Acute Coronary Syndrome (ACS)
Myocardial Infarction (MI)

JoAnn Smith, 68 years old

Primary Concept
Perfusion
Interrelated Concepts (In order of emphasis)
1. Fluid and Electrolyte Balance 2. Clinical Judgment 3. Communication 4. Collaboration

UNFOLDING Reasoning Case Study-STUDENT

Acute Coronary Syndrome/Acute MI

History of Present Problem:

JoAnn Smith is a 68-year-old woman who presents to the emergency department (ED) after having three days of progressive weakness. She denies chest pain, but admits to shortness of breath (SOB) that increases with activity. She also has epigastric pain with nausea that has been intermittent for 20-30 minutes over the last three days. She reports that her epigastric pain has gotten worse and is now radiating into her neck. Her husband called 9-1-1 and she was transported to the hospital by emergency medical services (EMS).

Personal/Social History:

JoAnn is a recently retired math teacher who continues to substitute teach part-time. She is physically active and lives independently with her spouse in her own home. She has smoked 1 pack per day the past 40 years. JoAnn appears anxious and immediately asks repeatedly for her husband upon arrival.

What data from the histories are RELEVANT and have clinical significance to the nurse?

RELEVANT Data from Present Problem:	**Clinical Significance:**
-Three days progressive weakness -SOB that increase with activity -Intermittent epigastric pain for the past 3 days -Radiating epigastric pain that is in her neck	-Not a normal finding in anyone, especially multiple days of weakness. Remember that although weakness is a generalized complaint, it is clinically significant because it is not uncommon for women to have atypical signs and symptoms with ACS. BSc -Pulmonary congestion may be occurring, along with presentation of symptoms of ACS with the epigastric pain. "When epigastric pain is present… It usually lasts for 20 minutes or longer and is more severe than usual anginal pain" (Lewis, Dirksen, Heitkemper, & Bucher, 2017, p. 720). Dyspnea is also a common feature of ACS and MI due to pulmonary congestion. BSc -More symptoms that show possible ACS/MI. You need to be more specific as to how these are clinically significant. BSc
RELEVANT Data from Social History:	**Clinical Significance:**
1 PPD for the past 40 years Anxious	Modifiable risk factor that leads to heart disease What does it do to an individual's body that causes heart disease? BSc Anxiety increases the workload of the heart. Her heart appears to be under stress as it is and more workload will not help decrease the stress.

What is the RELATIONSHIP of your patient's past medical history (PMH) and current meds?

(Which medications treat which conditions? Draw lines to connect)

PMH:	**Home Meds:**	**Pharm. Classification:**	**Expected Outcome:**
• Diabetes mellitus type II- Metformin • Hypertension- Lisinopril • Hyperlipidemia- Simvastatin Cerebral vascular accident (CVA) with no residual deficits- ASA/Clopidogrel • Gastro-esophageal reflux disease (GERD) – Omeprazole	1. Iron Sulfate 325 mg PO daily 2. Lisinopril 5 mg PO daily 3. Simvastatin 20 mg PO daily 4. Aspirin 81 mg PO daily 5. Clopidogrel 75 mg PO daily 6. Omeprazole 20 mg PO daily 7. Metformin 500 mg PO bid	1. Iron supplement 2. ACE inhibitor 3. Lipid lower agent 4. Salicylate 5. Platelet aggregation inhibitor 6. Proton pump inhibitor 7. Antidiabetic	1. Increase Hgb 2. Lower BP 3. Lower cholesterol 4. Prevention of MI 5. Prevention of MI 6. Decrease gastric acid 7. Lower blood glucose (Vallerand, A.H., Sanoski, C.A., &

• Anemia-Iron deficiency – Iron sulfate		(biguanides)	Deglin, J.H. (2018).

Excellent job identifying the relationship between your patient's past medical history and her current medications. You also did a great job identifying the correct pharmacological classification and expected outcomes. BSc

One disease process often influences the development of other illnesses. Based on your knowledge of pathophysiology (if applicable), which disease likely developed FIRST that created a "domino effect" in her life?

