N311 Care Plan #3

Lakeview College of Nursing

Mackenzie Melton

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
10/24/2020	R.W.	12/03/1936 (83 y/o)	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/Caucasian	Retired	Widowed	None
Code Status	**Height**	**Weight**	
Full	5’5”	252lbs	

Medical History (5 Points)

Past Medical History: Dementia, Coronary artery disease, Congestive heart failure, Chronic obstructive pulmonary disease, High cholesterol, Cerebrovascular accident, Hypertension, Hypothyroidism, Type 2 Diabetes mellitus

Past Surgical History: Tonsillectomy in 1947, Hysterectomy in 1986, Cataract surgery in 2013

Family History: Maternal and Paternal Grandparents: Patient is not aware of any known health problems related to her grandparents, Father: Heart attacks, Mother: Brain cancer, Brother: Heart attacks, Oldest daughter: Breast cancer, Youngest daughter: Stroke

Social History (tobacco/alcohol/drugs): Patient states she has had no past or present tobacco, alcohol, or recreational drug use.

Admission Assessment

Chief Complaint (2 points): Shortness of breath and chest pain

History of present Illness (10 points): Onset: On October 24th, an 83 y/o white, widowed female was admitted to Sarah Bush Lincoln Health Center after having arrived at the Emergency Room for shortness of breath and chest pain. Location: Chest. Duration: On the 24th, the pain presented itself constantly with the pain starting earlier in the morning, however, since being admitted the patient states

the pain has subsided. Characteristics: The patient was experiencing a tight, squeezing pain in which she rated it as an 8/10 at the time of. Aggravating: Taking a deep breath, lying down flat, and activity exacerbated her pain. Relieving: Sitting up straight and resting helped relieve the pain a bit. Treatment: Nothing helped treat the pain prior to arriving at the ER.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Paroxysmal Atrial fibrillation

Secondary Diagnosis (if applicable): N/a

Pathophysiology of the Disease, APA format (20 points):

Atrial fibrillation occurs when the two upper chambers of the heart, known as the atriums, start to quiver in a rapid, chaotic, and irregular rhythm (Amuthan & Cantillon, 2018). In order for the heart to contract and pump blood through the body, a signal has to be constructed and transmitted along the path of the hearts conduction system. Normally that conduction system would start with an impulse that is created by the sinoatrial node, which is the first part of the conduction system. From there, the signal travels through the atriums and to the atrioventricular node in the ventricles, which then cause the ventricles to constrict, before continuing to the bundle of his, bundle branches, and purkinje fibers. However, during atrial fibrillation because of the rapid increase of impulses being fired, the AV node is being over stimulated by the SA nodes signals, causing the ventricle then to beat rapidly as well, impairing the flow of blood (Mayo Clinic, n.d.).

There are four different types of atrial fibrillation; paroxysmal, persistent, long-standing, permanent, and nonvalvular. Paroxysmal atrial fibrillation is when the heart rhythm reverts back to normal either on its own or by intervention within seven days of its start. People who have paroxysmal usually have episodes a couple times a year or the can occur and happen every day to turn into a more permanent form (American Heart Association, n.d.). No matter what the type; the symptoms are generally the same. The most common symptoms people experience when they have symptoms are fatigue, weakness, palpitations, reduced ability to exercise, lightheadedness, dizziness, shortness of breath, and chest pain (Mayo Clinic, n.d.).

Anyone is at risk for developing atrial fibrillation, but the possibility and risk increases with age as well as several health factors. Some of those health factors are high blood pressure, underlying heart disease, drinking alcohol, smoking, family history of atrial fibrillation, sleep apnea, hyperthyroidism, diabetes, asthma, and other chronic medical problems (American Heart Association, n.d.). To diagnose atrial fibrillation the most common tests completed are an electrocardiogram that is used to record electrical signals as they move through the heart and conduction system and an echocardiogram which uses sound waves to create moving pictures of a heart in order to diagnose heart disease of blood clots (Mayo Clinic). A stress test, x-ray, and Holter monitor can also be used.

When a patient is experiencing atrial fibrillation, the patient needs to have their heart rhythm reset to regular rhythm using a procedure called cardioversion. Cardioversion is used to restore heart rhythm through sending electrical shock to the heart through electrodes or by medications such as Flecainide, Defetilide, Propafenone, Amiodarone, or Ibutilide (Mayo Clinic, n.d.). Atrial fibrillation can be prevented by different lifestyle habits such as eating a heart healthy diet, increasing physical activity, smoking

cessation, maintaining a healthy weight, limiting/avoiding caffeine and alcohol, reducing stress, and cautiously using over the counter medications (Mayo clinic, n.d.).

