

N311 Care Plan 4

Lakeview College of Nursing

Autumn McIntosh

Demographics (5 points)

Date of Admission 3-29-2021	Patient Initials SA	Age 66	Gender M
Race/Ethnicity White	Occupation Works at Subway	Marital Status Married	Allergies Morphine
Code Status Full Code	Height 5'11"	Weight 222	

Medical History (5 Points)

Past Medical History: Anemia, Asthma when he was a kid, Bleeding disorder, Diabetes Mellitus, HTN, Mixed dyslipidemia, Mitral valve repair, TIA

Past Surgical History: Appendectomy, Colonoscopy (8-17-2020), Hand surgery, Mitral valve replacement, R/L heart catheterization

Family History: Mother: Cancer; Maternal grandfather: Kidney disease and COPD; Maternal grandmother: Stroke; Daughter: Diabetes

Social History (tobacco/alcohol/drugs): 4.0 drinks once in a while usually 2 glasses of wine and 2 cans of beer per week

Admission Assessment

Chief Complaint (2 points): Severe MR due to flail leaflet s/p mitral valve repair

History of present Illness (10 points): SA is a 66 yr old male with Anemia, Asthma when he was a kid, Bleeding disorder, Diabetes Mellitus, HTN, Mixed dyslipidemia, Mitral valve repair, TIA. He has been diagnosed with severe MR and was awaiting cardiovascular surgery when he was first evaluated. He underwent surgery and is doing well but continued to have recurrence of AFIB. He presents now with sotalol loading. He denies any orthopnea, PND,

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lightheaded/dizziness, or presyncope/syncope. He feels chest tightness and irregular heartbeat with AFIB

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Persistent AFIB and atypical AFL

Secondary Diagnosis (if applicable):

Pathophysiology of the Disease, APA format (20 points): Atrial flutter and atrial fibrillation are common arrhythmias that both involve reentrant circuits. “Reentrant circuits are circular pathways in which electrical impulses can travel around the circle, reactivate the starting point, and create an endless loop” (Berkowitz, 2020). In AFIB there are many reentrant circuits spinning around the atria causing the EKG to appear as a wavy, chaotic disorganized baseline without recognizable P waves. Rates in the atria can be over 400 beats per minutes, but due to the refractory period of the AV node, the ventricle can not reach this speed. Since the beats that do make it through are essentially random, the ventricular rhythm is irregularly irregular. Some cause of AFIB can be a variety of heart disease, pulmonary disease, pulmonary embolism, hyperthyroidism. HTN. AFIB can also occur idiopathically. In atrial flutter, reentrant circuit in the atrium allows electrical impulses to spin around the loop at very high speed instead of following the normal conduction pattern. The EKG will have a saw-tooth appearance to the P waves. In atrial flutter, the atrial rate is typically between 200-400 beats per min. Some symptoms of AFIB are chest pain, fatigue, and dizziness.

Berkowitz, A. (2020). Clinical Pathophysiology made ridiculously simple., pg 19.

10.1080/14779072.2018.1540301.

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	N/A	N/A	N/A	N/A
Hgb	N/A	N/A	N/A	N/A
Hct	N/A	N/A	N/A	N/A
Platelets	N/A	N/A	N/A	N/A
WBC	N/A	N/A	N/A	N/A
Neutrophils	N/A	N/A	N/A	N/A
Lymphocytes	N/A	N/A	N/A	N/A
Monocytes	N/A	N/A	N/A	N/A
Eosinophils	N/A	N/A	N/A	N/A
Bands	N/A	N/A	N/A	N/A

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-	135-145	139	140	
K+	3.5-5.0	4.0	4.3	
Cl-	98-107	105	106	
CO2	22-29	29.8	28.6	

