N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
05/19/2021	K.A.N.	53 years old (12/11/1967)	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Forklift Driver	Single	Caffeine-loss of consciousness
Code Status	**Height**	**Weight**	
Full	171 cm	84.5 kg	

Medical History (5 Points)

Past Medical History: Acute heart failure with preserved ejection fraction, alcoholism, hypertension, thrombocytopenia, dehydration, lactic acidosis

Past Surgical History: Patient states he has never had any surgeries.

Family History: Patient states his father is an alcoholic and his mom "left before I knew anything about her".

Social History (tobacco/alcohol/drugs): Patient has consumed "15 Busch light beers a day for about 25 years, besides the last 3 years where I have went down to 3-4 beers a day." Patient denies any tobacco use or smoking tobacco. Patient denies any recreational drug use.

Assistive Devices: Patient does not use any assistive devices.

Living Situation: Patient lives at home by himself.

Education Level: Patient graduated high school but has no further education besides a forklift certification.

Admission Assessment

Chief Complaint (2 points): Syncope

History of present Illness (10 points):.

A 53-year-old Caucasian male presented to the Sarah Bush emergency room by emergency medical services on May 19th, 2021 with syncope after fainting and “falling on the sidewalk” while outside at his job. The patient described his syncope as “feeling really dizzy and weak.” The patient did not express any other symptoms besides a “very light headache” but still reported a score of 0 on the numerical pain scale during the symptoms. The patient stated that he felt better after he laid down in the bed and rested. The patient said he felt better after receiving Ativan but reported “no” when asked if other medications helped resolve his symptoms.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Atrial fibrillation with rapid ventricular response

Secondary Diagnosis (if applicable):

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

Atrial fibrillation with a rapid ventricular response is also known as an irregular heartbeat (Ambardekar, 2020). There are many reasons atrial fibrillation can occur. The pathophysiology behind this disorder is not entirely understood, though. One cause of atrial fibrillation can be from collagen fibers depositing around cardiomyocytes, which changes the interstitium, disrupting calcium handling and developing impaired contractility in the atria. A change in the cell's physiology and restructuring of the atrial myocytes causes the change in contractility. The difference in the cell's physiology includes remodeling the extracellular matrix composition and increasing fibrotic tissue. The myocytes can also lose contractile force, lose fetal-like proteins, and accumulate glycogen in the interstitium, causing atrial fibrillation. A change in electrical remodeling results from a decrease in the refractory period of atrial myocytes and a deceleration of the atrial conduction velocity (Rosenthal, 2019).

Some risk factors of atrial fibrillation include heart failure, heart disease, valve disease, and a history of heart surgery or a heart attack (Ambardekar, 2020). This change in a heartbeat is also associated with genetic factors, advancing age, neurologic disorders, endocrine disorders, inflammation, respiratory conditions, inflammation, hemodynamic stress, alcohol and drug use, and atrial ischemia (Rosenthal, 2019). The patient has a history of heart failure, has high blood pressure, chronic alcohol use, and possibly inflammation since his hemoglobin A1C was very high, causing inflammation in the vessels from high blood glucose levels. Heart failure can disrupt the electrical conduction, causing quivering of the atria. The patient's other risk factors may cause stenosis of the heart because of inflammation, decreasing blood to pass through the heart, causing further quivering.

The symptoms of atrial fibrillation may vary, including weakness, tiredness, shortness of breath, dizziness, fainting, chest pain, and tachycardia (Ambardekar, 2020). Although not a good indicator of atrial fibrillation, the patient only presented with syncope and later presented with tachycardia.

This condition is diagnosed with a 12-lead electrocardiography, which may show an irregular ventricular rate, an absence of P waves, a fast heart rate, and may have a bundle branch block. A transthoracic echocardiography can test for pericardial disease, ventricular function, pulmonary hypertension, atrial and ventricular chamber dimensions, and valvular heart disease. The patient may also be diagnosed with a transesophageal echocardiography to test for an atrial thrombus (Rosenthal, 2019). The patient only had a 12-lead electrocardiography evaluated as this showed an absence of P waves, an irregular ventricular rate, and a fast heart rate.

Treatment for atrial fibrillation includes beta-blockers or calcium channel blockers, diuretics if the patient has fluid overload, an antiarrhythmic, an analgesic for any pain, an

anticoagulant since the patient is now at risk for bleeding, and electro cardioversion if the heartbeat needs restoring to a normal heart rhythm. If left untreated, this condition may cause heart failure or a stroke (Ambardekar, 2020). The patient was prescribed digoxin for the high blood pressure, amiodarone and metoprolol for the arrhythmia, acetaminophen for the pain, and enoxaparin for the risk of bleeding.

