

O — Surgery and intensive care

10 statements · Recommended tool: CP-SURG Post-op & Critical Care Check · Validated scales: RASS, CPOT, Aldrete

O1 Fear before surgery

Group: Surgery and intensive care | Type: Actual problem

Definition: Worry about pain, anaesthesia, outcomes, or loss of control before an operation.

Possible causes: Anesthesia; pain; the unknown; outcomes; loss of control

Signs and symptoms: Tense; many questions; sleeplessness; sweating

Scenario. A patient is afraid he will not wake up after anesthesia.

S: "I'm afraid I won't wake up."

O: Before surgery; heart rate 102/min; sweating; asks repeated questions.

Tools: CP-SURG · RASS, CPOT, Aldrete ****CarePath diagnosis:**** Fear before surgery related to anesthesia, as evidenced by tense and many questions. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Explain the steps. | Knowing what will happen and when lowers fear of the unknown and gives him a sense of control. | | Allow questions. | Answering his questions fully corrects wrong ideas and shows that his worries are taken seriously. | | Teach breathing. | Slow, deep breathing lowers heart rate and muscle tension and helps him cope with anxiety, and it is useful after surgery too. | | Reassure. | Calm, honest reassurance, including that the anesthetist monitors him throughout, eases fear without making promises that cannot be kept. | | Involve family. | Familiar family members give emotional comfort and help him feel safe and supported and their presence can make the hospital setting feel less threatening. | ****Expected outcomes**** - Anxiety 3/10 or lower before surgery. - States understanding. - Calm entering theater. ****Linking the data to the diagnosis**** The patient says, 'I'm afraid I won't wake up.' Before surgery, his heart rate is 102/min, he is sweating and asks repeated questions. Fear is already present and affecting his body, so this is an actual problem and not a risk. It rests on fear of anesthesia, with tension and many questions as evidence. It is chosen over a general anxiety statement because the fear is tied to the operation. The plan aims for anxiety of 3/10 or lower, a stated understanding of what will happen and a calm patient entering theater.

CarePath diagnosis: Fear before surgery related to anesthesia, as evidenced by tense and many questions.

Intervention	Rationale
Explain the steps.	Knowing what will happen and when lowers fear of the unknown and gives him a sense of control.
Allow questions.	Answering his questions fully corrects wrong ideas and shows that his worries are taken seriously.
Teach breathing.	Slow, deep breathing lowers heart rate and muscle tension and helps him cope with anxiety, and it is useful after surgery too.
Reassure.	Calm, honest reassurance, including that the anesthetist monitors him throughout, eases fear without making promises that cannot be kept.
Involve family.	Familiar family members give emotional comfort and help him feel safe and supported and their presence can make the hospital setting feel less threatening.

Expected outcomes: Anxiety 3/10 or lower before surgery. · States understanding. · Calm entering theater.

Linking the data: The patient says, 'I'm afraid I won't wake up.' Before surgery, his heart rate is 102/min, he is sweating and asks repeated questions. Fear is already present and affecting his body, so this is an actual problem and not a risk. It rests on fear of anesthesia, with tension and many questions as evidence. It is chosen over a general anxiety statement because the fear is tied to the operation. The plan aims for anxiety of 3/10 or lower, a stated understanding of what will happen and a calm patient entering theater.

O2 Breathing problems after anaesthesia ⚠ URGENT

Group: Surgery and intensive care | Type: Actual problem

Definition: Shallow breathing, low oxygen, or airway problems after an operation.

Possible causes: Anesthesia drugs; pain; obesity; lung disease; sedation

Signs and symptoms: Shallow breathing; low oxygen; snoring; drowsiness; blue lips

Scenario. A patient in recovery has an oxygen saturation of 88% and is hard to wake.

S: (Drowsy, mumbling.)

O: Oxygen saturation 88%; shallow breathing; snoring; hard to wake in recovery.

