

MEDICATION WORKSHEET

Name: Eduard Matsko

Date: 01/31/2014

Patient: W.Y. **Diagnosis:** SDH, SAH, Bilateral Skull Fracture **Allergies:** NKA **Weight:** 106 KG

Unit/Bed: ICU/20

<p align="center"><u>ORDER</u></p> <p>Drug Name (generic & trade) Dosage, Frequency, Route</p> <p align="center"><u>Show dosage calculations</u> *Include all IV continuous medications*</p>	<p align="center"><u>DRUG CLASSIFICATION/ THERAPEUTIC USES</u></p> <p>Identify pharmacologic/therapeutic classification Describe mechanism of action for the drug and the END RESULT of that action Describe how <u>your patient</u> will benefit from this drug *For insulin, include onset, peak and duration</p>	<p align="center"><u>PATIENT-SPECIFIC NURSING RESPONSIBILITIES</u></p> <p>1. Identify <u>your specific nursing responsibilities</u> related to the administration of <u>this medication to your patient</u>. 2. Include all patient specific data relevant to this drug (i.e. HR=82, K=4.1)</p>
<p>Drug Name: FentaNYL Dose: 1mg in 230mL NS Frequency: Continuous Route: IV Rate: 6.25mL/hr Calculations:</p>	<p>1. Pharmacologic/therapeutic classification of drug: Opioid analgesic, opioid agonist</p> <p>2. Mechanism of action and the end result: Binds to opiate receptors in the CNS, altering the response to and perception of pain, which produces CNS depression. This causes a supplement in anesthesia and decreased pain.</p> <p>3. Pt. Specific Benefit of this drug: Analgesic supplement to general anesthesia, Induction/maintenance of anesthesia. Will help keep patient's ICP down.</p>	<p>1. Pt. specific nursing responsibilities for this drug: Monitor respiratory rate, heart rate, and blood pressure. Significant changes may indicate overdose. Check IV site.</p> <p>2. Pt. specific data relevant to this drug: BP - 180/74, 182/74 Respiratory Rate - 10, 10 Heart Rate – 63, 65</p>
<p>Drug Name: Propofol Dose: 100 mL Frequency: q8 hours Route: IV Rate: 5-10mcg/kg/min Calculations:</p>	<p>1. Pharmacologic/therapeutic classification of drug: General anesthetics</p> <p>2. Mechanism of action and the end result: Mechanism of action is unknown. It is a short-acting hypnotic that produces amnesia, but has no analgesic properties. It causes induction and maintenance of anesthesia.</p>	<p>1. Pt. specific nursing responsibilities for this drug: Monitor respiratory rate, heart rate, and blood pressure. Significant changes may indicate overdose. Check IV site. Assess sedation and LOC.</p> <p>2. Pt. specific data relevant to this drug: BP - 180/74, 182/74 Respiratory Rate - 10, 10</p>