The patient should try his best to reduce his alcohol consumption and include healthier foods in his diet, such as more vegetables, fruits, and lean meats. The patient should get therapy or rehabilitation for his alcohol addiction to prevent further complications. The patient agreed to attend a rehabilitation facility.

Pathophysiology References (2) (APA):

Ambardekar, N. (2020, June 14). *Afib with rapid ventricular response.* Webmd. https://www.webmd.com/heart-disease/atrial-fibrillation/afib-rapid-response

Rosenthal, L. (2019, November 18). *Atrial fibrillation.* Medscape. https://emedicine.medscape.com/article/151066-overview#a1

Laboratory Data (15 points)

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 (10^6/mcL)	4.28-5.41	3.97	4.01	Patient is not consuming the correct nutrients to produce red blood cells because he is on a diet. Patient's kidney values are also not within normal range, so they may not produce erythropoietin correctly (Capriotti, 2020).
Hgb (g/dL)	13-17	14.1	13.5	N/A
Hct (%)	38.1-48.9	41.3	41.0	N/A

Platelets (K/mcL)	149-393	309	368	N/A
WBC (K/mcL)	4.0-11.7	7.9	11.2	N/A
Neutrophils (%)	45.3-79.0	89.8	78.9	Patient has inflammation from fighting off alcohol withdrawal symptoms and cravings, so his neutrophil markers are increased (Capriotti, 2020).
Lymphocytes (%)	11.8-45.9	2.5	13.6	Patient has lower lymphocytes because his neutrophils are increased (Capriotti, 2020).
Monocytes (%)	4.4-12.0	7.5	6.9	N/A
Eosinophils (%)	0-6.3	2.7	0.3	N/A
Bands (%)	0-5.1	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- (mmol/L)	136-145	130	136	Patient was not consuming anything by mouth when he was admitted because of further diagnostic tests so some of his electrolytes are low (Capriotti, 2020).
K+ (mmol/L)	3.5-5.1	3.7	3.6	N/A
Cl- (mmol/L)	98-107	89	107	Patient was not consuming anything by mouth when he was admitted because of further diagnostic tests so some of his electrolytes are low (Capriotti, 2020).
CO2 (mmol/L)	21-31	17	24	Patient has low red blood cells, so this can cause the patient to have low CO2 levels. Patient also has a history of lactic acidosis, is taking aspirin, and has poor kidney levels, which all could explain the lower CO2 levels (Capriotti, 2020).
Glucose (mg/dL)	74-109	122	96	Patient has been under a lot of stress from withdrawing from alcohol so his insulin was increased, causing an increase in glucose (Capriotti, 2020).

BUN (mg/dL)	7-25	10	5	Patient is on a full liquid diet so he is not consuming very many nutrients so the patient may be malnourished (Capriotti, 2020).
Creatinine (mg/dL)	0.70-1.30	1.39	0.83	Patient is not drinking a lot of fluids because he is on a full liquid diet so this may be why his creatinine levels are high (Capriotti, 2020).
Albumin (g/dL)	3.5-5.3	N/A	N/A	N/A
Calcium (mg/dL)	8.6-10.3	9.1	8.7	N/A
Mag (mg/dL)	1.6-2.5	1.7	1.5	Since the patient's glucose is high, this can cause the kidneys to secrete more urine. The patient also may not be consuming enough magnesium since his diet is restricted (Capriotti, 2020).
Phosphate (mg/dL)	2.5-4.5	N/A	N/A	N/A
Bilirubin (mg/dL)	0.3-1.0	1.0	N/A	N/A
Alk Phos (unit/L)	34-104	78	N/A	N/A
AST (U/L)	10-30	109	N/A	N/A
ALT (U/L)	10-40	69	N/A	N/A
Amylase (U/L)	30-110	N/A	N/A	N/A
Lipase (U/L)	0-160	N/A	N/A	N/A
Lactic Acid (mEq/ L)	0.5-2.2	0.9	N/A	N/A
Troponin (ng/mL)	0.000-0.030	N/A	N/A	N/A
CK-MB (ng/mL)	0.60-6.30	N/A	N/A	N/A
Total CK (U/L)	30-223	N/A	N/A	N/A

