Adult Health II Clinical Case Study

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The purpose of this case study is to integrate previous knowledge from the humanities and sciences, including nursing research and theory, to plan, provide, and evaluate holistic care provided to a client. This study will include the appropriate physiological, psychological, social, cultural, and environmental influences pertaining to the patient as it relates to their disease process and the care necessary for it.

This case study reflects on patient TP, a 69 y/o Male, who was admitted to Mary Immaculate Hospital ED on 10/1/18, and then transferred to their cardiac unit, for respiratory distress related to his End Stage Renal Disease (ESRD) and early stages of pulmonary edema. He has a history of Diabetes Mellitus (DM), Hypertension (HTN), Coronary Artery Disease (CAD), prostate cancer, Congestive Heart Failure (CHF) exacerbation, hyperkalemia, liver metastasis, lumbar stenosis, Diastolic CHF, post-op fever, chest pain, pneumonia, pleural effusion, hypoxemia, hypoxia, fluid overload, hypertensive emergency and urgency, bilateral leg weakness, arthritis, unsteady gait, and he is blind in his left eye due to trauma from a car accident in 1976. TP was placed on fluid restrictions and he is a Monday, Wednesday, Friday dialysis patient.

Some background on TP is that he is from Yorktown, VA where he and his 18 brothers and sisters lived for most of their lives, in his family he is the 14th child. He has three adult daughters from different women, and each of them has school and toddler age children. TP was married to his eldest child’s mother, but she passed away 8 years ago. For about 40+ years he was a bricklayer and enjoyed his job. Unfortunately, he had to retire early on due to his DM diagnoses, TP stated that the illness runs in his family – 5 brothers and 3 sisters have it- and that he knew it would be detrimental to his health if he continued working. After that, he temporarily worked as a cashier at a Harris Teether where he would walk to work every day until he was “too old and too sick” to work. TP stated that he used to live alone and enjoyed it, but he would always fall and have to call the paramedics to help him. When asked if he would be willing to live with his daughters or siblings, he stated that he does not want to bother them. That they had their own families and lives to worry about. Now he currently resides at St. Francis Rehabilitation Center in Newport News, VA due to his lumbar stenosis surgery, and he states that he enjoys the facility.

**Medical Diagnosis**

TP was admitted to the hospital for respiratory distress related to ESRD and early stages of pulmonary edema. The underlying pathophysiology of his diagnoses all relates back to his ESRD which leads to fluid volume disturbances such as fluid overload. That excess fluid led to his pulmonary edema and eventually his respiratory distress.

ESRD is what occurs when Chronic Kidney Disease continues to be untreated and has reached the final stages of renal failure. This condition is often irreversible. ESRD then causes the blood to retain uremic waste products because the kidneys are no longer functioning enough to filter out the waste products. There are many reasons why CKD or even ESRD occurs, but it is believed to be caused by long-term acute inflammation (Hinkle & Cheever, 2013). TP was in Stage 5 ESRD, which is determined by the patient’s GFR levels. For Stage 5 ESRD, the GFR is <15 mL/mL/1.73m2, and TP’s was 12 mL/mL/1.73m2. In stage 5, the kidneys cannot remove the body’s metabolic wastes or perform their regulatory functions. This allows waste to build up in the blood. Oliguria and even anuria occur because the kidneys do not function enough, or they are not receiving enough blood flow to have an adequate output. In an average patient, ESRD can manifest as nausea, vomiting, anorexia, fatigue and weakness, sleep disturbances, oliguria/anuria, altered mental status, muscle twitches, and cramps, edema, pruritus, chest pain, dyspnea, shortness of breath (SOB), and hypertension; further complications when ESRD remains untreated are fluid retention which could be accompanied by weight gain and can spread to pleural spaces and the lungs, hyperkalemia, and cardiovascular disease (Mayo Clinic, 2018). A patient could also experience hyperphosphatemia and hypocalcemia. For labs, it is expected to find elevated serum creatinine levels, anemia, elevated potassium and phosphorus levels, decreased sodium and levels, decreased GFR, which is used as a diagnostic tool for the stage of ESRD, increased BUN, and they can have metabolic acidosis (Hinkle & Cheever, 2013).