	<p>3. Pt. Specific Benefit of this drug: Sedation of intubated, mechanically ventilated patients in intensive care units. Will help keep patient's ICP down.</p>	Heart Rate – 63, 65
<p>Drug Name: Levetiracetam Dose: 500mg in 100mL NS Frequency: q12 hours Route: IV Rate: 400mL/hr Calculations:</p>	<p>1.Pharmacologic/therapeutic classification of drug: Anticonvulsants, pyrrolidines</p> <p>2. Mechanism of action and the end result: Inhibits burst firing without affecting normal neuronal excitability and may selectively prevent hypersynchronization of epileptiform burst firing and propagation of seizure activity. This decreases the incidence and severity of seizures.</p> <p>3. Pt. Specific Benefit of this drug: To prevent seizures.</p>	<p>1. Pt. specific nursing responsibilities for this drug: Assess location, duration, and characteristics of seizure activity. Assess patient for adverse CNS effects throughout therapy. Check IV site.</p> <p>2. Pt. specific data relevant to this drug: SDH, SAH, Bilateral Skull Fracture</p>
<p>Drug Name: Piperacillin/ Tazobactam Dose: 3.375g in 50 mL NS Frequency: q8 hours Route: IV Rate: 12.5mL/hr Calculations:</p>	<p>1.Pharmacologic/therapeutic classification of drug: Anti-infectives, extended spectrum penicillins</p> <p>2. Mechanism of action and the end result: Piperacillin binds to bacterial cell wall membrane causing cell death. Tazobactam inhibits beta-lactamase, an enzyme that can destroy penicillins. This causes death of susceptible penicillins.</p> <p>3. Pt. Specific Benefit of this drug: Prevent infection.</p>	<p>1. Pt. specific nursing responsibilities for this drug: Check IV site. Assess patient for infection by checking vital signs, WBC, and appearance of wound, sputum, urine, and stool. Assess patient for signs and symptoms of anaphylaxis. Obtain specimens for culture and sensitivity. Evaluate renal and hepatic function, CBC, serum potassium and bleeding times before and during therapy.</p> <p>2. Pt. specific data relevant to this drug: Patient has a foley catheter, ICP bolt, and stage II pressure ulcer. Patient is sedated, immune system may not be working at 100%.</p>
<p>Drug Name: Vancomycin Dose: 1.25g in 50mL NS Frequency: q12 hours</p>	<p>1.Pharmacologic/therapeutic classification of drug: Anti-infectives</p> <p>2. Mechanism of action and the end</p>	<p>1. Pt. specific nursing responsibilities for this drug: Check IV site. Assess patient for infection by checking vital signs, WBC, and appearance of wound,</p>

<p>Route: IV Rate: 166.66mL/hr Calculations:</p>	<p>result: Binds to bacterial cell wall, resulting in cell death. Bactericidal action against susceptible organisms.</p> <p>3. Pt. Specific Benefit of this drug: Prevent infection.</p>	<p>sputum, urine, and stool. Obtain specimens for culture and sensitivity.</p> <p>2. Pt. specific data relevant to this drug: Patient has a foley catheter, ICP bolt, and stage II pressure ulcer. Patient is sedated, immune system may not be working at 100%.</p>
<p>Drug Name: Insulin Regular Dose: 100u in 100mL NS Frequency: Continuous Route: IV Rate: 5.05mL/hr Calculations:</p>	<p>1.Pharmacologic/therapeutic classification of drug: Antidiabetics, hormones, pancreatic</p> <p>2. Mechanism of action and the end result: Lower blood glucose by stimulating glucose uptake in skeletal muscle and fat.</p> <p>IV Insulin - onset 10-30min, peak 15-30min, duration 30-60min</p> <p>3. Pt. Specific Benefit of this drug: Lowers blood glucose.</p>	<p>1. Pt. specific nursing responsibilities for this drug: Check IV site. Assess patient for signs of hypoglycemia. Monitor blood glucose every 6 hours during therapy.</p> <p>2. Pt. specific data relevant to this drug: Patient has diabetes, his morning BS was 156.</p>
<p>Drug Name: Hydralazine Dose: 10mg Frequency: PRN q4hr Route: IV Calculations:</p>	<p>1.Pharmacologic/therapeutic classification of drug: Antihypertensives, vasodilators</p> <p>2. Mechanism of action and the end result: Lowering of blood pressure in hypertensive patients and decreased afterload in patients with CHF.</p> <p>3. Pt. Specific Benefit of this drug: Lowers blood pressure.</p>	<p>1. Pt. specific nursing responsibilities for this drug: Check IV site. Monitor heart rate and blood pressure.</p> <p>2. Pt. specific data relevant to this drug: BP - 180/74, 182/74 Heart Rate – 63, 65</p>
<p>Drug Name: Docusate Sodium Dose: 100mg Frequency: bid Route: Tube Calculations:</p>	<p>1.Pharmacologic/therapeutic classification of drug: Laxatives, stool softeners</p> <p>2. Mechanism of action and the end result: Promotes incorporation of water into</p>	<p>1. Pt. specific nursing responsibilities for this drug: Assess for abdominal distention, presence of bowel sounds, and usual pattern of bowel function.</p> <p>2. Pt. specific data relevant to</p>

