATIONS ARE ONLY SOME OF THE REASONS THAT MAY CONTRIBUTE TO PATIENT FALLS.

A ROOM CLOSE TO THE NURSES' STATION WILL MAKE IT EASY FOR THE STAFF TO LOOK IN OFTEN.

DIZZINESS, LOW BLOOD PRESSURE, STROKES, SURGICAL PROCEDURES AND VISUAL DISORDERS ARE SOME OF THE OTHER CAUSES RESPONSIBLE FOR FALLS.

THE CALL LIGHT WITHIN EASY REACH WILL ALSO HELP.

FOLLOW YOUR INSTITUTION'S POLICIES FOR DRESSING/TUBING CHANGES

IV SITE WITHOUT REDNESS OR SWELLING

IV SITE WITH REDNESS AND OOZING

IV ASSESSMENT

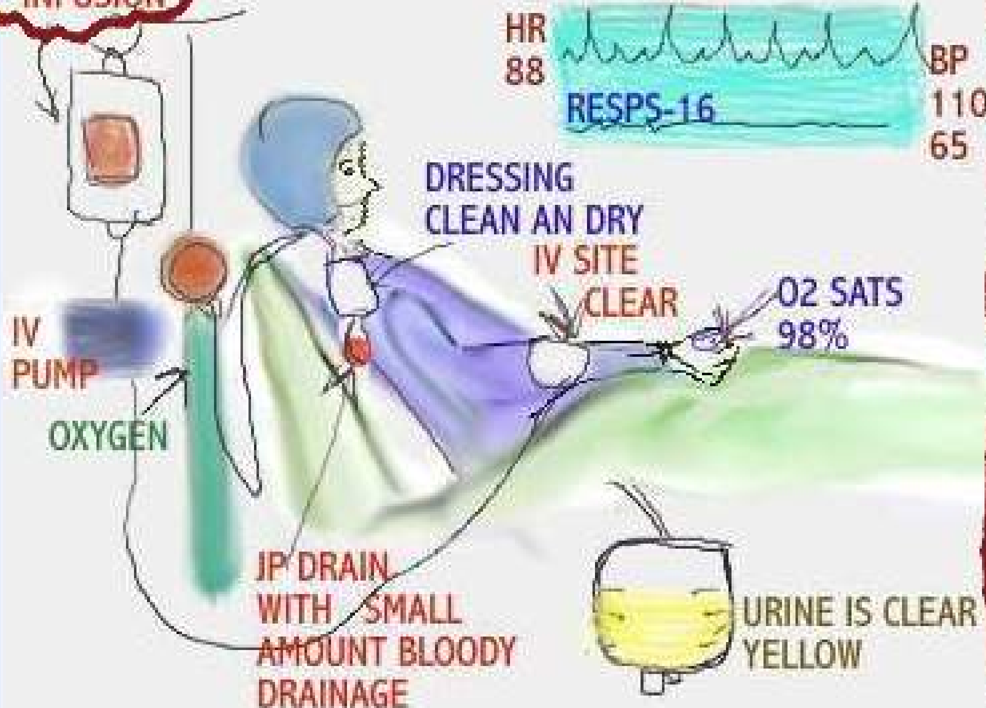
HELPFUL HINTS:

- ALWAYS FOLLOW MD ORDERS
- ENSURE PROPER DILUTION OF IV SOLUTIONS
- IF PAIN AT THE IV SITE OCCURS, STOP IV AND ASSESS FOR SIGNS OF INFILTRATION/ EXTRAVASATION
- FLUSH WITH NORMAL SALINE AT THE PORT CLOSEST TO THE PATIENT, DOCUMENT NOTIFY MD FOR FURTHER ORDERS

HEPARIN THERAPY

THE PATIENT ON HEPARIN THERAPY IS AT RISK FOR BLEEDING. ASSESS IV SITE FOR OOZING BLOOD. INCLUDE THIS IN THE PLAN OF CARE.

ANTICOAGULATION THERAPY



THE PATIENT ON ANTICOAGULATION THERAPY IS AT RISK FOR BLEED-ING.

CARE PLAN

-MONITOR IV SITE DRESSINGS, URINE DRAINAGE TUBES AND GUMS FOR SIGNS OF BLEED -ING. DISCUSS WITH PATIENT AND FAMILY WHAT CAN HAPPEN DUE TO HEPARIN THERAPY.

THIS PATIENT IS IN PACU, FOLLOWING SURGERY TO HER CERVICAL SPINE. SHE IS ALSO ON ANTICOAGULATION THERAPY FOR A PAST HISTORY OF ATRIAL FIBRILLATION.