Tools: CP-SURG, CP-BREATH, CP-NEURO · RASS, CPOT, Aldrete, NEWS2, SpO₂, ECG, GCS, pupils, NIHSS

****CarePath diagnosis:**** Breathing problems after anaesthesia related to anesthesia drugs, as evidenced by shallow breathing and low oxygen. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Open the airway. | Tilting the head back and lifting the jaw lifts the tongue off the back of the throat, which clears the blockage that causes snoring and low oxygen. | | Give oxygen. | Extra oxygen raises the oxygen level in the blood while the cause is corrected, protecting the brain and heart. | | Stimulate. | Calling his name and gentle touch rouse him so he breathes more deeply and responds, and show how awake he is. | | Position. | Positioning, such as head up or on his side as appropriate, keeps the airway open and lowers the chance of vomit being inhaled. | | Monitor. | Close monitoring of oxygen level, breathing and alertness shows whether treatment is working or he is worsening. | | Call for help. | Anesthesia effects can need drugs, suction or airway devices that the nurse cannot provide alone, so skilled help is needed quickly. | ****Expected outcomes**** - Within minutes: oxygen saturation 94% or higher, airway open, patient awake and breathing normally. ****Linking the data to the diagnosis**** The patient is drowsy and mumbling. In recovery his oxygen saturation is 88%, with shallow breathing and snoring, and he is hard to wake. This is a life-threatening emergency, so help is called first while the airway is opened and oxygen is given. The problem has already occurred, so an actual statement fits and not a risk, and the evidence is shallow breathing and low oxygen after anesthesia drugs. The plan aims, within minutes, for oxygen saturation of 94% or higher, an open airway and a patient who is awake and breathing normally.

CarePath diagnosis: Breathing problems after anaesthesia related to anesthesia drugs, as evidenced by shallow breathing and low oxygen.

Intervention	Rationale
Open the airway.	Tilting the head back and lifting the jaw lifts the tongue off the back of the throat, which clears the blockage that causes snoring and low oxygen.
Give oxygen.	Extra oxygen raises the oxygen level in the blood while the cause is corrected, protecting the brain and heart.
Stimulate.	Calling his name and gentle touch rouse him so he breathes more deeply and responds, and show how awake he is.
Position.	Positioning, such as head up or on his side as appropriate, keeps the airway open and lowers the chance of vomit being inhaled.
Monitor.	Close monitoring of oxygen level, breathing and alertness shows whether treatment is working or he is worsening.
Call for help.	Anesthesia effects can need drugs, suction or airway devices that the nurse cannot provide alone, so skilled help is needed quickly.

Expected outcomes: Within minutes: oxygen saturation 94% or higher, airway open, patient awake and breathing normally.

Linking the data: The patient is drowsy and mumbling. In recovery his oxygen saturation is 88%, with shallow breathing and snoring, and he is hard to wake. This is a life-threatening emergency, so help is called first while the airway is opened and oxygen is given. The problem has already occurred, so an actual statement fits and not a risk, and the evidence is shallow breathing and low oxygen after anesthesia drugs. The plan aims, within minutes, for oxygen saturation of 94% or higher, an open airway and a patient who is awake and breathing normally.

O3 Risk of internal bleeding after surgery ⚠ URGENT

Group: Surgery and intensive care | Type: Risk problem

Definition: Hidden bleeding may occur and show as low blood pressure, fast pulse, or pain.

Risk factors: Slipped clamp; clotting problems; injured large vessel

Warning signs: Falling blood pressure; fast pulse; pale skin; swollen belly

Scenario. A patient is six hours after major abdominal surgery and has a mildly raised clotting time.

S: "I am sore but alright."

O: Six hours after abdominal surgery; pulse 84/min; blood pressure 118/72; abdomen soft; INR 1.6; on blood-thinning injections.