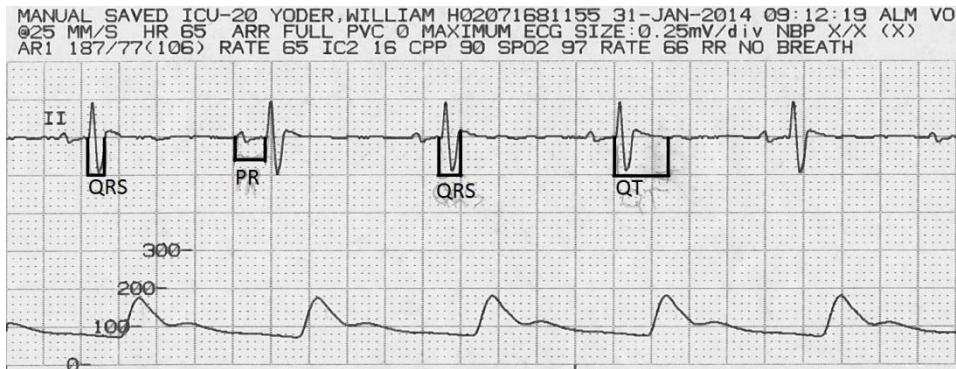
	<p>stool, resulting in softer fecal mass.</p> <p>3. Pt. Specific Benefit of this drug: Softening and passage of stool.</p>	<p>this drug: Bowel sounds hypoactive, abdomen distended.</p>
<p>Drug Name: Levophed Dose: 8mg in 250mL NS Frequency: qd Route: IV Rate: 9.675mL/hr Calculations:</p>	<p>1. Pharmacologic/therapeutic classification of drug: Alpha/Beta Adrenergic Agonists</p> <p>2. Mechanism of action and the end result: Strong beta1-adrenergic and alpha-adrenergic effects and moderate beta2 effects, which increase cardiac output and heart rate, decrease renal perfusion and PVR, and cause variable BP effects.</p> <p>3. Pt. Specific Benefit of this drug: Stabilize blood-brain barrier.</p>	<p>1. Pt. specific nursing responsibilities for this drug: Check IV site. Monitor heart rate and blood pressure. Assess renal function.</p> <p>2. Pt. specific data relevant to this drug: BP - 180/74, 182/74 Heart Rate – 63, 65 Urine output -160mL last shift</p>

ECG WORKSHEET

Student Name: Eduard Matsko

Date: 01/31/14

Label one complete complex. Mark and measure PRS, QRS and QT interval.



Underlying Rhythm

Underlying ventricular rhythm? Regular Irregular _____ Rate 66

P Waves present? Yes Regular? Yes

P Waves followed by QRS? Yes Atrial rate: 66

Describe configuration of P Wave or other atrial activity: Atrial depolarization and atrial contraction.

P-R Interval .16 Seconds. If variable, give range _____

Normal Prolonged _____ Shortened _____

QRS Duration _____ Seconds. If variable, give range .08-.12

Normal Prolonged _____

QT Interval 0.28 Seconds. Normal Prolonged _____

Other Observations: None.

Interpretation: Normal sinus rhythm with variable QRS.

Nursing Observations: Normal sinus rhythm with variable QRS.

Treatment: None needed.