Pathophysiology References (2) (APA):

American Heart Association. (n.d.). *Atrial Fibrillation: What is Atrial Fibrillation?* Retrieved October 28, 2020, from https://www.heart.org/en/health-topics/atrial-fibrillation/what-is-atrial-fibrillation-afib-or-af

Amuthan, R., Cantillon, D.J. (2018, August). *Atrial Fibrillation.* Cleveland Clinic: Center for Continuing Education. http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/cardiology/atrial-fibrillation/

Mayo Clinic. (n.d.). *Atrial Fibrillation.* Retrieved October 28, 2020, from https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.41 x10^6/mcL	3.87x10^6/mcL	3.94x10^6/mcL	
Hgb	11.3-15.2 g/dL	12.3g/dL	12.7g/dL	
Hct	33.2-45.3%	36.1%	24.8%	
Platelets	149-393 K/ mcL	198K/mcL	214K/mcL	
WBC	4.0-11.7 K/ mcL	7.0K/mcL	7.2K/mcL	
Neutrophils	45.3-79.0%	49.9%	48.2%	
Lymphocytes	11.8-45.9%	19.7%	23.5%	
Monocytes	4.4-12.0%	9.7%	9.8%	
Eosinophils	0.0-6.3%	1.5%	1.91%	
Bands	0.0-10.0%	*	*	*Did not run tests to determine the percentage of bands in the blood

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145 mmol/L	139mmol/L	139mmol/L	

K+	3.5-5.1 mmol/L	3.6mmol/L	3.9mmol/L	
Cl-	98-107 mmol/L	106mmol/L	102mmol/L	
CO2	21-31 mmol/L	23mmol/L	27mmol/L	
Glucose	74-109 mg/ dL	99mg/dL	133mg/dL	Reasons for high glucose levels can be associated/caused by diabetes (Hopkins, n.d.). My patient has a previous diagnosis of being a type 2 diabetic.
BUN	7-25 mg/dL	14mg/dL	55mg/dL	An elevated BUN level can occur because of most renal diseases, GI bleeding, dehydration, high-protein diet, and heart failure (Hopkins, n.d.). My patient is in congestive heart failure.
Creatinine	.70-1.30mg/ dL	.74mg/dL	1.79mg/dL	Elevated levels of creatine can occur because of impaired renal function or due to a lack of blood circulation to the kidney related to hypotension, heart failure, and shock (Capriotti,2020). My patient has congestive heart failure which can result in poor blood flow to the kidneys.
Albumin	3.5-5.2 g/dL	4.1g/dL	*Did not test for after admission	
Calcium	8.6-10.3mg/ dL	9.3mg/dL	8.6mg/dL	

Mag	1.5-2.5 mEq/L	1.9mEq/L	*Did not test for after admission	
Phosphate	2.5-4.5mEq/ dL	*	*	*Did not run a test to obtain Phosphate values.
Bilirubin	.3-1.0 mg/dL	1.0mg/dL	*Did not test for after admission	
Alk Phos	34-104 unit/ L	70unit/L	*Did not test for after admission	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value*	Reason for Abnormal
Color & Clarity	Yellow & clear	*Did not test for on admission.	Yellow & clear	
pH	5.0-8.0	*	5.0	
Specific Gravity	1.005-1.039	*	1.016	
Glucose	Normal	*	Normal	
Protein	Negative	*	Negative	
Ketones	Negative	*	Negative	

WBC	0.0-5.0HPF	*	3.0 HPF	
RBC	0.0-3.0HPF	*****	1.0 HPF	
Leukoesterase	Negative	*****	Negative	

*Values obtained on 10/26 and reviewed on 10/27

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative/No growth	*****	*****	*****No urine, blood, or stool cultures completed for this patient.
Blood Culture	Negative/No growth	*****	*****	
Sputum Culture	Negative/No growth	Negative	*Did not test for today.	
Stool Culture	Negative/No growth	*****	*****	

Lab Correlations Reference (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

Hopkins, T. B. (n.d.). *Lab notes: Nurse's guide to lab and diagnostic tests* (3rd ed). F.A. Davis Company.