As for TP, he had SOB and dyspnea, which was accompanied by a wet non-productive cough, wheezing upon inspiration and expiration, and crackles could be heard on expiration. When auscultating his lungs, crackles could be heard in the bottom and middle lung fields posterior and anterior. His SpO2 was 100% but only with 1L of oxygen nasal cannula, without it, it dropped to 93%. He also had a respiratory rate of 20, which made him slightly tachypneic. Pleural rubbing could also be heard near the bases. When assessing his skin, TP had non-pitting edema in his legs, and the skin was stretched, dry, cracking, pale, and dusky. His BUN was 31mg/dL which is elevated, creatinine 6.52 mg/dL increased, RBC was 4.06 mill/cumm normal low, his Hct was 32.5% and Hgb was 9.8 gm/dL which are low values for a male. His potassium was 4.1 mEq/L which is normal, sodium 142 mEq/L also in the normal range, calcium was 9.0 mEq/L also normal, and his phosphorus was not recorded. TP was also oliguric, only having liquid brown diarrhea. He did not present with anorexia, but he did have bilateral lower extremity weakness. He did have hypertension, having a high BP of 158/62 and his lowest BP 137/55. His mental status remained A&Ox4 throughout his stay, and he had no sleep disturbances. He also had a chest X-ray done on the day of his admission, and the notes taken were that there appeared to be patchy infiltrative change at the right base and left perihilar regions. Meaning that the area has lung consolidation, which is when fluid fills the lungs. TP also did not present with the anticipated metabolic acidosis, but rather with metabolic alkalosis due to his increased pH level of 7.46.

The fluid overload occurred for TP because his kidneys cannot concentrate or dilute urine normally. Therefore, the kidneys do not respond to the changes in the daily intake of water or electrolytes, it then causes him to retain water and sodium (Hinkle & Cheever, 2013, pg. 1541). Meaning that his fluid intake exceeded the ability if his kidneys to excrete fluid. Since TP was oliguric, little to no fluid was being excreted. Next, fluid overload led to his pulmonary edema. Which can develop slowly when it is caused by renal failure and its fluid overload manifestation. “What occurs is that the left ventricle cannot handle the volume overload, and the blood volume and pressure build in the left atrium. The rapid increase in atrial pressure results in an acute increase in pulmonary venous pressure, which produces an increase in hydrostatic pressure that forces fluid out of the pulmonary capillaries and into the interstitial spaces and alveoli” (Hinkle & Cheever, 2013, pg. 811). Finally, this developed into the respiratory distress that had TP admitted. His ventilation or perfusion mechanism in his lungs was impaired, which was caused by the accumulation of fluid in his lungs and alveoli, his Pulmonary edema. He could not get the adequate oxygenation that he needed, which could be seen from his previously stated respiratory data.

**Nursing Diagnosis**

TP’s diagnoses are impaired gas exchange related to his ventilation-perfusion imbalance and alveolar-capillary membrane changes, decreased cardiac output related to his decreased oxygenation, CHF and CAD, and fluid volume excess related to renal insufficiency, and deficient knowledge related to periodic lack of interest in learning, misinterpretation of information, and unfamiliarity with information resources, and powerlessness related to his chronic illness, his placement in his rehab center, his inability to perform role responsibilities, lack of knowledge, and loss of control over life decisions.

Impaired gas exchange is a priority diagnosis, because TP came in with respiratory distress, and still demonstrated respiratory distress the following day. While the fluid volume is a concern, a priority for him would be to make sure that he is getting enough oxygen into his system. In the ABC’s of nursing, airway, breathing, and circulation are the priorities in a patient. When following the same practice, there is no obstruction in TP’s airway, but there is an issue with his breathing. His ventilation-perfusion is off because no gas exchange can occur in his alveoli because there is too much fluid in his lungs. This is a priority, because out of the rest of his diagnoses, his inability to get oxygen circulating through in his system would be the first thing to kill him.