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Glucose	70-99	93	106	Atrial fibrillation was correlated with higher levels of blood glucose control, suggesting that poor glucose control also plays a role in risk for condition. (Lampner,2018)
BUN	6-20	22	23	Atrial fibrillation was correlated with higher levels of blood glucose control, suggesting that poor glucose control also plays a role in risk for condition (Lampner, 2018). Which can cause an increase in BUN levels
Creatinine	0.50-1.00	1.17	1.10	Atrial fibrillation was correlated with higher levels of blood glucose control, suggesting that poor glucose control also plays a role in risk for condition (Lampner, 2018). Which can cause an increase in creatinine levels
Albumin	N/A	N/A	N/A	N/A
Calcium	8.4-10.5	9.7	9.0	
Mag	1.6-2.6	2.3	2.4	
Phosphate	N/A	N/A	N/A	N/A
Bilirubin	N/A	N/A	N/A	N/A
Alk Phos	N/A	N/A	N/A	N/A

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	N/A	N/A	N/A	
pH	N/A	N/A	N/A	
Specific Gravity	N/A	N/A	N/A	

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Glucose	N/A	N/A	N/A	
Protein	N/A	N/A	N/A	
Ketones	N/A	N/A	N/A	
WBC	N/A	N/A	N/A	
RBC	N/A	N/A	N/A	
Leukoesterase	N/A	N/A	N/A	

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	N/A	N/A	N/A	
Blood Culture	N/A	N/A	N/A	
Sputum Culture	N/A	N/A	N/A	
Stool Culture	N/A	N/A	N/A	

Lab Correlations Reference (APA):

Lampner, C. (2018). Investigate the link between atrial fibrillation and type 2 diabetes.

Endocrinology Advisor, para 6.

<https://www.endocrinologyadvisor.com/home/topics/diabetes/type-2-diabetes/investigating-the-link-between-atrial-fibrillation-and-type-2-diabetes/>

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Prothrombin Time	12.1-14.9	N/A	28.4	Pt was diagnosed with AFIB. Pt is on blood thinner to prevent clotting in the heart from AFIB (Kamal & Pruthi, 2007)
INR	0.9-1.1	N/A	2.7	Pt was diagnosed with AFIB. Pt is on blood thinner to prevent clotting in the heart from AFIB (Kamal & Pruthi, 2007)

Kamal, A.H., & Pruthi, R.K. (2007). How to interpret and pursue an abnormal prothrombin time, activated partial thromboplastin time, and bleeding time in adults. *Concise Review for Clinicians*, 82(7), p. 864-873. DOI: <https://doi.org/10.4065/182.7.864>

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

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Medications (5 required)

Brand/Generic	Aspirin	Atorvastatin	Ferrous Sulfate	Lasix	Cozaar
Dose	81mg	20mg	324mg	60mg	25mg
Frequency	Daily	Daily	Daily	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	NSAIDs	Antihyperlipidemic	Antianemic	Antihyperlipidemic	Antihypertensive
Mechanism of Action	Blocks the activities of cyclooxygenase, the enzymes need for prostaglandin synthesis.	Produce plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by liver cells to enhance LDL uptake and breakdown	Acts of normalized RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial	Inhibits sodium and water reabsorption in the loop of henle and increase urine formation	Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle
Reason Client Taking	To reduce the severity of or prevent acute MI	To control lipid levels in pediatric heterozygous familial hypercholesterolemia	To prevent iron deficiency based on recommended daily allowance	To reduce edema caused by cirrhosis, heart failure, and renal disease, including nephrotic syndrome.	To manage HTN
Contraindications (2)	Active bleeding or coagulation disorders;	Active hepatic disease; breastfeeding	Hemochromatosis; Hemolytic anemias	Anuria; Hypersensitivity	Concurrent aliskiren therapy; hypersensitivity

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	Breastfeeding				tivity to losartan ortis componen ts
Side Effects/Adverse Reactions (2)	CNS depression; GI bleeding	Arrhythmias; Hypoglycemia	HTN; Hemolysis	Arrhythmia ; Azotemia	Hypotension; Thrombocytopenia

Medications Reference (APA):

Bartlett and Jones,. (2020).Nurse's drug handbook., (19th ed), pg 1-1327.