Normal lab values came from SBL Chem DXC700 documentation system within Cerner

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Electrocardiogram (ECG): The ECG that was taken on 10/24 at 1534 showed positive indication for atrial fibrillation with normal sinus rhythm and a ventricular rate of 132 beats per minute. Atrial fibrillation is different compared to normal heart rhythm. A normal heart rhythm with sinus rhythm is characterized as an organized pace of 60-100 beats per minute that causes an electrical impulse that starts at the sinoatrial node and moves through the rest of the hearts conduction system in order to pump blood out to the rest of the body. Atrial fibrillation is when the atria of the heart start to quiver in a rapid, chaotic, and irregular rhythm which results in an insufficient amount of blood to pushed out of the heart (Amuthan & Cantillon, 2018). In this patient case, the atria of her heart were firing off 132 impulses a minute, wanting to push blood from one atrium to the ventricles, regardless if there was enough blood or a need to do so. An ECG is performed in order to look at the electrical signals in your heart to see if it' causing the heart to beat at a normal rate and strength of 60-100 beats per minute, which can determine if your heart is adequately pumping blood through the body.

Chest X-ray: The x-ray taken on 10/24 at 1658 showed no positive results for a pneumothorax, AKA a collapsed lung, however it did show that the heart was mildly enlarged and thickening of the left ventricular wall of the heart had started to occur due to poor pumping actions of the heart as well as hypertension.

Echocardiogram with contrast: The echocardiogram performed on 10/25 at 1130 showed that the patient had a normal finding of an ejection fraction of greater than 70%. The echo also found abnormal findings of the left atrium being dilated, pulmonary hypertension, and Tricuspid and Mitral valve regurgitation, which is the inadequate closing of the valves

Current Medications (10 points, 2 points per completed med)
5 different medications must be completed

Medications (5 required)

Brand/Generic	Lasix/Furosemide	Lipitor/Atorvastatin	Diprivan/ Propofol	Toprol-XL/ Metoprolol	Tambocor/Flecainide
Dose	40mg	80mg	200mg	25mg	100mg
Frequency	1x day	1x day	PRN	1x Day	2x day
Route	PO	PO	PO	PO	PO
Classification	Loop diuretic	Antihyperlipidemic	Hypnotic	Antihypertensive	Antidysrhythmic
Mechanism of Action	Reabsorption of sodium and chloride is inhibited in the nephron of the	Cholesterol production is reduced by the inhibition of HMG-CoA reductase	Decreases intracranial pressure, cerebral blood flow, and metabolic oxygen	Reduces elevated renin levels in plasma and blocks beta-adrenergic receptors to lower	Stabilizes cardiac membrane by decreasing conduction in the heart.

	kidney.	enzyme.	consumption to depress the CNS.	blood pressure.	
Reason Client Taking	To reduce edema with heart failure	To reduce lipid levels	To provide sedation	To reduce hypertension	To prevent paroxysmal atrial fibrillation
Contraindications (2)	Anuria, Hypersensitivity	Breast feeding, Active hepatic disease	Respiratory depression, cardiac dysrhythmias	Sinus bradycardia, cardiogenic shock	GI hemorrhage, respiratory insufficiency
Side Effects/Adverse Reactions (2)	Arrhythmias, Renal failure	Liver dysfunction, Pancreatitis	Increased intracranial pressure, seizures	Pulmonary/peripheral edema, cardiac arrest	Heart failure, Cardiovascular arrest

Medications Reference (APA):

Jones and Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed). Jones and Bartlett Publishers.

Skidmore-Roth, L. (2020). *Mosby's 2020 nursing drug reference* (33rd ed). Elsevier.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and orientated to year, place, person, and reason for visit x4. Patient appears to be in no apparent distress at this time. Pt is appropriately dressed and well-groomed.
INTEGUMENTARY:	Skin is pink, warm, wrinkly, and intact in all

Skin color: **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	areas with no current presentation of open wounds. Patient does have skin that is more moist than usually in all areas except for the arms and legs, which are very dry, but underneath the breasts, in the groin, and in skin folds there was excessive moisture as well as were very red. Pt had poor skin turgor as it did not immediately fall back in to place, it took approx. 5 seconds to return to normal. No rashes or bruises located on the patient, however the patient did have a stage 2 pressure ulcer on her coccyx as it had an open, shallow, pink wound bed. Braden score- 16 which indicates patient is at high risk for pressure sores and impaired skin integrity!
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head appears to be round/normal with no obvious contusions or abnormalities. Pt has no tracheal deviation and the thyroid rises and falls during swallowing. No hair loss or abnormal thinning. Ears are placed bilaterally even/equal with the top of the ear lobe lining up straight with the eyes. Pupils are equal, round, and reactive to light and accommodation- patient uses reading glasses and has no vision problems otherwise as she had cataract surgery in 2013. Bridge of pt nose is straight and not crooked. Patient had bilaterally equal nares with no deviated septum. No abnormal turbinate findings as they were pink and had minimal swelling. No