- Circle what PMH problem likely started **FIRST**
- Underline what PMH problem(s) **FOLLOWED** as domino(s)

Great job! Remember, long term complications of DM includes disease of the large and small blood vessels in the body which leads to CAD, PVD, and HTN. Therefore, the patient's diagnosis of DM Type-2 likely started the domino effect. However, hypertension and hyperlipidemia are close seconds that worked together to cause the vascular complications that JoAnn also has experienced. BSc

Patient Care Begins:

Current VS:	**P-Q-R-S-T Pain Assessment (5th VS):**	
T: 99.2 F/37.3 C (oral)	**P**rovoking/Palliative:	Nothing/Nothing
P: 128 **(**regular)	**Q**uality:	Ache
R: 24 (regular)	**R**egion/Radiation:	Left arm that radiates into neck
BP: 108/58	**S**everity:	5/10
O2 sat: 99% room air	**T**iming:	Intermittent-20-30" at a time

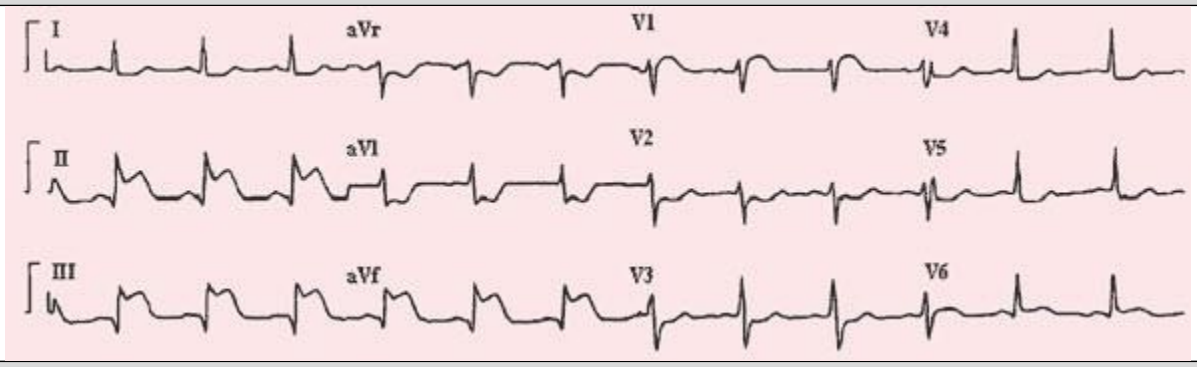
What VS data are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT VS Data:	**Clinical Significance:**
P: 128 RR: 24 BP: 108/58	Tachycardic could be related to the anxiety or she could be compensating for the decreased CO as is the case with ACS Tachypneic could also be related to her anxiety or with manifesting ACS and pulmonary edema occurring Her blood pressure is on the lower side and with her medications for BP you have to be wary and cautious with how you provide fluids and her medications. Excellent job! Remember, our ultimate goal here is to decrease the workload of the heart. Tachycardia is a major concern because it increases the workload of the heart, which in return increase the patient's oxygen demands that are already currently compromised. BSc

Current Assessment:	
GENERAL APPEARANCE:	Anxious, appears uncomfortable, body tense
RESP:	Respirations labored, coarse crackles present in bases bilaterally anterior/posterior
CARDIAC:	Pale, diaphoretic, no edema, heart sounds regular S1S2 with no abnormal beats, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks
NEURO:	Alert & oriented to person, place, time, and situation (x4)
GI:	Abdomen soft/non-tender, bowel sounds audible per auscultation in all 4 quadrants
GU:	Voiding without difficulty, urine clear/yellow
SKIN:	Skin integrity intact, skin turgor elastic, no tenting present

What assessment data is RELEVANT and must be recognized as clinically significant by the nurse?