Decreased cardiac output is next because when this occurs, the heart is not pumping enough blood throughout the body to meet its needs. This causes the heart to work harder to meet the body’s needs, but it is futile and tires the heart out. This can lead to decreased blood flow to the brain and other vital organs and can cause irreversible damage (Pai, Gabica, Husney & Fort, 2017). This is especially an issue with TP’s 1st degree AV block. While it is normally insignificant on its own, the delay in conduction to the ventricles can create more complications when it the heart pumps faster and works harder to make up for the decreased cardiac output. Normally the heart can compensate for heart failure for many years, but the duration of compensation can be extremely variable and depends on the source of heart failure and other medical problems (Pai et al., 2017). Alongside his 1st AV block, TP had fluid overload, CHF, CAD, and has a history of hypertensive crisis, all which can speed up the rate at which his heart could fail.

It is true that most TP’s problems are caused by his fluid overload, but as stated before, the consequences of fluid overload would kill him before the actual overload did itself. Fluid volume excess is next because it can be treated through dialysis and fluid restrictions for TP. Still, it is after impaired gas exchange and decreased cardiac output because there is no guarantee that when the fluid volume is addressed, that those two diagnoses would be resolved.

Deficient knowledge is next, because when passing his morning medications, TP would look out the window or watch TV rather than hear what his medications were for. Also, when speaking TP, he could not verbalize what his medications were for or what have the nurses done for him. He explained that he only waits for his doctor to come and tell him how he is doing and what is going to be done next. He was then asked he ever asks for clarification or asks questions and he stated no and that there is no need, the doctor will “fix him”. Until TP understands enough about his condition to consider and make decisions about his health, without being told what to do, he will continue to feel powerless. Patient education is important because it lets them know how to manage their conditions and avoid getting readmitted into the hospital. It also reduces fear and anxiety about interventions that can be done, because they know what to expect and why they are receiving the care they are. By getting TP interested in his health/treatment and letting him know the decisions he can make, it would increase his knowledge.

Powerlessness, is last because as stated before TP is used to being a provider for his family. He enjoys working, making his own money, and living on his own. Due to his condition and old age that is no longer a possibility for him. He is even unwilling to consider turning to his family for assistance, because he does not want to be a burden. This last diagnoses pairs with his deficient knowledge, because an increased knowledge of his condition and his treatments, TP can exercise more independence in his care and can understand that he also plays a role in his health and that it is not determined by outside forces.

**Nursing Theory**

A nursing theory that best encompasses each diagnosis and how they affect one another is The Nursing Process Theory by Ida Jean Orlando. The theory created the steps that are used in the nursing process today: assessment, diagnosis, planning, implementation, and evaluation. It focuses on the interaction between the nurse and patient and the use of the nursing process to increase positive outcomes or patient improvement (Petiprin, 2016). The theory believes that a patient is an individual who cannot manage their medical illnesses without outside assistance. When their medical needs are not met, they begin to feel helpless and powerless. It also states that it is important for the nurse to build a trusting and therapeutic relationship with the patient to address their needs, which is the nurse’s role. It is also the role of the nurse to use insight, perception, and intuition to determine what the patient's needs are. What must first be done in this theory is that the nurse needs to recognize that the patient has a problem, then they must understand that any observations the patient demonstrates, or shares are relevant and useful then and there to determine whether the patient is in need of assistance, and the nurse then monitors the patient to see how they react to the actions (Nursing Process, 2018).