Tools: CP-SURG, CP-SKIN, CP-BREATH · RASS, CPOT, Aldrete, Braden Scale, TIME wound chart, NEWS2, SpO₂, ECG ****CarePath diagnosis:**** Risk of internal bleeding after surgery related to major surgery and clotting problems (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check vital signs, abdomen and dressings at ordered times. | Changes in pulse, blood pressure, abdomen and dressings are the earliest signs of hidden blood loss, so checking them regularly allows early detection. | | Report a rising pulse, falling blood pressure, pallor, abdominal swelling or new pain at once. | Fast reporting matters because internal bleeding can worsen quickly and delay can lead to shock. | | Call the surgeon if bleeding is suspected. | The surgeon can examine, order tests and decide on treatment, so being called early lets bleeding be controlled sooner. | | If bleeding is confirmed, give intravenous fluids and prepare for return to theater as ordered. | Fluids support blood pressure while the cause is found, and preparing for theater means a bleed that needs repair is not delayed. | ****Expected outcomes**** - Pulse and blood pressure stay in the doctor's range. - Abdomen stays soft. - Any sign of bleeding is reported within minutes. ****Linking the data to the diagnosis**** The patient says, 'I am sore but alright.' Six hours after abdominal surgery his pulse is 84/min, blood pressure 118/72 and abdomen soft, so no bleeding has been found. He has an INR of 1.6 and takes blood-thinning injections, and these are the risk factors. This is why a risk statement fits, and it is not an actual hemorrhage statement. If signs appear, help is called first, as this is urgent. The plan aims for pulse and blood pressure to stay in range, a soft abdomen and any sign of bleeding reported within minutes.

CarePath diagnosis: Risk of internal bleeding after surgery related to major surgery and clotting problems (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Check vital signs, abdomen and dressings at ordered times.	Changes in pulse, blood pressure, abdomen and dressings are the earliest signs of hidden blood loss, so checking them regularly allows early detection.
Report a rising pulse, falling blood pressure, pallor, abdominal swelling or new pain at once.	Fast reporting matters because internal bleeding can worsen quickly and delay can lead to shock.
Call the surgeon if bleeding is suspected.	The surgeon can examine, order tests and decide on treatment, so being called early lets bleeding be controlled sooner.
If bleeding is confirmed, give intravenous fluids and prepare for return to theater as ordered.	Fluids support blood pressure while the cause is found, and preparing for theater means a bleed that needs repair is not delayed.

Expected outcomes: Pulse and blood pressure stay in the doctor's range. · Abdomen stays soft. · Any sign of bleeding is reported within minutes.

Linking the data: The patient says, 'I am sore but alright.' Six hours after abdominal surgery his pulse is 84/min, blood pressure 118/72 and abdomen soft, so no bleeding has been found. He has an INR of 1.6 and takes blood-thinning injections, and these are the risk factors. This is why a risk statement fits, and it is not an actual hemorrhage statement. If signs appear, help is called first, as this is urgent. The plan aims for pulse and blood pressure to stay in range, a soft abdomen and any sign of bleeding reported within minutes.

O4 Drain, tube, or line problems

Group: Surgery and intensive care | Type: Risk problem

Definition: Tubes and lines may block, slip out, kink, or be pulled.

Risk factors: Patient movement; poor securing; blockage; kinks

Warning signs: Pulled-out tube; no drainage; leaking; pain

Scenario. A restless patient with a chest drain and IV lines is about to be turned.

S: "I will be careful."

O: Chest drain and IV line in place; restless; drain tubing not secured; no kinks seen yet; dressing dry.

Tools: CP-SURG · RASS, CPOT, Aldrete **CarePath diagnosis:** Drain, tube, or line problems related to patient movement and poor securing (risk factors); no signs of the problem are present yet.