Assessment**Physical Exam (18 points)**

GENERAL: Alertness: Orientation: Distress: Overall appearance:	A & O X4 No distress Pt appeared pleasant. Pt was talkative and up walking around the hospital. Patient got himself ready and clothes on his own. Pt also took his own medications he brought from home.
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Pink Dry Warm 2+ None None None 22
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	.Head and Neck Symmetrical with no Tracheal deviation. Ear clear with no drainage. Pt has slight hearing loss. PERRLA. Nose clear no drainage and no deviated septum. Gums are pink and moist

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CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	 S1 and S2 sounds present Slightly tachycardic, No murmur noted Strong Less than 2 secs
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character	 Lung sounds clear with no signs of cracked or wheezing. No cough or shortness of breath noted
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 <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	 Cardiac Cardiac 5'11" 222 lbs. BS+ 3/27/2021 No pain noted None None None None None None
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:	 Yellow No odor 200 mL

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MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/>	. Alert and Oriented 4+ None Independent 1 Pt today was very independent and did not need any assistance with his morning routine. Pt ambulated around the hospital on his own a few times throughout the day.
NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:	. CNs II-XII intact Motor 5/5 all extremities Sensory normal
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 lives at home with wife. Pt is very independent. Pt doesn't like being in the hospital but understands why he has to be.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
7:31 am	67	159/96	18	97.6 F	97% RA

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions

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9:10	1-10	N/A	0	N/A	N/A
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Intake and Output (2 points)

Intake (in mL)	Output (in mL)
180 mL	200mL

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 		<ul style="list-style-type: none"> How did the patient/family respond to the nurse’s actions? Client response, status of goals and outcomes, modifications to plan.
<ol style="list-style-type: none"> SA is diagnosed with decrease cardiac output related to persistent AFIB as evidence by high levels of troponin, prothrombin and INR 	AFIB can cause a decrease in cardiac output	<ol style="list-style-type: none"> Pt will be placed on a Heparin drip Pt INR and Prothrombin time will be drawn per doctor's order daily 	Pt will convert back to normal sinus rhythm and have INR and Prothrombin within range.
<ol style="list-style-type: none"> SA is diagnosed with ineffective tissue perfusion related to decreased cardiac output as evidenced by pt having chest 	AFIB can cause a decrease in cardiac output which will result in ineffective tissue perfusion	<ol style="list-style-type: none"> Assess patient pain for intensity using a pain scale Elevate head of bed 	Pts goal is to have no pain

tightness and feeling fatigue			
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Overall APA format (5 points):

Concept Map (20 Points)

SUBJECTIVE DATA: Pt told me that he wasn't in any pain but had a slight headache earlier in the day but has now subsided.

NURSING DIAGNOSIS/OUTCOMES: **Diagnosis:** SA is diagnosed with decreased cardiac output related to persistent AFIBas evidenced by high levels of troponin, prothrombin and INR. **Outcome:** Pt will convert back to normal sinus rhythm and have INR and Prothrombin within range. **Diagnosis:** SA is diagnosed with ineffective tissue perfusion related to decreased cardiac output as evidenced by pt having chest tightness and feeling fatigue.

Outcome: Pts goal is to have no pain

OBJECTIVE DATA: Prothrombin was 28.4 , INR was 2.7

PATIENT INFORMATION: SA is a 66 yr old male with Anemia, Asthma when he was a kid, Bleeding disorder, Diabetes Mellitus, HTN, Mixed dyslipidemia, Mitral valve repair, TIA. He has been diagnosed with severe MR and was awaiting cardiovascular surgery when he was first evaluated. He underwent surgery and is doing well but continued to have recurrence of AFIB. He presents now with sotalol loading. He denies any chest pains, orthopnea, PND, lightheaded/dizziness, or presyncope/syncope. He feels chest tightness and irregular heartbeat with AFIB.

Nursing Intervention: Pt will be placed on a Heparin drip and Pt INR and Prothrombin time will be drawn per doctor's order daily. Assess patient pain for intensity using a pain scale and Elevate head of bed

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