

Student Name: Allie Marion

ATI Real Life Scenario: MI

*Complete and submit to the corresponding dropbox by 1600 on the assigned clinical day.

To Be Completed Before the Simulation

** Blue boxes should be completed using textbook information. What do you expect to find? This information should be collected before you start the ATI simulation.

Medical Diagnosis/ Disease: Myocardial Infarction

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

Anatomy and Physiology
Normal Structures

The heart is a 4 chambered hollow muscular organ about the size of a fist. Composed of 3 layers: endocardium, myocardium, epicardium. 4 valves keep blood flowing in a forward direction: tricuspid, pulmonary, mitral, aortic. Depolarization triggers mechanical activity: systole contraction, diastole relaxation (allows for filling of the ventricles). Arteries, except for the pulmonary artery, carry oxygenated blood away from the heart. Veins, except for pulmonary veins, carry deoxygenated blood toward the heart.

Pathophysiology of Disease

A MI occurs because of an abrupt stoppage of blood flow through a coronary artery with a thrombus caused by platelet aggregation. Causes irreversible myocardial cell death beyond the blockage. Serum cardiac biomarkers are released into the blood. A STEMI, caused by an occlusive thrombus causing ST-elevation. NSTEMI caused by a nonocclusive thrombus, does not cause ST-elevation. The acute MI process evolves over time. Most MIs affect the LV and are usually based on location of damage.

NCLEX IV (7): Reduction of Risk

Anticipated Diagnostics

Labs
Troponin, Myoglobin, CBC, BMP, Creatine kinase MB

Additional Diagnostics
EKG, Chest x-ray,

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors
Smoking, obesity, family history, unhealthy diet, little exercise.

NCLEX IV (7): Reduction of Risk

Signs and Symptoms
Chest pain- burning, heavy pressure, tightness, crushing feeling. Chest discomfort, weakness, nausea/vomiting, indigestion, SOB, fatigue, diaphoresis.

NCLEX IV (7): Reduction of Risk

Possible Therapeutic Procedures

Non-surgical
Continuous cardiac monitoring, bed rest, thrombolytic therapy

Surgical
Cardiac catheterization, PCI, CABG, coronary angiography

NCLEX IV (7): Reduction of Risk

Prevention of Complications
(What are some potential complications associated with this disease process)
Dysrhythmias, heart failure, cardiogenic shock, papillary muscle dysfunction or rupture, left ventricular aneurysm, ventricular septal wall rupture, pericarditis, and Dressler syndrome.

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<u>Parenteral Therapies</u>	<u>Non-Pharmacologic Care Measures</u>	<u>Care Needs</u>
<u>Anticipated Medication Management</u> Nitroglycerine, morphine, aspirin, ace inhibitors, beta blockers, antiarrhythmics, and stool softeners.	Oxygen, high/semi fowlers, cardiac monitoring, foley catheter, and a dark, quiet, calming environment.	<u>What stressors might a patient with this diagnosis be experiencing?</u> Anxiety, hospitalization
<u>Client/Family Education</u> <u>List 3 potential teaching topics/areas</u> <ul style="list-style-type: none">• How to take nitroglycerin correctly• Importance of a healthy diet and good exercise• Educate signs and symptoms to seek medical attention immediately after discharge.	<u>NCLEX I (1): Safe and Effective Care Environment</u> <u>Multidisciplinary Team Involvement</u> (Which other disciplines do you expect to share in the care of this patient) Cardiologist, dietician, pharmacy, hospitalist, PT/OT, home health	

Anticipated Patient Problems, Goals, & Interventions Based on Medical Diagnosis

** This worksheet should be completed before you begin the ATI simulation.

Problem #1: Acute pain: chest

Patient Goals:

1. Will have a pain score less than 3 on a 0 to 10 numerical pain score throughout my time of care.
2. Will maintain a respiratory rate between 12 and 20 and a heart rate between 60 and 100 throughout my time of care.

Assessments:

- Assess quality, intensity, location, duration, and onset of pain throughout my time of care. Reassess pain 30 minutes – 1 hour after giving meds (po/IV) during my time of care. Assess vital signs continuously every 15 minutes throughout my time of care.