<p>Medications</p> <ul style="list-style-type: none"> -Albuterol -Pantoprazole -Docusate Sodium -Potassium Chloride -Hydralazine -Heparin -Acetaminophen -Dextran -Petrolatum 	<p>Student Name <u>Ed Matsko</u> Client Initials <u>W.Y.</u> Date <u>1/30/2014</u></p> <p>Age <u>51</u> Gender <u>Male</u> Room # <u>20</u> Admit Date <u>1/23/2014</u></p> <p>CODE Status <u>Full Code</u> Allergies <u>NKA</u></p> <p>Diet <u>NUTREN 2.0 at 35 mL/hr via tube feed continuous</u> Activity <u>Full Assist</u> Braden Score <u>9</u></p>	<p>State lab values and identify trends.</p> <p>Na <u>157 H (135-145)</u> Cl <u>129 H (98-107)</u> BUN <u>16 (7-26)</u> Glu <u>148 H (70-100)</u> K <u>3.9 (3.5-5)</u> CO2 <u>139.9 (135-145)</u> Cr <u>0.757 (0.67-1.17)</u></p> <p>Ca <u>7.4 L (8.5-10)</u> Hgb <u>10.5 L (13.5-17.5)</u> Hct <u>33.7 L (41-53)</u> Mg <u>1.8 (1.6-2.6)</u> WBC <u>6.5 (4.5-11)</u> Plt <u>173 (150-450)</u> PO4</p> <p>State other appropriate lab results</p> <p>RBC <u>3.77 L (4.5-6)</u></p> <p>State diagnostic test results</p> <p>1/23</p> <p><u>-Chest X-Ray-</u> Consolidation at the left lower lobe with infiltrate, edema, left pleural effusion, and hemothorax</p> <p><u>-CT Abd & Pelvis-</u> Negative.</p> <p><u>-CT Thorax-</u> External bilateral lung consolidation.</p> <p><u>-CT Cervix-</u> Arthritis, no fracture.</p> <p><u>-CT Sinus-</u> Linear, minimally displaced fracture at right temporal squamosa and posterior frontal bone. Fluid at bilateral middle ears.</p> <p><u>-CT Head-</u> Epidural bleed with subarachnoid hemorrhage and posterior parietal</p>
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		<p>subdural hematoma..</p> <p>1/25 <u>-CT Head-</u> Decrease in size of right temporoparietal epidural hematoma, left midline SDH has no change, decreases in left SAH, 4mm shift left to right of blood within intraparenchymal hematoma with edema. <u>-Echocardiogram-</u> Effusion at 65%. <u>-Unrine Analysis-</u> Negative <u>-Cardiogram-</u> Normal</p> <p>1/26 <u>Chest X-Ray-</u> More apparent pleural effusion with left greater than right, central edema remains with basilar airspace.</p>
<p>IV Sites</p> <p>-PICC line, right arm -A-line, left radius -#20, right hand</p> <p>Fluids</p> <p>-Insulin -fentaNYL -Levetiracetam -Piperacillin/Tazobactam -Vancomycin -Propofol -Levophed -0.9 NS</p>		
<p>Monitoring: Invasive/Non-Invasive State specific monitoring device and specific values with each device</p> <p>-Continous vital sign</p>	<p>Chief Complaint/Admitting Diagnosis(es):</p> <p>-SDH, SAH, and bilateral skull fracture</p> <p>Medical/Surgical Diagnosis(es):</p> <p>-SDH, SAH, and bilateral skull fracture</p>	