Interventions and rationale | Intervention | Rationale | | Secure tubes. | Secure tubes cannot be dragged, pulled out or kinked during turning or restless movement, which protects the drain and lines. | | Check they are open. | A drain that is open and draining properly removes air or fluid, and a blocked tube can harm his breathing. | | Teach the patient not to pull. | When he understands why the tubes matter, he is less likely to pull on them, especially when restless. | | Keep drainage below the site. | Keeping the drainage system below the site lets fluid and air flow out and stops fluid running back into the chest. | | Report problems. | Early reporting of kinks, leaks, blockages or displacement allows quick correction before harm occurs so a blocked or displaced drain does not harm the patient. | **Expected outcomes** - Drain and lines stay secured with no accidental removal. - No infection or leakage. - Patient states not to pull on it. **Linking the data to the diagnosis** The patient says, 'I will be careful.' He has a chest drain and an IV line, is restless, and the drain tubing is not secured. No kinks are seen yet and the dressing is dry, so no problem has occurred. This is why a risk statement fits, and it rests on patient movement and poor securing. It is chosen over a tube discomfort statement because no harm or distress is documented. The plan aims for the drain to be secure, no infection or leakage, and for the patient to state he will not pull on it.

CarePath diagnosis: Drain, tube, or line problems related to patient movement and poor securing (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Secure tubes.	Secure tubes cannot be dragged, pulled out or kinked during turning or restless movement, which protects the drain and lines.
Check they are open.	A drain that is open and draining properly removes air or fluid, and a blocked tube can harm his breathing.
Teach the patient not to pull.	When he understands why the tubes matter, he is less likely to pull on them, especially when restless.
Keep drainage below the site.	Keeping the drainage system below the site lets fluid and air flow out and stops fluid running back into the chest.
Report problems.	Early reporting of kinks, leaks, blockages or displacement allows quick correction before harm occurs so a blocked or displaced drain does not harm the patient.

Expected outcomes: Drain and lines stay secured with no accidental removal. · No infection or leakage. · Patient states not to pull on it.

Linking the data: The patient says, 'I will be careful.' He has a chest drain and an IV line, is restless, and the drain tubing is not secured. No kinks are seen yet and the dressing is dry, so no problem has occurred. This is why a risk statement fits, and it rests on patient movement and poor securing. It is chosen over a tube discomfort statement because no harm or distress is documented. The plan aims for the drain to be secure, no infection or leakage, and for the patient to state he will not pull on it.

05 Infection from lines

Group: Surgery and intensive care | Type: Risk problem

Definition: Intravenous lines and other devices can carry germs into the body.

Risk factors: Long dwell time; poor hygiene; contaminated hubs; weak immunity

Warning signs: Redness; pus at the site; fever; chills

Scenario. A patient has had a central line for nine days, and hub care has been inconsistent.

S: "My line site is fine."

O: Central line day 9; site clean and dry; temperature 36.9 C; hub handled without gloves twice; low white cell count.

Tools: CP-SURG · RASS, CPOT, Aldrete ****CarePath diagnosis:**** Infection from lines related to long dwell time and poor hygiene (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use aseptic technique. | Sterile technique and clean hands keep germs from entering the bloodstream through the line. Strict hygiene every time the line is handled is the most important protection. | | Clean hubs. | Cleaning hubs before each use removes germs that can be pushed into the line. Gloves and a thorough scrub of the hub before each access stop contaminated hubs causing bloodstream infection. | | Check the site. | Regular site checks find redness, swelling, pus or pain early, before infection spreads. This matters more because his low white cell count weakens defenses. | | Remove unneeded lines. | The longer a line stays in, the higher the infection risk, so removing lines that are not needed removes the pathway for germs. | | Report infection. | Reporting fever, chills or site changes quickly allows early cultures and treatment, which is important with a low white cell count. | ****Expected outcomes**** - No fever, redness, or pus at the line site. - Hub cleaned with the correct technique every time. - Any early sign of infection reported at once. - Line removed as soon as it is no longer needed. ****Linking the data to the diagnosis**** The patient says, 'My line site is fine.' The central line is on day 9, the site is clean and dry, temperature is 36.9 C, but the hub was handled without gloves twice and the white cell count is low. There is no infection, so a risk statement fits, not an actual infection. It rests on long dwell time and poor hygiene, with weak defenses adding to the danger. The plan aims to prevent infection, and if signs appear, to recognize them early, take cultures, start treatment and remove the line if needed.