Interventions (In priority order):

1. Administer nitroglycerin sublingual or as ordered during my time of care.
2. Administer aspirin chewable as ordered during my time of care.
3. Provide oxygen therapy via nasal canula as ordered during my time of care.
4. Maintain head of bed at high fowlers during my time of care.
5. Provide a dark, quiet, relaxing environment during my time of care.
6. Maintain strict bedrest/ limited activity during my time of care.

Problem #2: Decreased cardiac output

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Patient Goals:

1. Will have a heart rate between 60 and 100 during my time of care.
2. Will have a blood pressure between 120/80 and 130/70 during my time of care.

Assessments:

- Assess cardiac markers throughout my time of care. Assess urine output throughout my time of care. Assess VS continuously every 15 minutes. Assess for fatigue and dyspnea throughout my time of care. Assess fluid balance and weight gain throughout my time of care.

Interventions (In priority order):

1. Obtain a 12 lead EKG stat during my time of care.
2. Obtain a lab draw for cbc, bmp, and cardiac markers during my time of care.
3. Administer nitroglycerin sublingual or as ordered during my time of care.
4. Provide oxygen therapy via nasal canula throughout my time of care.
5. Maintain head of bed at high fowlers while laying in bed during my time of care.
6. Maintain strict bedrest/limited activity throughout my time of care.

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At this time, complete assigned ATI Real Life Simulation

Actual Patient Problems & Goals

** The following should be completed after the ATI simulation.

Problem #1: Acute pain: chest

Patient Goals:

1. R.D will have a pain score less than 3 on a 0 to 10 numerical pain score throughout my time of care. Met X
Unmet
2. R.D will maintain a respiratory rate between 12 and 20 and a heart rate between 60 and 100 throughout my time of care. Met
Unmet X

Problem #2: Impaired gas exchange

Patient Goals:

1. R.D will have no dyspnea at rest during my time of care. Met X
Unmet
2. R.D will have a respiratory rate between 12 and 20 during my time of care. Met X
Unmet

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SOAP Notes Based on Priority Problems

Priority Patient Problem #1: Acute pain: chest

<p><u>Subjective:</u></p> <p><i>This section explains the client symptoms. Include a narrative of the patient's complaints/concerns and/or information obtained from secondary sources.</i></p>	<p>Chief Complaint: Chest tightness that is not relieved by nitroglycerine tablets</p> <p>PMH: Hypertension, coronary artery disease with angina, asthma, quit smoking 1 month ago and occasionally chews tobacco</p> <p>Allergies: Penicillin, peanuts, and sulfa, shellfish</p> <p>Current Medications: Nitroglycerin sublingual tablets, lisinopril, albuterol inhaler</p>
<p><u>Objective:</u></p> <p><i>This section is your clinical observations. Include, pertinent vital signs, pertinent labs and diagnostics related to priority problem.</i></p>	<p>Vital Signs: 1722: BP- 96/55, HR- 104, T- 37.2, RR- 26, O2- 94% 4L/min/nc 1725: BP-100/66, HR-106, RR- 24, O2- 96% 4L/min/nc 1730: BP-98/60, HR- 102, RR-22, O2- 96% 4L/min/NC 1735: BP-102/68, HR- 104, RR-22, O2-97% 4L/min/NC</p> <p>Labs: 1745: Troponin T- 0.2, Troponin I- 0.06, lactic acid venous- 0.6</p> <p>Diagnostics: 1725 ECG completed confirms STEMI</p>
<p><u>Assessment:</u></p> <p><i>Focused assessment on your priority problem.</i></p>	<p>RD is alert and oriented x4. States he is having chest tightness and it hurts to breathe. States pain is a 8 out of 10 on a numerical pain score. Shallow respirations and grabbing of chest. Wife at bedside. After cardiac catheterization pain was a 0 out of 10 on a numerical pain scale.</p>
<p><u>Plan</u> <u>*Based on priority problem only</u></p>	<p>Plan: Stat 12 lead EKG is ordered and performed. STEMI confirmed and RD is scheduled for cardiac</p>