<p>monitoring- BP 180/74 & 182/74, HR 63 & 65, O2 Sat 97 & 97, Respirations 13 & 13 -Ventriculostomy- CPP 82 & 89, ICP 9 & 15. -Ventilator- 13 &13</p>		
<p>ECG Interpretation</p> <p>-Normal sinus rhythm with variable QRS</p>	<p>1.Describe the patient’s condition, including signs/symptoms that led to this admission</p> <p>Patient was found by a co-worker at St. Paul’s Church, where he is a custodian. Patient was trying to get up and was found against a pole with blood coming out of his right ear. EMS arrived and took him to ER. Patient had been following simple commands and answering question with yes or no in ER. He was moving all the extremities and his pupils were reactive to light. ER intubated the patient for airway protection. On admission to the ICU, there was a change in mental status.</p> <p>2.Briefly describe the pathophysiology related to the patient’s diagnosis and current medical/surgical condition.</p> <p>SDH A subdural hematoma or SDH is an accumulation of blood between the arachnoid layer and the dura. An SDH is caused by the disruption of venous sinuses or the tearing of the surface veins. The risk for SDH is increased in the elderly. There are three categories of SDH. The first is acute SDH. In this SDH, symptoms manifest 24 to 48 hours after the injury. Symptoms include decreasing level of consciousness, unilateral pupil abnormalities, focal neurological deficits, and headaches. Observation of the level of consciousness and the size and location of the hematoma are used in deciding whether surgical intervention is needed. A subacute hematoma is an SDH that takes 2 days to 2 weeks to develop. The slower expansion of the hematoma results in a delay in the onset of symptoms. Symptoms are similar to those of acute SDH. Surgical intervention may be performed if needed (holistic 922). A chronic hematoma that is caused over time by capillaries leaking proteinaceous fluid. This produces symptoms of increase ICP. Symptoms include lethargy, headache, confusion, and seizures (holistic, p. 923).</p> <p>SAH A subarachnoid hemorrhage or SAH is bleeding in the subarachnoid space (Urden, Kathleen, & Lough, p. 652). It is usually caused by an arteriovenous malformation (AVM) or a rupture of a cerebral aneurysm (Urden et al., p. 652-653). In an AVM, one or more cerebral arteries supply the AVM. Over time these arteries tend to enlarge and the volume of blood shunted over to the AVM increased. large, dilated, tortuous draining veins develop. As the mean capillary pressure drops, this</p>	

allows blood with a mean pressure of around 35 to flow into the venous side. Since veins have no muscular layer, they enlarge and rupture easily. Symptoms of unruptured AVMs include syncope, headaches, and neurological deficit. In a cerebral aneurysm, more stress is placed on thin vessel walls. This causes a ballooning of the vessel to occur. Over time this vessel can become so thin that it will rupture, sending blood into the subarachnoid space. After the rupture, cerebral perfusion decreases causing altered consciousness (Urden et al., p. 654).

Bilateral skull Fracture

A bilateral skull fracture is traumatic brain injury that occurs on both sides of the skull. The fracture can be open or closed. The primary injuries of a skull fracture occur at the time of the injury. They include injury to the parenchyma or vessels, that may cause hemorrhaging, which can compress nearby objects. The secondary injury of a skull fracture is the cellular and biochemical response to the trauma. Secondary injury can exacerbate the primary injury and can be caused by ischemia, which can increase intracranial volume and ICP, hypercapnia, which can result in vasodilation causing an increase in cerebral blood volume and an increase in ICP, hypotension, which may cause inadequate perfusion to the neural tissues, and cerebral edema, which increases ICP (Urden et al., 855).

3. Describe the patient's head to toe assessment findings and explain how they relate to the pathophysiology. Include the vital signs.

Patient was laying in his bed when the head to toe assessment was done. The patient was sedated and so orientation could not be assessed. The patient had no eye opening, no motor response, and no verbal response with the Glasgow Coma Scale of a 3. This could be due to the SAH and SDH which could have been caused by the skull fracture causing loss of consciousness, as well as him being sedated. The patient had a pupil size of 2mm in both eyes and they were both nonreactive due to the patient's SDH and SAH. The patient had severe generalized weakness with all extremities being flaccid and hand grasps being absent. There was no response or reflex to painful stimuli because of the SAH and SDH causing loss of consciousness and focal neurological deficits. The patient has a tracheostomy. Lung sounds are clear bilaterally. The patient is on a ventilator on AC mode with the rate at 13, FiO2 at 40%, TV of 650, and PEEP at 0. The patient has no cough or gag reflex due to the SAH and SDH causing focal neurological deficits. He has blood tinged sputum, which could be from the hemothorax that the chest x-ray found. He has sinus rhythm with an S1 and S2 present. He has normal body color and a warm skin temperature. He has a bilateral capillary refill of 3 seconds or less. The patient has mild facial edema with bilateral racoon eyes, moderate scleral edema, and moderate bilateral