CarePath diagnosis: Infection from lines related to long dwell time and poor hygiene (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Use aseptic technique.	Sterile technique and clean hands keep germs from entering the bloodstream through the line. Strict hygiene every time the line is handled is the most important protection.
Clean hubs.	Cleaning hubs before each use removes germs that can be pushed into the line. Gloves and a thorough scrub of the hub before each access stop contaminated hubs causing bloodstream infection.
Check the site.	Regular site checks find redness, swelling, pus or pain early, before infection spreads. This matters more because his low white cell count weakens defenses.
Remove unneeded lines.	The longer a line stays in, the higher the infection risk, so removing lines that are not needed removes the pathway for germs.
Report infection.	Reporting fever, chills or site changes quickly allows early cultures and treatment, which is important with a low white cell count.

Expected outcomes: No fever, redness, or pus at the line site. · Hub cleaned with the correct technique every time. · Any early sign of infection reported at once. · Line removed as soon as it is no longer needed.

Linking the data: The patient says, 'My line site is fine.' The central line is on day 9, the site is clean and dry, temperature is 36.9 C, but the hub was handled without gloves twice and the white cell count is low. There is no infection, so a risk statement fits, not an actual infection. It rests on long dwell time and poor hygiene, with weak defenses adding to the danger. The plan aims to prevent infection, and if signs appear, to recognize them early, take cultures, start treatment and remove the line if needed.

06 Slow gut recovery after surgery

Group: Surgery and intensive care | Type: Actual problem

Definition: Bowel movement is slow to return, causing bloating, nausea, or constipation.

Possible causes: Anesthesia; pain medicines; bowel handling; immobility

Signs and symptoms: Bloating; vomiting; no gas; absent bowel sounds

Scenario. A patient on day 2 after bowel surgery has not passed gas.

S: "I'm bloated and haven't passed gas."

O: Day 2 after bowel surgery; abdomen distended; vomited once; absent bowel sounds.

Tools: CP-SURG, CP-ELIM, CP-FLUID · RASS, CPOT, Aldrete, Bristol Stool Chart, bladder scan, MUST, fluid chart, glucose ****CarePath diagnosis:**** Slow gut recovery after surgery related to anesthesia, as evidenced by bloating and vomiting. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Encourage walking. | Walking stimulates the bowel to start moving again, and it also lowers the risk of clots and chest problems. | | Limit opioids. | Opioids slow the bowel, so using the lowest effective dose, with other pain relief as ordered, helps movement return. | | Give intravenous fluids as ordered, and keep nothing by mouth if instructed. | Vomiting and a distended gut mean oral fluids may be vomited or inhaled, so the doctor decides the route. | | Listen to bowel sounds. | Bowel sounds and the abdomen show whether movement is returning or a blockage is developing. | | Report vomiting. | Vomiting with a distended abdomen may mean obstruction or a leak, so the surgical team needs to know promptly. | ****Expected outcomes**** - By day 3-4: passes gas and stool, vomiting stops, tolerates diet, walks daily. ****Linking the data to the diagnosis**** The patient says, 'I'm bloated and haven't passed gas.' On day 2 after bowel surgery his abdomen is distended, he has vomited once and bowel sounds are absent. The slow recovery is already present, so this is an actual problem and not a risk. It rests on anesthesia, with bloating and vomiting as evidence. It fits better than a constipation statement because it follows surgery and includes vomiting. The plan aims, by day 3 to 4, for gas and stool to pass, vomiting to stop, diet to be tolerated and daily walking.

CarePath diagnosis: Slow gut recovery after surgery related to anesthesia, as evidenced by bloating and vomiting.

Intervention	Rationale
Encourage walking.	Walking stimulates the bowel to start moving again, and it also lowers the risk of clots and chest problems.
Limit opioids.	Opioids slow the bowel, so using the lowest effective dose, with other pain relief as ordered, helps movement return.
Give intravenous fluids as ordered, and keep nothing by mouth if instructed.	Vomiting and a distended gut mean oral fluids may be vomited or inhaled, so the doctor decides the route.
Listen to bowel sounds.	Bowel sounds and the abdomen show whether movement is returning or a blockage is developing.
Report vomiting.	Vomiting with a distended abdomen may mean obstruction or a leak, so the surgical team needs to know promptly.