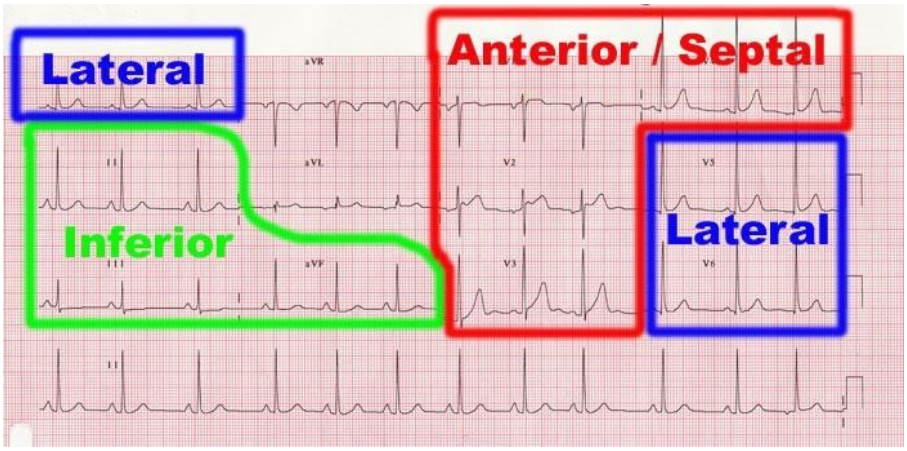
RELEVANT Assessment Data:	Clinical Significance:
Anxious, appears uncomfortable, tense body Labored RR, coarse crackles in bases bilaterally Pale, diaphoretic, strong pulses	With an anxious person, a number of their body systems are working harder. For instance, the cardiac workload of the heart, oxygen demands, and BP can all increase as anxiety remains. Alveoli are filling with fluid, likely due to pulmonary edema. If they are persistent, could indicate worsening of the lungs and more critical problems may occur. More anxiety filled findings here. Could have triggered the fight-or-flight response and this response can further point us to MI. Great job! BSc

12 Lead EKG:

Interpretation:
Leads II, III, and AVF there is clear ST elevation, which is diagnostic for an MI, in this cause a STEMI (ST elevation myocardial infarction. Great job identifying ST elevation in leads II, III, and aVF. Remember, this is clinically indicative of an inferior wall infarction which occurs with occlusion of the right coronary artery. BSc
Clinical Significance:
STEMI is more serious and concerning vs a non-STEMI because of how much of the myocardium of the heart is involved and with that, how much can be susceptible to damage. What is the significance of the RCA being blocked? BSc

Location of ST Segment Changes (lateral/anterior/inferior)**:**

Use the diagram below to identify the location of the infarction:

Though this content on basic 12-lead EKG interpretation may be above the scope of knowledge required for most programs, take advantage of the APPLICATION of the principle that ***ischemia causes distinct EKG changes****. This is relevant when a patient on routine cardiac telemetry monitoring begins to have NEW ST-T wave changes. If the nurse understands the significance of these changes, a RESCUE of a patient with a change of status can begin!*



Radiology Report: Chest x-ray

What diagnostic results are RELEVANT and must be recognized as clinically significant to the nurse?

RELEVANT Results:	Clinical Significance:
Scattered bilateral opacities consistent with atelectasis or pulmonary edema	This shows depressed LV function due to an MI and pulmonary edema.

Radiology Report: Echocardiogram

What diagnostic results are RELEVANT and must be recognized as clinically significant to the nurse?