upper edema. The patient has normal bilateral radial, post tibial, and dorsalis pedis pulses. He has SCD's on to help prevent edema and DVT. His abdomen was soft and distended with his bowel sounds being hypoactive which could be due to the SAH and SDH cause altered body functioning. He has an oral-gastric tube for feedings that is secured with tape. Placement was checked and he had a residual of 10 mL that was refed. He had an indwelling catheter. The urine was yellow and he had 160n mL of urine during night shift. The patient had some ecchymosis. He had bilateral stage 2 pressure ulcers on the buttocks that was cleansed and optifoam was gently applied. The patient had a Braden Score of 9, which would indicate potential skin breakdown. His vitals were a blood pressure of 180/74 & 182/74, a heart rate of 63 & 65, a CPP of 82 & 89, a temperature of 100.2, O2 saturation of 97% & 97%, and respirations being 13 & 13. His blood pressure is high due to the head trauma and SAH and SDH, as well as he has a diagnosis of hypertension. Also since his BP is wide, as in the systolic is a lot higher than the diastolic, this is indicative of increased ICP.

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.

The low Hgb, Hct, and RBC is low due to the SAH and SDH because of blood leaving the vessels and pooling in the brain. He receives The high Na is due to blood leaving the vessel, which causes hypovolemia, which will increase the serum sodium. His glucose is high due to the patient having diabetes mellitus. His head CTs and sinus CT show blood pooling in the head, specifically in the subdural and subarachnoid areas, which is indicative of SDH and SAH. Traumatic brain injuries sometimes have low calcium levels due to the calcium rushing into the cell, which would explain the low calcium level that the patient is experiencing (Sun 2008). To keep the ICP below 20, the patient is receiving Propofol and fentanyl, as well as he has orders for his HOB to be at 45 degrees and to not to turn him. To help brain perfusion, he has orders to keep his CPP at least above 60 and O2 sats to be above 93%. Since he has diabetes mellitus, he is receiving insulin, but he is being kept at a BS between 140-180 because his body does well with that. The patient is receiving Vancomycin and Piperacillin/Tazobactam because he has a foley catheter, ICP bolt, and stage II pressure ulcer, a-line, PICC line, as well, he is sedated and so his immune system may not be working at 100%. Since the patient had a SDH, SAH, and a skull fracture, he might be prone to seizures, so that is why he is receiving Levetiracetam. Since the patient has a high temperature he is receiving Acetaminophen. The chest x-rays and echocardiogram indicate a possible bilateral pneumonia,

	<p>hemothorax, or respiratory failure. The patient has hypoactive bowel sounds, so he is receiving docusate sodium to prevent constipation. Since the patient is on bed rest, he is receiving heparin to prevent blood clots. the patient is receiving hydralazine to lower blood pressure. The patient is receiving levophed which is used in hypotension, but it has been shown to help stabilize the blood-brain barrier, which would have suffered some injury from the skull fracture. Dextran and petrolatum is used to keep the patients eyes moist. With all these interventions and treatments, the patient condition is stabilized, but due to his extremely poor neurological condition, his outcome is unknown.</p>	
<p>Past Medical/Surgical History Relevant to this admission</p> <ul style="list-style-type: none"> -Newly diagnosed hypertension -Diabetes Mellitus -Syncopal episode at 1/20 		<p>Treatments/ Medical and Nursing Interventions</p> <ul style="list-style-type: none"> -HOB 45 degrees -Do not turn patient due to ICP bolt -Accucheck with insulin gtt, keep BS between 140-180 -O2 Sat > 93% -ICP < 20 -Sodium < 160 -CPP 70-80, but okay if in the 60s

