


**box 27-4 collaborative care guide**
**for the Patient with Acute Respiratory Distress Syndrome (ARDS) (Continued)**
**OUTCOMES**
**Comfort/Pain Control**

Patient will be as comfortable as possible as evidenced by stable vital signs or cooperation with treatments or procedures.

**Psychosocial**

Patient demonstrates decreased anxiety.

**Teaching/Discharge Planning**

Patient/significant others understand procedures and tests needed for treatment.

Significant others understand the severity of the illness, ask appropriate questions, and anticipate potential complications.

**INTERVENTIONS**

- Objectively assess comfort/pain using a pain scale.
- Provide analgesia and sedation as indicated by assessment.
- Monitor patient cardiopulmonary and pain response to medication.
- If patient is receiving neuromuscular blockade for ventilatory control:
  - Use peripheral nerve stimulator to assess pharmacological paralysis.
  - Provide continuous or routine (every 1 to 2 hours) intravenous sedation and analgesia.
- Assess vital signs during treatments, discussions, and the like.
- Cautiously administer sedatives.
- Consult social services, clergy, as appropriate.
- Provide for adequate rest and sleep.
- Prepare patient/significant others for procedures, such as bronchoscopy, pulmonary artery catheter insertion, or laboratory studies.
- Explain the causes and effects of ARDS and the potential for complications, such as sepsis, barotrauma, or renal failure.
- Encourage significant others to ask questions related to the ventilator, the pathophysiology of ARDS, monitoring, and treatments.


**box 27-5**
**Considerations for the Older Patient With Acute Respiratory Distress Syndrome (ARDS)**

- People who are 65 years of age or older are at increased risk for multisystem organ involvement with less chance of recovering from ARDS; therefore, the mortality rate is increased in this population.
- Because of increased immunosuppression with aging, the elderly are at greater risk for infection; therefore, nosocomial infections, such as urinary tract infections and ventilator-associated pneumonia (VAP), are more common.
- Hemodynamic instability adds metabolic insults to already-decreased renal function, thus predisposing this group to renal failure.
- Decreased stroke volume; possible coronary artery disease (CAD), atherosclerosis, or both, and increased systolic blood pressure and peripheral vascular resistance alter hemodynamic recovery.
- Decreased maximal oxygen uptake associated with decreased lung volumes puts elderly patients at greater risk for ventilator-associated lung injury (VALI).
- Decreased muscle mass associated with aging makes recovery from prolonged immobility more difficult. Therefore, an elderly person with ARDS may require prolonged rehabilitation.
- Generalized peripheral edema, multiple invasive tests, and prolonged bed rest, combined with the decreased skin integrity associated with old age, increase the elderly patient's potential for development of pressure ulcers and skin tears.
- Elderly patients with ARDS are at risk for not receiving the same quality and quantity of treatment and care as younger patients, owing to the effects of ageism. The patient's age is one factor to consider in outcome and prognosis, but not the only one.
- The incidence of comorbid conditions, especially non-insulin-dependent diabetes mellitus and CAD, increases with age. Research findings indicate that the presence of comorbidity increases the risk of death for patients with ARDS.
- The patient and family may request no initiation of, or early removal from, life support based on previously expressed wishes. A person's life experience or vision of risk related to prolonged illness with high possibility of mortality may influence this decision, and these wishes should be respected.