RELEVANT Results:	Clinical Significance:
Global left ventricle hypokinesis with ejection fraction of 25%	The left ventricle is significantly damaged due to the MI that has happened. What is a normal EF? BSc

Lab Results:

Complete Blood Count (CBC):	Current:	High/Low/WNL?
WBC (4.5-11.0 mm 3)	10.5	WNL
Hgb (12-16 g/dL)	12.9	WNL
Platelets(150-450x 103/µl)	225	WNL
Neutrophil % (42-72)	70	WNL

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:
ALL	All labs that a patient has drawn are significant. Labs and their data can be used to trend data and see if anything is worsening in the patient's condition. Please provide detail related to how each of the labs are specifically relevant for a patient with a STEMI, as well as the clinical significance for each lab. In other words, what can the lab tell us about what is going on in the patient's body? BSc

Basic Metabolic Panel (BMP):	Current:	High/Low/WNL?
Sodium (135-145 mEq/L)	135	WNL
Potassium (3.5-5.0 mEq/L)	4.1	WNL
Glucose (70-110 mg/dL)	184	H
Creatinine (0.6-1.2 mg/dL)	1.5	H
Misc. Labs:		
Magnesium (1.6-2.0 mEq/L)	1.8	WNL

RELEVANT Lab(s):	Clinical Significance:
Creatinine	Shows kidney function and renal perfusion. Elevated creatinine can have an impact on other organ systems too and can be related to heart failure. Would you consider the patient's sodium, potassium, and magnesium levels to be relevant data as well? Although they are within normal limits, how are they important for a cardiac patient? BSc

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

Cardiac Labs:	Current:	High/Low/WNL?
Troponin (<0.4 ng/mL)	1.8	H
BNP (B-natriuretic Peptide) (<100 ng/L)	1150	H

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:
Troponin BNP 1150	Troponin is a cardiac enzyme that is secreted when damage to the heart occurs. Whenever it is elevated, it can be assumed that a patient has suffered an MI. It does remain elevated for days after the fact and takes a while (2-6 hours) to elevate. BNP is another cardiac marker that can signal heart damage. With BNP being this high, it can confirm heart failure.

Lab Planning: Creating a Plan of Care with a PRIORITY Lab:

Lab:	Normal Value:	Clinical Significance:	Nursing Assessments/Interventions Required:
Troponin **Value:** **1.8** ng/mL	**<0.05** **Critical Value:** >0.4	Protein found in cardiac muscle that is released from damaged tissue into the circulation.	**Assess for chest pain** ECG measurement (VT, PVCs, Afib) Measure vital signs (BP, HR) Assess tolerance to activity Administer IV NTG

Clinical Reasoning Begins…

1. ***What is the primary problem that your patient is most likely presenting with?***
   Acute Myocardial infarction
   Great job! BSc

2. ***What is the underlying cause/pathophysiology of this primary problem?***
   Myocardial infarction occurs when there is an abrupt stoppage of blood flow through a coronary artery from a thrombus.

What could be some underlying causes specific to this patient? Think about her history. BSc

Collaborative Care: Medical Management

Care Provider Orders:	Rationale:	Expected Outcome:
Establish 2 large bore peripheral IVs	Many IV medications will be needed and having two will serve the purpose of running different meds at the same time.	IV access will be established
Metoprolol 5 mg IV push x1 now	To decrease HR and maintain or lower blood pressure.	HR will decrease to a therapeutic level and BP will stabilize
Nitroglycerin IV drip-start at 10 mcg and titrate to keep SBP >100	Dilation of arteries to allow improvement of blood flow through coronary arteries (Will this help with the patient's CP?) BSc	Improve circulation to coronary arteries
Clopidogrel 600 mg po x1 now	Inhibit platelet aggregation and prevent further development of clots.	No further clots will develop
Aspirin 324 mg (81 mg tabs x4) chew x1 now	Same as clopidogrel	Same as with clopidogrel
Heparin 60 units/kg IV x1 now	Heparin can prevent a clot from growing	Clots will hold their current size
To cath lab as soon as team ready	Gold standard is a PCI procedure within 90 minutes. Will open up blocked artery.	Stent will be placed successfully and open up the blocked artery

PRIORITY Setting: Which Orders Do You Implement First and Why?