	pain on palpitation of the frontal or maxillary sinuses. Did not feel an swollen occipital, preauricular, or submental lymph nodes- did not assess for the others. Pt uses dentures- had no apparent chipping or staining of the dentures. Gums were pink, firm, and moist. Observed the rise and fall of the soft pallet and pt has had a tonsillectomy so no tonsils were present. .
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:**	S1 and S2 sounds heard, no detected murmurs or S3 gallops. Pt had a pulse of 51/bpm**.** Patient stated she had experienced palpitations when she first came into the ER but had not experienced them since being admitted. Equal and bilateral, bounding carotid, brachial, radial, popliteal, posterior tibial, and dorsalis pedis pulses. Didi not assess the patient's formal pulses. Patient had poor capillary refill as it took longer than 3 seconds for color to return to the finger tips. Pt did have some bilateral pitting edema in her lower legs and feet. 2+ pitting edema on the feet and lower legs as it took more than 3 second for the tissue to rebound and it was approx. 3-4 cm deep.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds were decreased/diminished- very faint but were clear and non-labored. Pt averaged approx. 24 respirations initially, however when was reassessed later after nursing interventions, her breath rate decreased to 20 a

	minute. No wheezes, crackles, stridor, or rhonchi notes.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Pt is on a cardiac healthy diet here at the hospital but states she isn't very good about limiting sodium and excessive fluid intake at home. 5'5" 252lbs Auscultated the bowel sounds- heard approximately 17 clicks and gurgling noises during a full 5 minutes of listening, which is normal. (5-30 is the normal range) Did not palpate the abdomen. Pts last BM was on 10/27 @ 1120- was a medium size amount and was soft in texture, dark brown in color. No visible distention, incisions, drains, scars, or wounds.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Yellow & clear No abnormal odor. Voided 500mL during the shift. Pt stated she does feel like she experiences some frequency when having to urinate, which sometimes can result in incontinence when she can't get to the bathroom. Did not inspect the genitals but the patient did have some redness and moisture in the skin fold of the groin.
MUSCULOSKELETAL:	Pt has fluid, nonrestrictive, or impaired range of

Neurovascular status: **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	motion in all extremities with bilateral grip and strength in both hands, arms, and legs. Pt is a 1x stand by assist with ambulating and very minimal assistance with ADLs-mainly just assistance when showering. Pt also uses a walker during ambulation for added support and balance. Briggs fall risk assessment score of 12 which indicates she is a high fall risk. Pt did state she has a little bit of pain/discomfort in her left knee during ambulation, but also stated she is aware it is from arthritis and has been a chronic issue.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Pt has fluid, nonrestrictive, or impaired range of motion in all extremities with bilateral grip and strength in both hands, arms, and legs. Pt's pupils are equal, round, and reactive to light and accommodation. Alert and orientated to year, place, person, and reason for visit x4. Pt does have a history of dementia but was fully alert and orientated during my assessment. Appears to have no current, impaired decision-making abilities. No slurring or stuttering of her speech. Speaks clearly and loudly. No reported loss of consciousness.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Pt relies on her children, grandchildren, and significant other, to help cope and relive stress that she feels during points of her life. Pt did state she was/is Baptist but does not practice and had not for many years. Pt lives in a trailer home with her significant other, Fred, but does have 4 children and 5

	grandchildren that live in the area and she sees approximately once a week.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0845	51	162/92	24	37.5 deg C	92%
1145	62	128/66	20	37.3 deg C	94%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0845	Numeric 0-10	Chest	0/10	Tight, squeezing	Elevate head of the bed, educate patient on deep breathing and pursed lip breathing exercises, and administer oxygen as ordered by the physician.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
Water= 12oz Coffee= 8oz Total= 600ml total Food: Ham and cheese omelet, 2 sausage links, and a small fruit cup. 75% of breakfast ate- pt was saving fruit cup to eat later.	Voided 175mL of urine at 0750 Voided 325mL of urine at 1120 BM: 1x medium size @ 1120 Total: 500mL of urine voided

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis • Include full nursing diagnosis with	**Rational** • Explain why the nursing	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond

"related to" and "as evidenced by" components	diagnosis was chosen		to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Decreased cardiac output related to diagnosis of congestive heart failure, hypertension, and atrial fibrillation as evidenced by blood pressure reading of 162/92, strong-bounding peripheral pulses, and EKG finding of atrial fibrillation with a ventricular rate of 132 beats per minute.	This diagnosis was chosen because of the patients' elevated blood pressure as well as the results of her EKG stated she had an increased ventricular rate of 132 beats per minute while in atrial fibrillation.	**1.** Assess and monitor heart rate, blood pressure, and rhythm every 4 hours. **2.**Administer cardiac medications, such as Metoprolol and Flecainide, on time and as prescribed.	Goal met. Patient's vitals were stabilized as seen on cardiac monitor. BP: 128/66 and HR:62. Goal met. Proper administration of cardiac medications as ordered help to stabilize patients' vitals.
2. Impaired gas exchange related to diagnosis of chronic obstructive	This diagnosis was chosen because of the patients' prior diagnosis of COPD, her current increased	1. **1.** Keep the head of the bed elevated. **2.**Educate patient	Goal met. Patient was able to comfortable perform breathing exercises and helped relive any discomfort.

pulmonary disease as evidenced by increased respiratory rate of 24 breaths per minute and an oxygen saturation of 92% with dependence of supplemental oxygen.	respiration rate, and decreased SaO2 vitals.	on how to perform proper deep breathing and pursed lip breathing exercises, and how to use an incentive spirometer.	Goal met. Patient was able to correctly explain and demonstrate/perform proper use of the incentive spirometer, deep breathing, and pursed lip breathing.

Other References (APA):

Amuthan, R., Cantillon, D.J. (2018, August). *Atrial Fibrillation.* Cleveland Clinic: Center for Continuing Education.

http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/cardiology/atrial-fibrillation/

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

1. Decreased cardiac output related to congestive heart failure diagnosis, hypertension, and atrial fibrillation as evidenced by blood pressure reading of 162/92 and EKG finding of atrial fibrillation with a ventricular rate of 132 beats per minute.

-Goal met. Patient's vitals were stabilized as seen on cardiac monitor. BP: 128/66 and HR: 62.
-Goal met. Proper administration of cardiac medications as ordered help to stabilize patients' vitals.

2. Impaired gas exchange related to chronic obstructive pulmonary disease diagnosis as evidenced by increased respiratory rate of 24 breaths per minute and an oxygen saturation of 92% with dependence of supplemental oxygen.

- Goal met. Patient was able to comfortable perform breathing exercises and helped relive any discomfort.
- Goal met. Patient was able to correctly explain and demonstrate/perform proper use of the incentive spirometer, deep breathing, and pursed lip breathing.

Patient rated the pain she felt in her chest at the time, as a constant, tight, squeezing pain which is aggravated by lying flat, taking a deep breath, and activity. At the time of coming into the ER, the patient had rated her pain as an 8/10, but upon my assessment on 10/27/2020 that patient rated her pain as a 0/10 and stated she hadn't had any pain since.

Objective Data

Patient Information

Nursing Interventions

1. Assess and monitor heart rate, blood pressure, and rhythm every 4 hours.
2. Administer cardiac medications, such as Metoprolol and Flecainide, on time and as prescribed.
3. Keep the head of the bed elevated.
4. Educate patient on how to perform proper deep breathing and pursed lip breathing exercises, and how to use an incentive spirometer.

<u>Vitals</u>

	@0845	**@1145**
BP:	162/92	128/66
Pulse:	51	62
RR:	24	20
Temp:	37.5 C	37.3 C
O2:	92%	94%

Pt had an EKG that showed atrial fibrillation with sinus rhythm and a rapid ventricular rate of 132bpm. Following the EKG, the patient also had a chest x-ray that showed no pneumothorax but did show some mild enlargement of the heart and a thickened ventricle wall. The pt then had an echocardiogram which showed an ejection fraction of greater than 70%, left atrial dilation, pulmonary hypertension, and tricuspid and mitral valve regurgitation.

83 y/o female presents with a chief complaint of chest pain which started in the early morning of October 24th. Patient has a past medical history of Dementia, Coronary artery disease, Congestive heart failure, Chronic obstructive pulmonary disease, High cholesterol, Cerebrovascular accident, Hypertension, Hypothyroidism, Type 2 Diabetes mellitus. Patient also had a previous surgical history which consists of Tonsillectomy in 1947, Hysterectomy in 1986, Cataract surgery in 2013.