IT IS IMPORTANT TO ASSESS AND DOCUMENT ANY SIGNS OF BLEEDING FROM JP DRAIN, DRESSINGS, IV SITE, URINARY OUTPUT OR MUCOUS MEMBRANES.

LAB VALUES ARE USUALLY DRAWN TO MAKE SURE LEVELS ARE THERAPEUTIC. NOTIFY MD OF SIGNS OF BLEEDING.

TPN (TOTAL PARENTERAL NUTRITION)

(IV NUTRITION)

TPN

CENTRAL LINE

IV PUMP

FILTER ATTACHED TO IV TUBING

MELISSA WAS INVOLVED IN A CAR ACCIDENT AND SUSTAINED ABDOMINAL INJURIES. SHE DEVELOPED A PERITONITIS AND IS UNABLE TO EAT OR DRINK. SHE IS RECEIVING TPN , INTRAVENOUSLY VIA A CENTRAL LINE.

TPN IS USUALLY GIVEN IV AS A STERILE SOLUTION.THERE IS A FILTER ATTACHED TO THE IV TUBING. IV TUBING IS CHANGED PER INSTITUTION'S PROTOCOL.

COMPLICATIONS OF TPN MAY INCLUDE INFECTION, ELEVATED BLOOD GLUCOSE AND VENOUS THROMBOSIS.

CENTRAL LINE

CARE PLAN

-ASSESSMENT OF IV SITE FOR SIGNS OF INFECTION, INFILTRATION (COOLNESS, SWELLING AND PAIN) OR EXTRAVASATION (PAIN, REDNESS, SWELLING, STINGING, TENDERNESS).

CERTAIN MEDICATIONS LIKE POTASSIUM, EVEN WHEN GIVEN CORRECTLY, MAY CAUSE IRRITATION.

- DOCUMENTATION AND NOTIFY MD

A PATIENT WHO HAS NEVER BEEN ON A VENTILATOR MAY BE REALLY FRIGHTENED. THE FAMILY MAY ALSO HAVE DIFFICULTY WITH WHAT THEY SEE.
LINES, TUBES AND ALARMS MAY ALL BE NEW. IT IS THE RESPONSIBILITY OF THE MEDICAL STAFF TO HELP ALLAY THESE FEARS.

PATIENT AND FAMILY EDUCATION SHOULD NOT BE IGNORED. REASSURE PATIENT AND MEDICATE AS ORDERED. ENCOURAGE FAMILY TO VENTILATE THEIR CONCERNS.
EXPLAIN POLICIES AND PROCEDURES.

SAMPLE OF A CARE PLAN FOR THE VENTILATED PATIENT

- FOLLOW MD ORDERS
- RESPIRATORY TX. AS ORDERED

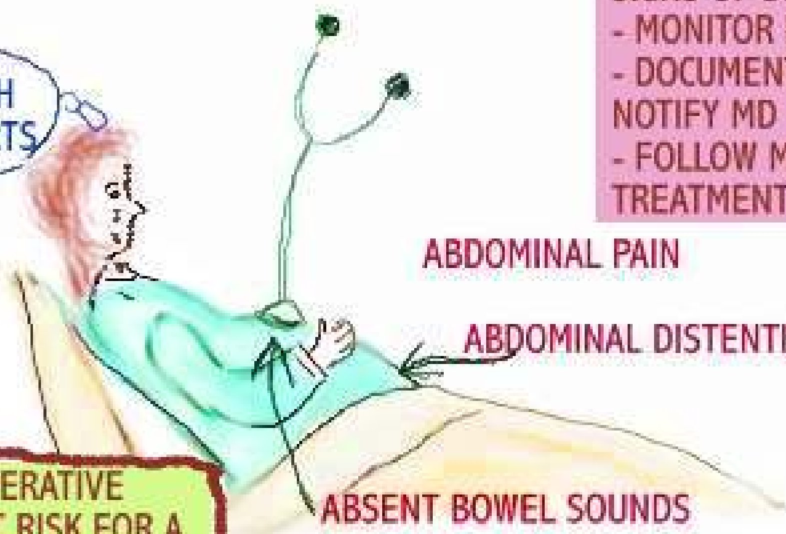
VENTILATOR SETTINGS, LAB VALUES, PAIN AND ANXIETY MEDICATIONS

- MAINTAIN A PATENT AIRWAY
- SUCTION AS ORDERED
- POSITION FOR COMFORT
- CHECK LUNGS Q 4 HR AND PRN
- MONITOR RESPIRATORY, NEURO AND CARDIAC STATUS
- TURN Q 2HR OR AS ORDERED
- MONITOR FOR SKIN BREAKDOWN
- CHECK VENTILATOR TUBINGS FOR WATER
- CHECK ALARMS ARE ACTIVATED
- RECORD ALL FINDINGS AND INTERVENTIONS, NOTIFY MD IF ANY PROBLEMS

PARALYTIC ILEUS

CARE PLAN

- MONITOR ABDOMEN FOR SIGNS OF DISTENTION
- MONITOR BOWEL SOUNDS
- DOCUMENT FINDINGS AND NOTIFY MD
- FOLLOW MD ORDERS FOR TREATMENT



ARE SYMPTOMS OF AN ILEUS.