Care Provider Orders:	Order of Priority:	Rationale:
1.Establish 2 peripheral IVs 1. Metoprolol 5 mg IV push x1 now 2. Nitroglycerin IV drip-start at 10 mcg and titrate to keep SBP >100 3. Clopidogrel 600 mg po x1 now 4. Aspirin 324 mg (81 mg tabs x4) chew/po x1 now 5. Heparin 60 units/kg IV x1 now 6. To cath lab as soon as team ready	1: Aspirin 2: Clopidogrel 3: 2 IV starts 4: Metoprolol 5: Nitro 6: Heparin 7: Cath	1&2: Quick establishment of DAPT will prevent the scenario from worsening and is a quick and easy way to get the medications flowing. 3: Will prepare to infuse IV medications. Want to establish the medication therapy with DAPT first however. 4: Will bring down HR, decreasing the workload of the heart. 5: Dilate arteries and decrease workload of the heart 6: Prevent growth of current thrombus 7: Gold standard treatment is with heart cath but does take time for everything and everyone to get into place. Excellent job! BSc

Medication Dosage Calculation:

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Metoprolol 5 mg IV push (5 mg/5 mL vial)	Blocks stimulation of beta1 (myocardial)-adrenergic receptors. Does not usually affect beta2 (pulmonary, vascular, uterine)-adrenergic sites,	5 mL q 2 min for 3 doses 5 mL over 1 minute **IV Push:** **Volume every 15 sec?** 1 mL	Obtain BP and HR before administering. Hold if SBP <90 and BP <60. Monitor I and O. Tell patient to change positions slowly. Assess for HF symptoms (crackles, JVD, dyspnea, etc.)

Medication/Dose:	Mechanism of Action:	Volume/time frame to Safely Administer:	Nursing Assessment/Considerations:
Heparin 60 units/ kg Weight: 62 kg (1000 units/mL)	Neutralizes thrombin, preventing conversion of fibrinogen to fibrin	3720 units (62x60) 3.72 mL (3720/1000) **IV Push:** **Volume every 15 sec?** 1 mL Great job! BSc	Assess for signs of bleeding after infusion is finished Monitor labs (aPTTT) and platelet count every 2-3 days through therapy. Use electric razor Report any signs of bleeding Protamine sulfate is the antidote for reversal of anticoagulation

Collaborative Care: Nursing

3. What nursing priority(ies) will guide your plan of care? *(if more than one-list in order of PRIORITY)*

Impaired gas exchange
Decreased cardiac output
Acute pain
Anxiety
Excellent job! BSc

4. What interventions will you initiate based on this priority?

Nursing Interventions:	Rationale:	Expected Outcome:
Medications: Metoprolol, ASA, Heparin Assess VS ECG monitoring O2 via nasal cannula Raise HOB Reduce environmental stimuli Prepare for probable PCI Lab draw	1: Decrease HR, as well as BP, which will decrease workload of heart. ASA will prevent clot from getting larger, along with heparin. 2: Vital signs to get an indication of what is happening, any worsening etc. 3: ECG monitoring looking for rhythm changes if any are present.	1: HR and BP will stabilize 2: HR and BP will be lowered after implementation of medication. 3: Be able to assess and react to a change in

What about a focused cardiovascular assessment as well as a respiratory assessment? BSc	4: O2 to help take ease off of respirations and workload of heart. 5: Promote maximum effort of breathing 6: Reduce stimuli will help in easing anxiety 7: PCI will likely be needed, and you want to have the patient prepped and ready to go once they are ready. 8: See if any changes have taken place since last draw	rhythm. 4: Workload of breathing will decrease. 5: Same as above. 6: Anxiety will reduce. 7: Patient will be ready to go to cath lab 8: Blood will be drawn and changes will be assessed

5. ***What body system(s) will you most thoroughly assess based on the primary/priority concern?***
Cardiopulmonary

6. ***What is the worst possible/most likely complication to anticipate?***
Ventricular tachycardia or ventricular fibrillation

Great job! Why is this a concern? What about cardiogenic shock? BSc

7. ***What nursing assessments will identify this complication EARLY if it develops?***
Make sure alarms are set on the ECG monitor and someone is keeping an eye on the monitor and the patient constantly.
Make sure to remain calm and call a code.
Start compressions and assure someone gets the crash cart and the essential medications and defibrillator.