 This theory relates to the nursing diagnoses because the nursing process was used to determine what issues TP had and what to prioritize him with. When assessing him and looking at his labs and diagnostics, it was clear that he was not getting enough oxygen in his system due to his respiratory distress. TP’s main complaint was that it hurt to breathe, and it felt like he had a chest cold. Based on a patient statement and supporting assessment data, that was stated previously, his impaired gas exchange is a priority. TP could not verbalize that his decreased cardiac output and fluid overload needed to be addressed next, but again, his assessment data demonstrated that they needed to be addressed. The decreased cardiac output is the next priority for him, because he would not be able to manage it on his own in the condition that he is in, nor would he have enough of an understanding to manage it on his own. Finally, TP showed that he had deficient knowledge and powerlessness when he demonstrated that he did not understand his medications, what they were for, and how they work to help him. TP was also unaware that he has power in his health and has a say in what he wants to be done. This was observed when taking the time to communicate with him. TP is used to being a provider for his family, and caring for himself, so this is a change for him. By knowing this, proper intervention could be done to reduce his helplessness.

**Outcomes**

Outcomes for TP’s impaired gas exchange that would prove improved health are: clear lung fields upon auscultation and see that he is remaining free of signs of respiratory distress, SpO2 is within normal range while on room air, and that his blood gases go back to a normal range rather than remain in metabolic alkalosis. As for his decreased cardiac output some outcomes are: TP has clear lung sounds as manifested by absence of pulmonary crackles, he will verbalize the importance of participating dialysis, and that he will be able to describe symptoms that would require a trip to his doctor as well as state actions and precautions he needs to take for cardiac disease all before discharge.

**Literature** **Review**

**Article 1**

The article “Extracorporeal membrane oxygenation for critically ill adults in ICU – A nurse-led multidisciplinary Cochrane Collaboration systematic review”, is a systemic review of randomized control trials, with a sample size of four. It examines the effectiveness of Extracorporeal membrane oxygenation for critically ill adults. EMCO provides gas exchange and circulation when the body can no longer do it on its own. While ECMO is often used for critically ill newborns and infants, it has begun being used for adult patients to see if it has the same effectiveness. In this study, data was collected and analyzed to determine whether ECMO is effective in supporting the respiratory and circulatory system of adults. It was measured through mortality rates within 30, 60, 90 days and/or at six months. Unfortunately, the results remained inconclusive. One of the trials did show that there was a higher survival of patients who were using the ECMO during the six-month period. The evidence could not be further analyzed, because of changes in the clinical trial process, that prevented meta-analysis to be conducted for all four RCTs (Tramm, Ilic, Davies, Pellegrino, Romero & Hodgson, 2015).

Even with the lack of results, there is significance to this article in its relation to TP. TP was in critical condition when he was admitted to the ER for his respiratory distress. While that was his priority concern, he also had issues with his cardiovascular and renal systems that landed him on the cardiac unit. Even though his condition was stabilized, it can be said that he could have easily taken a turn for the worst. In that situation, it would be beneficial to know if using ECMO on him would be successful in getting his gas exchange and circulation back to his normal baseline. Which would be addressing his top two priority diagnoses. The lack of results also demonstrates that there is a need for more nursing-based research on interventions for impaired gas exchange in patients that fit the similar criteria as TP.

**Article 2**

The next article is a systemic review, which included 13 studies with a total of 540 patients “Severe hypoxemia: which strategy to choose”. The article tries to determine the best management strategies for ARDS patients with severe hypoxemia. The results ended up being that it the interventions that best worked are tailoring ventilation therapy to the individual patient to reduce the risk of lung injury, have a target oxygenation of 88–92 %, while allowing moderate levels of hypercapnia, using neuromuscular blocking agents (NMBAs) to maintain patient–ventilation equilibrium; positioning patients in prone or semi-Fowler's position to improve oxygenation, promote a more equal distribution of ventilation, and reducing the risk of lung injury; and the use of extracorporeal membrane oxygenation (ECMO). While the latter is still debatable, much like stated in the first article, it should still be considered as a rescue intervention. All the interventions resulted in an improved outcome when applied in the acute phase in the most severe cases. Overall, when the interventions are applied efficiently and accurately, they ensure adequate gas exchange while minimizing the risk of lung injury (Chiumello & Brioni, 2016).