Other Tests 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
INR	1 (2-3 therapeutic)	N/A	N/A	N/A
PT (seconds)	9.5-11.8 (1.5-2.5 times therapeutic)	N/A	N/A	N/A
PTT (seconds)	30-40 (1.5-2.5 times therapeutic)	N/A	N/A	N/A
D-Dimer (ng/mL)	</= 250	2.59	N/A	N/A
BNP (pg/mL)	<100	N/A	N/A	N/A
HDL (mg/dL)	>60	N/A	N/A	N/A
LDL (mg/dL)	<130	N/A	N/A	N/A
Cholesterol (mg/dL)	<200	N/A	N/A	N/A
Triglycerides (mg/dL)	<150	N/A	N/A	N/A
Hgb A1c (%)	4-5.6	135	N/A	Patient consumes a lot of alcohol and is obese, so this may cause his glucose levels to be increased as his diet may be poor (Capriotti, 2020).
TSH (mU/L)	0.4-4	3.6	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	Pale yellow-deep amber/ clear	Pale Yellow	Pale Yellow	N/A
pH	5-8	6.0	7.0	N/A
Specific Gravity	1.005-1.035	1.022	1.007	N/A
Glucose	0-14.41	30	100	Patient consumes a lot of alcohol

(mg/dL)				and is obese, so this may cause his glucose levels to be increased as his diet may be poor (Capriotti, 2020).
Protein	Negative	Trace	Negative	N/A
Ketones	Negative	1	Negative	N/A
WBC	Negative	Negative	Negative	N/A
RBC	0-5	Negative	Negative	N/A
Leukoesterase	0-5	Negative	Negative	N/A

Arterial Blood Gas 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
pH	7.31-7.41	**7.44**	N/A	Patient has low BUN and high creatinine levels so his kidneys may not be properly removing acids (University of California San Francisco Health, 2019).
PvO2 (mmHg)	40-50	**44.8**	N/A	N/A
PvCO2 (mmHg)	40-50	**28.2**	N/A	Patient has low BUN and high creatinine levels so his kidneys may not be properly removing acids (Biggers, 2019).
HCO3 (mEq/L)	22-26	**21**	N/A	Patient's kidneys are compensating by decreasing the acidity of bicarbonate.
SaO2 (%)	60-75	**80.3**	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	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	Negative	There was no growth of foreign bacteria seen in the patient's blood (Sarah Bush Lincoln Health Reference Guide, 2021).
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Biggers, A. (2019, May 23). *What to know about the co2 blood test.* Medical News Today. https://www.medicalnewstoday.com/articles/325259

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

Sarah Bush Lincoln Health Reference Guide. (2021). *Cerner*. https://www.sarahbush.org

University of California San Francisco Health. (2019, July 4). *Urine ph test.* https://www.ucsfhealth.org/medical-tests/urine-ph-test

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

The patient had a chest x-ray performed on 06/05/2021. The x-ray showed slight cardiomegaly and mild pulmonary edema. There was no pleural effusion or pneumothorax detected (Sarah Bush Lincoln Health Reference Guide, 2021).

The patient had a magnetic resonance imaging (MRI) test with contrast on 06/06/2021 to test for masses and intracranial hemorrhage. The results showed a lot of signal throughout the central pons, measuring an area of 2.7 cm x 2 cm. There was no hemorrhage detected during the test (Sarah Bush Lincoln Health Reference Guide, 2021).

The patient had a computed tomography (CT) test of the brain and head without contrast performed on 06/07/2021. The test showed no masses, hemorrhages, infarctions, extra cranial fluid, and the cerebral spinal fluid is normal in size (Sarah Bush Lincoln Health Reference Guide, 2021).

Diagnostic Test Correlation (5 points):

The chest x-ray looks at the size of the heart and the outline of the big blood vessels in the heart. There may be calcium deposits within the blood vessels and this test is able to see those deposits. The x-ray can rule out heart failure, pleural effusions, cardiomegaly, a pneumothorax, a heart valve disorder, and constrictive pericarditis as hypertrophy of the heart is shown during this test. The patient presented with symptoms similar to these conditions, so ruling them out is necessary (Shea & Cascino, 2019).

The MRI looks at the anatomy of the brain and looks specifically at certain parts of the brain, including the areas that deal with speech, sensation, and movement. These areas can help a provider look for hemorrhage, stroke, brain tumors, seizures, vascular problems, infections, and developmental problems. The patient presented with signs of a stroke and a brain tumor, so these should be ruled out, along with hemorrhage as the patient fell when they fainted (Cedars Sinai, 2018).

The CT scan gives more elaborate information about brain structures and tissue than x-rays do. This scan can look at axial and horizontal images of the brain. This scan can look for

injuries, lesions, intracranial bleeding, clots, and cerebral spinal fluid abnormalities (John Hopkins Medicine, 2019).