8. ***What nursing interventions will you initiate if this complication develops?***
Initiate a code team or MET
Assess patient and check LOC
Start CPR until defibrillator can be placed

9. ***What psychosocial needs will this patient and/or family likely have that will need to be addressed?***
Knowledge on what happened, what could have potentially caused this, and how to manage going forward
Excellent, we would also want to provide them emotional and spiritual support as well. BSc

10. ***How can the nurse address these psychosocial needs?***
Answer all questions honestly and to the best of their ability
Face the patient, look them in their eyes
Build up the teaching, do not do it all at once
Allow for questions to be asked
Provide them with any resources they may need

Evaluation: Two Days Later…

JoAnn had an angiogram that revealed an occluded proximal right coronary artery (RCA). She received two bare metal stents with 0 percent residual stenosis. She has been in the intensive care unit (ICU) the past two days and is now transferring to the cardiac telemetry floor. She has been receiving scheduled furosemide 40 IV mg every 12 hours. Her

creatinine increased from 1.7 to 2.1 today. The last dose of furosemide was given four hours ago. She has had 100 mL urine output the past four hours. She fatigues easily, but tolerates being up in the chair for short periods of time. Faint basilar crackles persist bilaterally and her O2 is at 2 liters per n/c.

What data from this history are RELEVANT and must be recognized as clinically significant to the nurse?

RELEVANT Data from History:	**Clinical Significance:**
Lasix q 12 hr Creatinine increase from 1.7-2.1 100 mL of output over 4 hours Fatigues easily Crackles persist bilaterally in bases	-Lasix via IV says that there is still volume overload and the need to accurately assess intake and output is vital. Creatinine increase means that some sort of kidney injury must be present and not responding to other treatments. The 100 mL of output is also significant because that equates to less than 30 mL/hr. Along with that, if a patient is getting a diuretic, you would expect a much higher number. Fatigues easily means that she can be deemed a fall risk and the nurse needs to assess her closely and provide her interventions together so she does not tire out and promote periods of rest Crackles mean that fluid or excess volume is present. Could be a manifestation of HF as well/

Current VS:	**Most Recent:**	**P-Q-R-S-T Pain Scale:**	
T: 97.2 F/36.2 C (oral)	**T:** 97.5 F/36.4 C (oral)	**P**rovoking/Palliative:	
P: 76 **(**regular/irregular)	**P:** 82 **(**regular)	**Q**uality:	Denies pain
R: 20 (regular)	**R:** 20 (regular)	**R**egion/Radiation:	
BP: 122/58	**BP:** 116/68	**S**everity:	
O2 sat: 95% room air	**O2 sat:** 94% room air	**T**iming:	

Current Assessment:	
GENERAL APPEARANCE:	Resting comfortably, appears in no acute distress
RESP:	Denies SOB, non-labored respiratory effort, breath sounds equal aeration bilaterally with faint crackles in both bases
CARDIAC:	Pink, warm & dry, 1+ pitting edema in lower extremities, heart sounds regular–S1S2, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks
NEURO:	Alert & oriented to person, place, time, and situation (x4)
GI:	Abdomen soft/non-tender, bowel sounds audible per auscultation in all 4 quadrants
GU:	50 mL urine output since furosemide IV administered two hours ago, urine clear/yellow
SKIN:	Skin integrity intact, femoral puncture site soft, non-tender with no drainage, redness, or bruising

1. What clinical data are RELEVANT and must be recognized as clinically significant?

RELEVANT VS Data:	**Clinical Significance:**
RR: 20	This Is WNL but is on the higher end of the spectrum and the patient is currently resting. More thorough assessment to see if the nurse can find as to why these are a tad high.
RELEVANT Assessment Data:	**Clinical Significance:**