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<p><i>Include what your plan is for the client. What treatments or medications are needed. You can include procedures, consults, labs/diagnostics, etc. What nursing interventions are being performed?</i></p>	<p>catheterization. Troponin and lactate levels are drawn and are elevated. Blood pressure, pulse, and respirations every 5 minutes. Oxygen is provided at 4L/min/NC. Morphine 2 mg IV every 10 minutes for moderate to severe chest pain.</p> <p>Post cath orders: Troponin T now, in 3 hours, and then in 6 hours. Continuous telemetry and arterial blood pressure monitoring. Vital signs every 15 minutes for 1 hour, every 30 minutes for 1 hours, and then every hour. Elevate head of bed 10 degrees for 2 hours and ab lib after. Bed rest and keep right leg straight for 12 hours until 0900. Morphine 2 mg IVP prn every 4 hours for moderate pain.</p> <p>Teaching/Resources: Educated signs and symptoms of an MI (heart attack). Educated what a cardiac catheterization was and what to expect afterwards. Follow up with a cardiologist regularly as an outpatient. Educated when to seek medical help to RD and wife. Educate modifiable risk factors that RD could change.</p>
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Priority Patient Problem #2: Impaired gas exchange

<p>Subjective:</p> <p><i>This section explains the client symptoms. Include a narrative of the patient's complaints/concerns and/or information obtained from secondary sources.</i></p>	<p>Chief Complaint: Stated started coughing, feels like he is coming down with a cold and his nose is a little stuffy and is unable to catch his breath.</p>
<p>Objective:</p> <p><i>This section is your clinical observations. Include vital signs, pertinent labs and diagnostics related to priority problem.</i></p>	<p>Vital Signs: 2100: BP- 112/66, HR-96, T-36.0, O2-98% 2L/min/NC 2110: Arterial BP- 118/72, HR-112, RR- 20, O2-96% 2L/min/NC 2115: Arterial BP- 148/94, HR-112, RR- 32, O2-94% 2L/min/NC 2120: Arterial BP- 155/98, HR- 116, RR-32, O2-87% non-rebreather mask – 100% oxygen 15L/min</p>

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	<p>Labs: not applicable to nursing diagnosis/problem</p> <p>Diagnostics: not applicable to nursing diagnosis/problem</p>
<p>Assessment:</p> <p><i>Focused assessment on your priority problem.</i></p>	<p>Nonproductive cough, dyspnea, wheezing. Intermittent stridor after applying nonrebreather mask of 15L/min O₂. Skin has turned ashen and nail beds are dusky. RD is showing signs of distress.</p> <p>After epinephrine administration: RD states he feels much better, breathing and itching are gone. Still has cough.</p>
<p>Plan</p> <p>*Based on priority problem only</p> <p><i>Include what your plan is for the client. What treatments or medications are needed. You can include procedures, consults, labs/diagnostics, etc. What nursing interventions are being performed?</i></p>	<p>Plan: Diphenhydramine given 25 mg IV bolus prn every 4 hours for itching and restlessness. Provided oxygen 15L/min via nonrebreather mask. Administered epinephrine 0.3 mg IM. Nasal canula now applied replacing nonrebreather.</p> <p>Teaching/Resources: Educated the importance of informing his primary doctor and other members in his care about his shellfish allergy. Educated the signs and symptoms of an anaphylactic reaction and when to seek medical attention.</p>

Reflection:

1. Go back to your Preconference Template:
 - a. Indicate (circle, star, highlight, etc.) the components of your preconference template that you saw applied to the care of this virtual patient.
2. What was your biggest “take-away” from participating in the care of this patient? How did this impact your nursing practice?

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The biggest “take-away” from this assignment is seeing how fast a patient’s status can decline. It is important to recognize these changes early for the best outcome for the patient. It is important to assess the situation timely and promptly by asking direct questions focused on the problem. Knowing that he had a cardiac catheterization with dye to visualize the arteries, it was important that the nurse questioned the shellfish allergy that could’ve been triggered through the iodine dye used in the procedure. Although the patient did not know he had an allergy to shellfish it was important that he recognized the signs and symptoms of an allergic reaction to that procedure. It is also important to recognize the potential complications a procedure or an illness could have on a patient afterwards. The nurse was able to quickly recognize the vital signs and the clinical picture was not normal and was able to figure out the patient was experiencing cardiogenic shock after the heart attack and having the cardiac catheterization done. Recognizing these changes impacted my nursing practice by allowing me to see how fast you react changes the outcome for the patient. I will work more on my critical thinking skills so I am able to see these changes quicker and I can react promptly and efficiently to give my patient the best outcome.

Time Allocation: 8 hours