Expected outcomes: By day 3-4: passes gas and stool, vomiting stops, tolerates diet, walks daily.

Linking the data: The patient says, 'I'm bloated and haven't passed gas.' On day 2 after bowel surgery his abdomen is distended, he has vomited once and bowel sounds are absent. The slow recovery is already present, so this is an actual problem and not a risk. It rests on anesthesia, with bloating and vomiting as evidence. It fits better than a constipation statement because it follows surgery and includes vomiting. The plan aims, by day 3 to 4, for gas and stool to pass, vomiting to stop, diet to be tolerated and daily walking.

07 Needs of sedated or unconscious patient

Group: Surgery and intensive care | Type: Risk problem

Definition: The person cannot protect their own airway, skin, eyes, or position.

Risk factors: Sedatives; coma; paralysis; ventilator

Warning signs: Cannot move; no cough; eyes unprotected; skin at risk

Scenario. An ICU patient on a ventilator and sedation cannot turn or protect his airway.

S: (Sedated; cannot speak.)

O: Ventilated and sedated; no cough or gag reflex; eyes partly open; skin intact; cannot turn himself.

Tools: CP-SURG, CP-SKIN · RASS, CPOT, Aldrete, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Needs of sedated or unconscious patient related to sedatives and loss of protective reflexes (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Turn regularly. | Changing position regularly relieves pressure on the skin, helps the lungs expand and prevents joint stiffness. | | Give eye and mouth care. | Without blinking or normal saliva, eyes and mouth dry out and become infected, so regular cleaning and lubrication protects them. | | Suction. | Without a cough or gag, secretions collect in the airway, so suction clears them and helps prevent chest infection. | | Monitor. | Continuous monitoring finds changes in breathing, heart rate, sedation level or ventilator function early so problems are treated before they become dangerous. | | Protect skin. | Keeping skin clean, dry and free from pressure lowers the chance of breakdown in a patient who cannot move himself. | | Keep communicating. | Hearing may still be present, so speaking to him explains care, supports dignity and may reduce distress. | ****Expected outcomes**** - Airway protected. - Skin intact. - Eyes protected. - Repositioned every 2 hours. - No complications. ****Linking the data to the diagnosis**** The patient is sedated and cannot speak. He is on a ventilator with no cough or gag reflex, his eyes are partly open, his skin is intact and he cannot turn himself. He has not yet come to harm, so a risk statement fits, and it rests on sedatives and loss of protective reflexes. The nurse acts for him because he cannot protect his airway, eyes and skin. The plan aims for a protected airway, intact skin, protected eyes, repositioning every 2 hours and no complications.

CarePath diagnosis: Needs of sedated or unconscious patient related to sedatives and loss of protective reflexes (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Turn regularly.	Changing position regularly relieves pressure on the skin, helps the lungs expand and prevents joint stiffness.
Give eye and mouth care.	Without blinking or normal saliva, eyes and mouth dry out and become infected, so regular cleaning and lubrication protects them.
Suction.	Without a cough or gag, secretions collect in the airway, so suction clears them and helps prevent chest infection.
Monitor.	Continuous monitoring finds changes in breathing, heart rate, sedation level or ventilator function early so problems are treated before they become dangerous.
Protect skin.	Keeping skin clean, dry and free from pressure lowers the chance of breakdown in a patient who cannot move himself.
Keep communicating.	Hearing may still be present, so speaking to him explains care, supports dignity and may reduce distress.

Expected outcomes: Airway protected. · Skin intact. · Eyes protected. · Repositioned every 2 hours. · No complications.

Linking the data: The patient is sedated and cannot speak. He is on a ventilator with no cough or gag reflex, his eyes are partly open, his skin is intact and he cannot turn himself. He has not yet come to harm, so a risk statement fits, and it rests on sedatives and loss of protective reflexes. The nurse acts for him because he cannot protect his airway, eyes and skin. The plan aims for a protected airway, intact skin, protected eyes, repositioning every 2 hours and no complications.