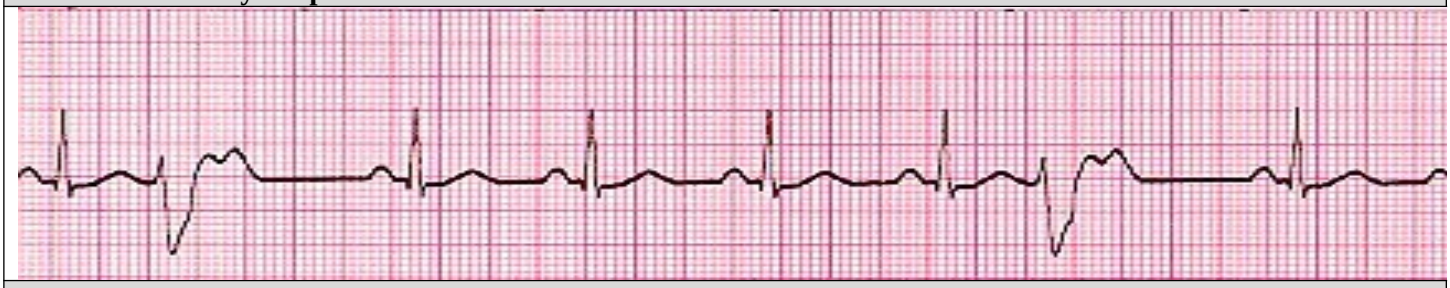
+1 pitting edema in lower extremities Faint crackles in both bases 50 mL output in two hours	Pitting edema indicates that a small amount of fluid volume remains and that the patient should be putting out more fluid than what has currently been diueresed. Crackles still in bases indicates fluid or perhaps HF are present 50 mL/2 hours is below the normal of 30 mL/hr and the patient has received a diuretic on top of that. This number should be higher and an AKI is perhaps at play. Great interpretations! BSc

2. ***Has the status improved or not as expected to this point?***
   Although the vital signs and some assessment parameters are WNL, there are indicators that would suggest she is worsening at this point. The fluid volume overload on top of the AKI indicate that organ damage could come soon if some changes are not had.

3. ***Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment?***
   I would still keep the plan of care the same

Is there another body system we need to closely monitor now that you maybe didn't consider initially? What about Genitourinary? BSc

Cardiac Telemetry Strip:



Interpretation:

Normal sinus rhythm with PVCs (unifocal)

Clinical Significance:

PVCs are not serious if they are present in someone with a normal, healthy heart. In this patient's case since she had an MI, they could indicate ventricular irritability. What the nurse needs to do is further assess the patient and keep checking the monitor to make sure she is not having runs of PVCs.

Great job! Are there any specific labs we would be concerned about monitoring? BSc

Two hours later…

JoAnn is resting quietly in bed. Foley catheter assessment reveals no new urine in bag from previous assessment two hours ago. Bladder scan reveals no residual urine. Review of labs reveal increased creatinine. The primary nurse gives the following SBAR to the on-call cardiologist:

Situation:

Name/age: JoAnn Smith, 68-year-old woman

BRIEF summary of primary problem: No urine output for the past two hours. Patient has been receiving Lasix 40mg IV q 12 hours and output has been very low and now is at zero. Creatinine also increased from 1.7-2.1 on most recent labs.

Day of admission/post-op #: Day 2

Background:

Primary problem/diagnosis:
Acute MI

RELEVANT past medical history:
DM type 2, HTN, HLD, CVA with no residual deficits.