 This is significant, because TP was in respiratory distress, and that raised his risk of becoming hypoxemic, especially since he has a history of it. Without oxygen in his blood, it can cause more damage to his organs, especially his kidneys, lung, heart, and brain. The need for perfusion and circulation is necessary for the improvement of his condition. If he were to get to that point and need interventions, this article provides that information. It allows nurses to know that the interventions chosen are very likely to have a high success rate.

**Article 3**

The final article, “A New, Noninvasive Method of Measuring Impaired Pulmonary Gas Exchange in Lung Disease: An Outpatient Study” is a cohort study with 17 patients who are afflicted with some sort of pulmonary disease, and 31 “normal” patients, making a total sample size of 48. The purpose of the study is to determine if there can be a noninvasive method of measuring impaired gas exchange in patients with lung disease. It was discovered that gas exchange could be calculated by having PCO2 continually measured by small, rapidly responding analyzers, and calculating the PO2 difference between the end-tidal gas and the calculated arterial value to determine if there is a deficit. The results even should that the results were the same in both groups for when using this method and comparing the results received from arterial blood gases (West, Crouch, Fine, Makadia, Wang & Prisk, 2018).

The significance of this article to TP is that it reduces the need to continuously puncture patients for arterial blood, and in turn reduces the risk of patients getting an infection or having more complications. This is relevant to TP, because part of his treatment is monitoring his ABGs, and to do so, it would require multiple punctures to get arterial blood. TP only had one ABG conducted during the study, using this method could also allow for a closer monitoring of his blood gases that would track his progress. Also, given that TP has multiple other chronic illnesses, it is in his best interest to make most of his interventions non-invasive. It is also more convenient and would not necessarily require orders to conduct.

**Interventions**

For TP’s impaired gas exchange, a dependent intervention for TP was placing him on 1L O2 when his breathing became more labored, and wheezing could be heard upon his inspiration and expiration, his respiratory rate was 20, and his SpO2 went down to 93% momentarily. TP tolerated this intervention well because his SPO2 rose to 100%. It was expected that his oxygenation levels would increase, and they did. The rationale behind providing TP with supplemental oxygen is that it was necessary to increase and maintain his blood oxygen levels. When respiratory failure occurs, there is a reduction of oxygen in the blood, and an increase of carbon dioxide; oxygen then is prescribed to treat hypoxemia in respiratory failure (Lynes & Kelly, 2013). Not only that but like stated in the article, “Severe hypoxemia: which strategy to choose” it also states that supplemental oxygen allows for adequate gas exchange and reduces the risk of lung injury (Chiumello & Brioni, 2016). An independent intervention that was done was raising the head of TP’s bed to Semi-Fowler’s position when his breathing became labored, he began to cough more, used accessory muscles, and had nasal flaring. It was the expected that the work of breath would decrease. The success of the positioning of the bed was determined by patient statement and assessment, TP stated that his breathing became easier when the head of the bed was elevated, and his use of accessory muscles and nasal flaring decreased. The same literature “Severe hypoxemia: which strategy to choose” can be used for this intervention, putting a patient in semi-Fowlers also allowed for adequate gas exchange and reduced the risk of lung injury. Unfortunately, there were no collaborative interventions conducted for TP in relation to his impaired gas exchange, but an alternative intervention could have been implemented, as explained later. Additional rationale states that raising the head of the bed to semi-Fowler’s also allows increased thoracic capacity, full descent of diaphragm, and increased lung expansion preventing the abdominal contents from crowding (Gulanick, & Myers, 2017, pg. 94).