O8 Discomfort from tubes

Group: Surgery and intensive care | Type: Actual problem

Definition: Tubes and devices cause soreness, irritation, or restlessness.

Possible causes: Tubes; ventilator; catheters; dressings; noise

Signs and symptoms: Restlessness; pulling at tubes; grimacing; sleeplessness

Scenario. A ventilated patient bites the tube and grimaces.

S: (Tries to speak.) Grimaces.

O: Bites the ventilator tube; restless; pulls at lines; heart rate 118/min.

Tools: CP-SURG, CP-PAIN · RASS, CPOT, Aldrete, NRS 0–10, FLACC, PAINAD ****CarePath diagnosis:**** Discomfort from tubes related to tubes, as evidenced by restlessness and pulling at tubes.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Give comfort. | Comfort measures such as mouth care, repositioning and pain relief reduce the irritation that makes him restless. | | Secure the tube. | A secure tube is less likely to move, rub or be pulled out, which protects his airway and reduces discomfort. | | Give sedation as ordered. | Ordered sedation or pain relief eases distress and prevents him from harming himself or removing the tube. | | Talk reassuringly. | A calm voice and explanation lower fear and agitation, even when he cannot answer. Hearing a familiar, steady voice helps him feel safe. | | Check the tube position. | Checking the tube position confirms it is correctly placed and not causing pain, leaks or poor ventilation. | ****Expected outcomes**** - Settles with comfort. - Tube secure. - No self-removal. - Sedation adjusted by plan. ****Linking the data to the diagnosis**** The patient tries to speak and grimaces. He is ventilated, bites the tube, is restless, pulls at lines and has a heart rate of 118/min. The distress is already present, so this is an actual problem, and it rests on the tubes, with restlessness and pulling as evidence. It is chosen over a risk of line problems because discomfort is happening now. The plan aims for him to settle with comfort measures, the tube to stay secure, no self-removal and sedation adjusted by plan.

CarePath diagnosis: Discomfort from tubes related to tubes, as evidenced by restlessness and pulling at tubes.

Intervention	Rationale
Give comfort.	Comfort measures such as mouth care, repositioning and pain relief reduce the irritation that makes him restless.
Secure the tube.	A secure tube is less likely to move, rub or be pulled out, which protects his airway and reduces discomfort.
Give sedation as ordered.	Ordered sedation or pain relief eases distress and prevents him from harming himself or removing the tube.
Talk reassuringly.	A calm voice and explanation lower fear and agitation, even when he cannot answer. Hearing a familiar, steady voice helps him feel safe.
Check the tube position.	Checking the tube position confirms it is correctly placed and not causing pain, leaks or poor ventilation.

Expected outcomes: Settles with comfort. · Tube secure. · No self-removal. · Sedation adjusted by plan.

Linking the data: The patient tries to speak and grimaces. He is ventilated, bites the tube, is restless, pulls at lines and has a heart rate of 118/min. The distress is already present, so this is an actual problem, and it rests on the tubes, with restlessness and pulling as evidence. It is chosen over a risk of line problems because discomfort is happening now. The plan aims for him to settle with comfort measures, the tube to stay secure, no self-removal and sedation adjusted by plan.

09 Sleep loss in ICU

Group: Surgery and intensive care | Type: Actual problem

Definition: Noise, light, and care routines prevent restful sleep.

Possible causes: Alarms; lights; noise; pain; routines

Signs and symptoms: Poor sleep; confusion; irritability

Scenario. An ICU patient sleeps only 2 hours at night.

S: "I never get to sleep in here."

O: Sleeps 2 hours; confused at night; noise and lights constant.