Diagnostic Test Reference (1) (APA):

Cedars Sinai. (2018). *Mri brain.* https://www.cedars-sinai.org/programs/imaging-center/exams/mri/brain.html

John Hopkins Medicine. (2019). *Computed tomography (ct or cat) scan of the brain.* https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/computed-tomography-ct-or-cat-scan-of-the-brain

Sarah Bush Lincoln Health Reference Guide. (2021). *Cerner*. https://www.sarahbush.org

Shea, M., & Cascino, T. (October 2019). Magnetic resonance imaging (mri) of the heart. *Merck Manual. https://www.merckmanuals.com/home/heart-and-blood-vessel-disorders/diagnosis-of-heart-and-blood-vessel-disorders/magnetic-resonance-imaging-mri-of-the-heart*

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/ Generic	Cordarone/ Amiodarone	Lopressor/ Metoprolol Tartrate	Ecotrin/ Aspirin	Lovenox/ Enoxaparin	Ativan/ Lorazepam
Dose	200 mg (1 tab)	12.5 mg (0.5 tab)	650 mg (2 tab)	80 mg=0.8 mL	1 mg=0.5 mL
Frequency	Daily	Twice a day	Daily	Twice a day	As needed for Clinical Institute Withdrawal assessment of Alcohol

					score between 9-14, but don't exceed 2 mg/min
Route	Oral	Oral	Oral	Subcutaneously	Intravenous push
Classification	Benzofuran derivative	Beta1-adrenergic blocker	Salicylate	Low-molecular-weight heparin	Benzodiazepine
Mechanism of Action	Prolongs repolarization and the refractory period, increasing the ventricular fibrillation threshold. This drug can also relax the vascular smooth muscles, improving myocardial blood flow (Jones & Bartlett, 2020).	Blocks the stimulation of beta1-receptr sites, decreasing cardiac output, myocardial oxygen demand, and cardiac excitability. This medication also reduces blood pressure by reducing renal release of renin (Jones & Bartlett, 2020).	Blocks cyclooxygenase, the enzyme needed for prostaglandin synthesis. This blockage decreases inflammatory symptoms. This medication also disrupts the production of thromboxane A2, blocking platelet aggregation (Jones & Bartlett, 2020).	Binds to antithrombin III which inactivates clotting factors thrombin and factor Xa. Without thrombin, fibrinogen can't convert to fibrin and clots can't form (Jones & Bartlett, 2020).	Increases the effects of gamma-aminobutyric acid by binding to the benzodiazepine receptors in cortical and limbic areas in the central nervous system. This acid prevents excitatory stimulation, controlling emotional and providing antianxiety effects (Jones & Bartlett, 2020).
Reason Client Taking	Patient has atrial fibrillation.	Patient has hypertension.	Patient has atrial fibrillation and this medication	Patient has atrial fibrillation and this medication	Patient is withdrawing from alcohol and symptoms

			prevents the blood from clotting.	prevents the blood from clotting.	can include tremors, increased heart rate, and anxiety, so this medication decreases these symptoms.
Contraindications (2)	Cardiogenic shock, bradycardia that causes shock	Acute heart failure, cardiogenic shock	Other non-steroidal anti-inflammatory drugs, active bleeding	Acitve major bleeding, pork products	Acute angle-closure glaucoma, psychosis
Side Effects/Adverse Reactions (2)	Headache, increased liver enzymes	Arrhythmias, orthostatic hypotension	Hepatotoxicity, headache	Elevated liver enzymes, thrombocytopenia	Thirst, increased liver enzymes
Nursing Considerations (2)	Dilute the medication in dextrose 5% in water or normal saline solution and mix in polyvinyl chloride or polyolefin. Monitor the liver enzymes, ALT and AST (Jones & Bartlett, 2020).	Assess ECG as this medication increases the patient's risk of an atrioventricular block. Before a patient with heart failure starts on this medication, they should begin taking an ACE inhibitor, digoxin or a diuretic (Jones & Bartlett, 2020).	Ask the patient about tinnitus, as this is an indicator the maximum dosage is occurring. Instruct patient to take mediation with food to prevent gastrointestinal upset (Jones & Bartlett, 2020).	Don't give this drug intramuscularly. Test the stool for blood in stool.	Use cautiously in patients with alcohol or drug abuse as this medication can cause physical and psychological dependence. Dilute with an equal amount of dextrose 5% in water for an intravenous injection (Jones & Bartlett, 2020).