THE POST OPERATIVE PATIENT IS AT RISK FOR A PARALYTIC ILEUS, RELATED TO MEDICATIONS USED IN AND AFTER SURGERY.

AN ILEUS MAY DEVELOP IN THE POST-OPERATIVE PATIENT FOLLOWING ABDOMINAL SURGERY OR FROM THE USE OF NARCOTICS.

SYMPTOMS OF ABDOMINAL PAIN AND DISTENTION, ABSENT BOWEL SOUNDS, NAUSEA AND VOMITING ARE COMMOMLY FOUND WITH AN ILEUS.

IT IS IMPORTANT TO ASSESS AND DOCUMENT FINDINGS. NOTIFY MD AS SOON AS POSSIBLE. A NASOGASTRIC TUBE IS USUALLY ORDERED TO RELIEVE THE DISTENTION.

Mr.O is in liver failure. Past history includes 20 years of alcohol ingestion. He has an enlarged liver. His abdomen is grossly distended. He is very limited in what he can do. He is lethargic and has pedal edema.

CARE PLAN

- POTENTIAL FOR SKIN BREAKDOWN DUE TO EDEMA
- ASSESS AND DOCUMENT ANY SKIN BREAKDOWN
- MONITOR NUTRITIONAL STATUS AND URINARY OUTPUT

CARE PLAN

- FOLLOW MD ORDERS
- POSITION FOR COMFORT
- MONITOR RESPIRATORY STATUS , O2 AS ORDERED
- TURN COUGH AND DEEP BREATHE
- DISCUSS WITH PATIENT AND FAMILY THE PLAN OF CARE

SPECIAL CONSIDERATIONS FOR THE PATIENT ON LONG TERM BEDREST.

Skin is jaundiced

POTENTIAL FOR SKIN BREAK -DOWN

PREVENT DEEP VEIN THROMBOSIS

TED hose

SEQUENTIAL COMPRESSION DEVICE (SCD)

SPECIALTY BED WITH AIR MATTRESS TO PREVENT PRESSURE SORES

PREVENT PNEUMONIA

CARE PLAN

FOLLOW MD ORDERS

- SPECIALTY BED
- TURN, COUGH/DEEP BREATHE
- TRIFLOW AS ORDERED
- COMPRESSION STOCKINGS
- GOOD MOUTH CARE

GOOD MOUTH CARE HEL
PREVENT INFECTION.

TOOTHPASTE

TOOTHBRUSH

RENAL FAILURE

DIETARY CHANGES SUCH AS LOW SODIUM AND POTASSIUM ARE PART OF THE TREATMENT

RENAL ARTERY

RENAL PELVIS

RENAL MEDULLA

RENAL VEIN

A STETHOSCOPE CAN BE USED TO HEAR THE LOUD, PULSATING SOUND(CALLED A BRUIT)AT THE AV FISTULA SITE.

CHECK THE CIRCULATION

AV FISTULA

FOR MORE HELPFUL INFORMATION ON RENAL FAILURE, PLEASE GO TO CHAPTER 3.

WHEN THE KIDNEYS ARE NO LONGER ABLE TO PERFORM THEIR NORMAL FUNCTION, RENAL FAILURE OCCURS. DEPENDING ON THE CAUSE, RENAL FAILURE MAY BE ACUTE OR CHRONIC.

THE PATIENT IN RENAL FAILURE MAY DISPLAY NEUROLOGICAL CHANGES, SUCH AS MENTAL CONFUSION AND LETHARGY, RELATED TO RENAL STATUS. ASSESSMENT AND DOCUMENTATION OF THE NEUROLOGICAL AS WELL AS THE RENAL STATUS IS IMPORTANT. DISCUSS WITH PATIENT AND FAMILY WHAT TO EXPECT, AS WELL AS DIETARY CHANGES AND HEMODIALYSIS.

CARE PLAN

- FOLLOW MD ORDERS
- MONITOR NEURO AND RENAL STATUS
- STRICT I/O, WEIGHTS,
- PREVENT SKIN BREAKDOWN, TURN, COUGH AND DEEP BREATHE IF ON BEDREST, TED HOSE OR SCDS
- MONITOR AV FISTULA FOR CIRCULATION AND INFECTION
- NOTIFY MD OF ANY SIGNIFICANT CHANGES

HOPE YOU ENJOYED LEARNING!