Tools: CP-SURG, CP-OLDER · RASS, CPOT, Aldrete, 4AT / CAM, Mini-Cog ****CarePath diagnosis:**** Sleep loss in ICU related to alarms, as evidenced by poor sleep and confusion. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Group care. | Doing several tasks at one visit leaves longer uninterrupted periods in which he can sleep. | | Dim lights. | Dim lights at night help the body clock tell night from day, which supports sleep and reduces night-time confusion. | | Reduce noise. | Noise and alarms wake patients repeatedly, so lowering sound levels and responding quickly to alarms protects sleep. | | Offer earplugs. | Earplugs block some noise and help him fall asleep, if he agrees and it is safe to use them. | | Keep a routine. | A regular night routine signals bedtime and supports a natural sleep pattern. Keeping the same pattern each night also helps him feel settled. | ****Expected outcomes**** - Sleeps 4-6 hours with grouped care. - Orientation improves. - Less agitated. ****Linking the data to the diagnosis**** The patient says, 'I never get to sleep in here.' He sleeps only 2 hours, is confused at night, and noise and lights are constant. The sleep loss has already happened, so this is an actual problem and not a risk. It rests on alarms, with poor sleep and confusion as evidence. It is chosen over a general confusion statement because the main driver is the environment. The plan aims for 4 to 6 hours of sleep with grouped care, improved orientation and less agitation.

CarePath diagnosis: Sleep loss in ICU related to alarms, as evidenced by poor sleep and confusion.

Intervention	Rationale
Group care.	Doing several tasks at one visit leaves longer uninterrupted periods in which he can sleep.
Dim lights.	Dim lights at night help the body clock tell night from day, which supports sleep and reduces night-time confusion.
Reduce noise.	Noise and alarms wake patients repeatedly, so lowering sound levels and responding quickly to alarms protects sleep.
Offer earplugs.	Earplugs block some noise and help him fall asleep, if he agrees and it is safe to use them.
Keep a routine.	A regular night routine signals bedtime and supports a natural sleep pattern. Keeping the same pattern each night also helps him feel settled.

Expected outcomes: Sleeps 4-6 hours with grouped care. · Orientation improves. · Less agitated.

Linking the data: The patient says, 'I never get to sleep in here.' He sleeps only 2 hours, is confused at night, and noise and lights are constant. The sleep loss has already happened, so this is an actual problem and not a risk. It rests on alarms, with poor sleep and confusion as evidence. It is chosen over a general confusion statement because the main driver is the environment. The plan aims for 4 to 6 hours of sleep with grouped care, improved orientation and less agitation.

O10 Family distress in ICU

Group: Surgery and intensive care | Type: Actual problem

Definition: Relatives feel fear, shock, or helplessness while the patient is critically ill.

Possible causes: Fear; uncertainty; unfamiliar environment; lack of information

Signs and symptoms: Anxiety; crying; sleeplessness; constant questions

Scenario. A wife stays beside her husband in ICU, shaking.

S: "Is he going to die?"

O: Wife shaking; no sleep for 2 days; asks questions repeatedly.

Tools: CP-SURG · RASS, CPOT, Aldrete **CarePath diagnosis:** Family distress in ICU related to fear, as evidenced by anxiety and crying. **Interventions and rationale** | Intervention | Rationale | |---|---| | Give updates. | Regular honest updates reduce fear of the unknown and help relatives feel included and trusted. | | Explain equipment. | Explaining monitors, alarms and tubes makes the environment less frightening and helps her understand what she sees. | | Allow visits. | Being near the patient comforts both of them, so visits are allowed within safe unit rules. | | Offer support. | Showing care, listening and encouraging rest and food help her cope with stress and exhaustion. | | Refer to a counselor. | A counselor can give ongoing emotional help beyond what the bedside nurse can offer. This is useful when her distress continues beyond what ordinary updates can ease. **Expected outcomes** - Receives regular updates. - Understands the equipment. - Rests. - Feels supported. **Linking the data to the diagnosis** The wife asks, 'Is he going to die?' She is shaking, has had no sleep for 2 days and asks questions repeatedly. Her distress is already present, so this is an actual problem. It concerns the family, not the patient, and it rests on fear, with anxiety and crying as evidence. The plan aims for regular updates, an understanding of the equipment, rest and a feeling of being supported, so her fear lessens and she can cope.

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