<p>Primary Nursing Diagnosis with Relational Statement Risk for ineffective cerebral perfusion R/T interruption of blood flow by hemorrhage and hemotoma, and cerebral edema</p>	<p>Short Term Goal Relevant to Nursing Diagnosis Patient will will have stable vital signs and have ICP below 20 from the start of shift until the end of shift.</p>	<p>6 Nursing Diagnosis with Relational Statement</p> <ol style="list-style-type: none"> 1. Total self-care deficit R/T immobility, generalized weakness, sedation, neurological status 2. Impaired gas exchange R/T brain injury 3. Impaired tissue integrity of cornea R/T absent corneal reflex 4. Impaired urinary elimination R/T impairment in neurologic sensing and control 5. Bowel incontinence R/T impairment in neurologic sensing and control and change to tube feeding 6. Impaired oral mucous membrane R/T ventilator and absence of gag reflex
<p>Source: Doenges, Moorhouse & Murr, 2011, p. 226-228</p>	<p>Outcome Criteria (Must be specific and measurable) -Vital signs were stable, but blood pressure was high. -Patient had no motor response. -Patient had no eye opening response with no eye movement and pupils were not reactive to light, but were equal in size and shape. -Patient was absent of the blink, cough, and gag reflex. -Bed was kept elevated at 45 degrees to promote venous drainage from the head. -ICP and CPP were monitored and were normal throughout the whole shift.</p>	
<p>AEB: Defining characteristics specifically exhibited by your patient that support primary nursing diagnosis -Altered LOC -Neurological deficits -Decrease in motor and sensory responses.</p>		
<p>Identify nursing interventions that you implemented with this patient. Evaluate patient progress towards achieving</p>		

<p>outcome criteria as a result of nursing interventions.</p> <ul style="list-style-type: none"> -Monitor vital signs. -Assess motor responses. -Evaluate eye opening, movement of eyes, and pupils, noting size shape, equality and light reactivity. -Note absence of reflexes. -Keep bed elevated at 45 degrees. -Monitor ICP and CPP <p>-Patient demonstrated stable vital signs and had an ICP below 20 during the whole shift.</p>		
<p>Secondary Nursing Diagnosis with Relational Statement Risk for impaired skin integrity R/T immobility, stage 2 ulcer, PICC line, a-line, IV access, pulmonary edema, hemothorax, and ICP monitoring system.</p>	<p>Short Term Goal Relevant to Nursing Diagnosis Patient will be free of signs of infection from the start of shift until the end of shift.</p>	<p>What I Would Do Differently Since this is a high risk patient with a neurological problem, I would have been more receptive to subtle signs and symptoms as they could indicate changes in the patient's physiology, since the patient is non receptive and cannot communicate needs</p>
<p>Source: Doenges, Moorhouse & Murr, 2011, p. 234</p>	<p>Outcome Criteria (Must be specific and measurable) <ul style="list-style-type: none"> -Hands were washed before and after patient interaction. -Wounds were looked at the make sure there was no further skin breakdown and the presence of inflammation and drainage. -Perineal area was cleaned and catheter integrity was checked -Specimen was collected and sent. </p>	
<p>AEB: Defining characteristics specifically exhibited by your patient that support primary nursing diagnosis</p> <ul style="list-style-type: none"> -Traumatized tissues -Stasis of body fluids -Possible nutritional deficits -Neurological deficits, could compromise the immune system -Sedation, which could compromise the immune system 		
<p>Identify nursing interventions that you implemented with this patient. Evaluate patient progress towards achieving</p>		

<p>outcome criteria as a result of nursing interventions.</p> <ul style="list-style-type: none">-Provide clean care and maintain good handwashing technique.-Observe areas of impaired skin integrity , noting the presence of of inflammation and drainage.- Provide perineal care and maintain the integrity of the closed foley catheter.-Observe color and clarity of urine.-Obtain specimen as needed. <p>-Patient was free from signs of infection.</p>		
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References

Urden, L. D., Kathleen, M. S., & Lough, M.E. (2012). *Critical Care Nursing* (7th ed.). St. Louis
MI: Elsevier.

Morton, G.M., & Fontaine, D. K. (2009). *Critical Care Nursing* (9th ed.). Philadelphia, PA: Wolters
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