For his decreased cardiac output, a dependent intervention done was to administering TP’s cardiac medications: amlodipine besylate 5 mg PO, aspirin 81 mg PO, carvedilol 25 mg PO; clonidine hydrochloride 0.3 mg PO bid, and hydrALAZINE hydrochloride 50 mg PO. The purpose of TP’s amlodipine besylate is that it is a calcium channel blocker and it works to increase cardiac output and decrease peripheral resistance, his aspirin is an anticoagulant used prevent clots, and reduce his risk of getting a heart attack, carvedilol is a beta blocker used to treat high blood pressure and heart failure, clonidine hydrochloride is an antihypertensive to treat high blood pressure, and hydrALAZINE hydrochloride is a vasodilator to treat high blood pressure (Kizior & Witmer, 2018). Before administering his medication, his blood pressure, heart rate, pulse, and capillary refill were assessed. The rationale behind administering TP’s medication is that they prevent his heart from failing, as recommended by national organizations (Gulanick, & Myers, 2017, pg. 337). Not only that, but when referring to “Extracorporeal membrane oxygenation for critically ill adults in ICU – A nurse-led multidisciplinary Cochrane Collaboration systematic review” it states that in more severe cases respiratory failure or severe cardiac failure ECMOs are used, as rescue therapy, or a last resort. It works to provide gas exchange and systemic circulation (Tramm et al., 2015). When administering TP’s cardiac medication, it allows for proper system circulation and in turn gas exchange, that would not require the usage of a rescue therapy. An independent intervention that was assessing TP’s skin color, temperature, and moisture. The color of his skin remained dry, flaky, dusky, and pale during his stay, and his temperature began elevated at 98.6F but dropped to 97.4F. The rationale for this intervention is that “cool, pale, clammy skin is secondary to a compensatory increase in sympathetic nervous system stimulation and low cardiac output and desaturation” (Gulanick, & Myers, pg. 385). A collaborative intervention that was done was that TP’s laboratory data was monitored, especially arterial blood gases and electrolytes, including his potassium levels. The rationale behind this connects to the article “A New, Noninvasive Method of Measuring Impaired Pulmonary Gas Exchange in Lung Disease: An Outpatient Study”. The purpose of ABGs are to measure impaired gas exchange but can also indicate if there is damage to the heart. The article “The Prognostic Value of Arterial Blood Gas Analysis in Acute Heart Failure Patients” elaborates more on this by stating that in acute heart failure (AHF) patients, pulmonary edema and low tissue perfusion may lead to changes in the acid-base balance, and ABG provides an additional prognostic value and may be used to determine high-risk AHF patients (Park et al, 2014).

**Cultural Considerations**

The culture and special needs of TP impacted the care that he was provided. While it was not an obvious cultural need, to care for TP patience was required. He needs someone to take the time and calmly listen to him and let him air out his frustrations before calming down and getting his point across. Like stated before, TP is used to being a provider and have the responsibility of taking care of his children and wife. Also, he will not place himself in a position that would burden his children, he does not even want to live with his daughters because of this reason. Living at the St. Francis Rehabilitation center and being admitted to the hospital is a great change for him. Not only that but TP does not fully understand why he’s in the hospital, he does not understand what the nurses are doing for him, and why they are doing it. He is not in a position where he feels in control. It was interpreted that one-way TP attempts to regain his control is by having nursing wipe him even if he can wipe himself. Though it may not be true, there is also the possibility that relates to his fear of falling. TP knows that he is unsteady and can fall without assistance, and so by having someone wipe for him when he’s done using his bedside commode, he is able to have both hands holding and stabilizing him so that he does not fall. While it may seem on the surface that TP is being difficult in having nurses wipe him, having the patience to take a step back and view him holistically can see there are other factors at play when considering his behavior. Another cultural consideration is TP’s age, he is at an age where independence is not as possible as it would be for a younger counterpart. Normally for a patient his age, the best route it to tell the patient what needs to be done, and state, it is his best route. This is due to the patriarchal take of medicine -where the doctors and nurses tell the patient what needs to be done- that older generations are used to. Making their own medical decisions was not as much of a priority. For TP that is not the case, he needs to know that he can still control some things in his life, so letting him know of his options and allowing him to make his own decisions can be beneficial. Using this approach with patient teaching would be beneficial because then TP will understand what each medication is for. Not only that, but he can understand the role PRN medications play in his health and could start requesting them himself, rather than with promoting by the nurse.