Assessment:

Vital signs:
T: 97.2 (oral)
P: 76 (regular/irregular) R: 20 (regular)
BP: 122/58
O2 sat: 95% room air

RELEVANT body system nursing assessment data:
CARDIAC: Pink, warm & dry, 1+ pitting edema in lower extremities, heart sounds regular–S1S2, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks
RESPIRATORY: Denies SOB, non-labored respiratory effort, breath sounds equal aeration bilaterally with faint crackles in both bases
GU: 50 mL urine output the past 2 hours after furosemide IV given, urine clear/yellow

TREND of any abnormal clinical data (stable-increasing/decreasing):
Creatinine draw indicated increase from 1.7 to 2.1

INTERPRETATION of current clinical status (stable/unstable/worsening):
Condition is worsening

Recommendation:

Suggestions to advance plan of care:
Recheck BMP
Repeat furosemide or increase how often we are giving it. Excellent! BSc

The physician addresses your concern and orders a repeat basic metabolic panel (BMP and repeat x1 furosemide (Lasix) 40 mg IV push. You obtain the following results one hour later:

Basic Metabolic Panel (BMP):	Current:	High/Low/WNL?	Most Recent:
Sodium (135-145 mEq/L)	135	WNL	132
Potassium (3.5-5.0 mEq/L)	5.9	H	4.1
Glucose (70-110 mg/dL)	152	H	184
Creatinine (0.6-1.2 mg/dL)	2.9	H	2.1

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:
Potassium 5.9	Potassium increasing along with the	High, worsening

Glucose 152 Creatinine 2.9	creatinine can be linked together. Due to the kidney injury, the kidneys are not able to excrete potassium from the body and thus, the body is holding onto it and causing the lab value to go up. The glucose is expected to be elevated due to the DM, it is still worth noting.	High, worsening High Worsening
Current Assessment:		
GU:	One hour post furosemide administration IV, continues to have no urine output.	

1. ***Has the status improved or not as expected to this point?***

The status has not improved and it appears as if renal failure is occurring.

2. ***Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment?***

Modifying the plan of care to include possible dialysis or continuous renal replacement therapy.

3. ***Based on your current evaluation, what are your nursing priorities and plan of care?***

Continue to assess intake and output closely. At the same time, you need to balance the fluids you are giving with the fluids she is holding onto/not getting rid of. Assessing for worsening lung sounds is also important at this point. Getting updated other labs and having the physician on close contact will be essential.

Caring and the "Art" of Nursing

1. ***What is the patient likely experiencing/feeling right now in this situation?***

Without her husband in the room, the patient is probably very scared and alone. Getting him in with her to try and ease some of that anxiety is of importance too. She is more than likely wondering what is happening and if she is going to make it out of the hospital alive or not.

2. ***What can you do to engage yourself with this patient's experience and show that she matters to you as a person?***

Therapeutic communication
Showcase empathy and compassion
Maintain eye contact
Allow questions to be asked
Allow the patient to participate in his own care
Be a voice and advocate for him throughout his entire stay

Use Reflection to THINK Like a Nurse

Reflection-IN-action (Tanner, 2006) is the nurse's ability to accurately interpret the patient's response to an intervention in the moment as the events are unfolding to make a correct clinical judgment.

1. ***What did I learn from this scenario?***

I learned that a patient can come in with one problem and leave with several others. A patient is most likely not going to have just one body system affected at a time. Multiple problems exist and usually they occur simultaneously. In cases like this, collaboration between multiple specialties and persons is key in making sure the best care is provided to the patient.

2. ***How can I use what has been learned from this scenario to improve patient care in the future?***

Continue to ask why something is happening. Think as a whole and look at the entire picture. No urine output? Ask yourself why and think of the potential causes and solutions.

Zach,

You did an excellent job with this unfolding case study. Please take the time to revisit the areas in which I identified there may have been some missing information, or more information that could be added after further deliberation and deeper thinking. This will greatly benefit you and your care in the clinical setting in the future. Additionally, please incorporate my feedback in order to improve in following virtual clinical experiences. If you have any questions about the content or need further clarification, please do not hesitate to reach out to me. Keep up all your hard work! BSc

References

Lewis, S., Dirksen, S., Heitkemper, M., & Harding, M. (2017). *Medical surgical nursing: Assessment and management of clinical problems* (10th ed.). St. Louis, MO: Mosby, Elsevier.

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2018). *Davis's drug guide for nurses* (16th ed). F. A. Davis Company: Skyscape Medpresso, Inc.