**Evaluation**

Based on the outcomes for TP, the effectiveness of the plan of care could not be fully determined, because TP’s discharge was not examined during the time of the study. The outcomes for TP’s impaired gas exchange that would have been good to see by his discharge to show his impaired gas exchange was addressed are that clear lung fields upon auscultation and see that he is remaining free of signs of respiratory distress, SpO2 is within normal range while on room air, and that his blood gases go back to a normal range rather than his metabolic alkalosis. His outcomes were partially met during the study. TP’s final assessment showed that there were still crackles heard when auscultating TP’s lungs, he still had dyspnea and bouts of coughing and SOB. TP did achieve a SpO2 within a normal range on room air, by the end of the clinical day, TP was at 98% on room air. Lastly, TP’s ABGs were not taken again during the clinical day, and so it was not determined if his blood gasses went back to normal levels.

As for his decreased cardiac output the outcomes were that TP has clear lung sounds as manifested by absence of pulmonary crackles, he will verbalize the importance of participating dialysis, and that he will be able to describe symptoms that would require a trip to his doctor as well as state actions and precautions he needs to take for cardiac disease all before discharge. The outcomes were partially met during the study. As stated before, TP did not have clear lung sounds. He was able to verbalize the importance of participating in dialysis and even stated that he would be sure to attend each of his sessions. TP understood that he had too much fluid in his body, and even restricted his fluids with no prompting from the nurses. TP was able to verbalize 3 precautions that he needs to consider for his cardiac disease, he knew to avoid sodium, to have a diet that is low in “bad” fats, and to keep his blood pressure low.

**Alternative Interventions**

An alternative intervention for impaired gas exchange would be a collaborative one. To encourage or assist with ambulation as per physician’s order or through physical therapy. TP had bilateral lower extremity weakness, meaning he was bedridden for much of his stay, only ambulating to use a bedside commode.TP did not use any assistive devices, even though he could have greatly benefited from one. This led him to remain a fall risk. The benefit of working with PT and encourage and assisting him with the exercises would allow him to build strength in his lower extremities. As for his impaired gas exchange, participating in PT would help facilitate lung expansion, secretion clearance, and stimulate deep breathing (Gulanick, & Myers, 2017).

A collaborative alternative intervention for decreased cardiac output it to work with TP’s case manager and plan to have him discharged to heart failure program or cardiac rehabilitation program for education, evaluation, and guided support to increase activity and rebuild a life. TP already resides in a rehabilitation facility, if his heart’s condition would worsen, it would be in TP’s best interest to be in a more specialized rehab facility. The rationale for this intervention is that it would provide a monitored exercise program can improve both functional capacities and left ventricular function (Gulanick, & Myers, 2017).

**Conclusion**

In this study, the clinical journey of a patient admitted for respiratory distress was examined to gain an understanding of the nursing process dealing with his care. Not only that but the pathophysiology of ESRD, its complications, the treatment of both, and nursing implications were carefully reviewed and developed. When approaching this type of patient demonstrating this clinical picture, it is best to communicate with the patient, they understand their body best, even when they cannot understand their illnesses. They are a crucial piece in achieving health. It is in the best interest of the nurse and the patient that there is no judgment when caring for a patient, it leads to assumptions about the reasoning behind a patient’s behavior, signs, and symptoms, and can lead to poor care provided. This study is important because it is important as nurses to understand the nursing process in this clinical setting, and how to properly provide care to patients.

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Nursing Honor Code

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(Print Name)

Signature: \_\_\_\_\_\_\_\_\_Sarah Jean\_\_\_\_\_\_\_\_\_\_

Date: 10.15.18