Key Nursing Assessment(s) /Lab(s) Prior to Administration	Assess the patient's liver enzymes. Assess the patient's thyroid levels as this can cause hyperthyroidism (Jones & Bartlett, 2020).	Assess the patient's heart rate to make sure it does go below 60 beats per minute. Assess the patient's blood pressure to make sure it does drop below 90 mmHg systolic (Jones & Bartlett, 2020).	Assess the patient's platelets. Assess the patient's red blood cells for bleeding (Jones & Bartlett, 2020).	Assess the patient's liver enzymes. Assess the patient's clotting time labs.	Assess patient's ideation of suicide as this medication can cause suicidal thoughts. Assess the patient's respiratory status as this medication can cause respiratory depression (Jones & Bartlett, 2020).
Client Teaching needs (2)	Report any cough, dyspnea, fatigue, nausea, vomiting, dark urine, wheezing, yellow skin, or a sudden change in pulse. Avoid drinking grapefruit juice or taking St. John's Wort while taking this mediation (Jones & Bartlett, 2020).	Take the medication at the same time each day. Check blood glucose levels often as this medication can increase their blood glucose (Jones & Bartlett, 2020).	Patient should dissolve medication in water. Do not take medication with other non-steroidal anti-inflammatory medication (Jones & Bartlett, 2020).	Notify the provider of any adverse reactions, especially bleeding. Teach the patient how to give subcutaneously in the to the abdomen in the umbilical region, thigh or lateral part of the lower area of the upper arm (Jones & Bartlett, 2020).	Patient should stop taking this medication if they experience severe diarrhea, accompanied by lightheadedness, decreased urine output, and unexplained tiredness. Report signs of liver impairment including yellowing of skin or sclera, fluid in abdomen,

					or flu-like symptoms (Jones & Bartlett, 2020).

Hospital Medications (5 required)

Brand/ Generic	Lasix/ Furosemide	Cholac/ Lactulose	Protonix/ Pantoprazole	Zofran/ Ondansetron	Ofirmev/ Acetaminophen
Dose	20 mg=1 tab	20 g=30 mL	40 mg=10 mL	4 mg=2 ml	100 mg=10 mL
Frequency	Daily	Daily	Daily	Every 6 hours as needed	Every 6 hours as needed
Route	Oral	Oral Suspension	Intravenous Push	Intravenous push	Intravenous Piggyback
Classification	Loop Diuretic	Disaccharide	Proton Pump Inhibitor	Selective serotonin receptor antagonist	Nonsalicylate, para-aminophenol derivative
Mechanism of Action	Prevents the loop of Henle from absorbing sodium and water and this increases urine formation. This medication also increases the excretion of	Breaks down into lactic, acetic, and formic acids in the colon, acidifying fecal contents. This acidification increases osmotic pressure in the colon	This medication prevents the proton pump from working in the gastric parietal cells, which decreases gastric acid secretion, decreasing acid reflux. The proton pump is inhibited by	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and at the vagal nerve terminals in the intestine. This blockage reduces nausea and	Disrupts cyclooxygenase, blocking prostaglandin production and pain impulse generation in the peripheral nervous system. This medication also acts on the hypothalamus by inhibiting synthesis of prostaglandin E2, decreasing

	calcium, magnesium, bicarbonate, ammonium, and phosphate. Blood pressure decreases since the fluid volume decreases (Jones & Bartlett, 2020).	which increases stool water and this prevents ammonia diffusion from the intestine in the blood. The decreased diffusion of ammonia prevents hepatic encephalopathy (Jones & Bartlett, 2020).	blocking the exchange of extracellular potassium and intracellular hydrogen ions in the stomach (Jones & Bartlett, 2020).	vomiting (Jones & Bartlett, 2020).	fever (Jones & Bartlett, 2020).
Reason Client Taking	To decrease fluid from acute heart failure	Patient has high liver function labs (ALT, AST), so this medication is preventing ammonia build up.	Patient is not able to consume very much by mouth because he is on a thickened liquid and mechanical diet, so he is on this medication prophylactically to prevent gastric ulcers.	Patient is experiencing nausea related to liquid thickening in his water.	Patient was experiencing headaches from withdrawing from alcohol when he was admitted to the hospital.
Contraindications (2)	Anuria, hypersensitivity to furosemide	Hypersensitivity to lactulose, low-galactose diet	Lansoprazole, rabeprazole	Congenital long QT syndrome, concomitant use of apomorphine	Sever hepatic impairment, hypersensitivity to acetaminophen
Side Effects/ Adverse Reactions (2)	Arrhythmias, hyperglycemia	Hyperglycemia, hypokalemia	Hyperglycemia, hypomagnesemia	Arrhythmias, elevated liver enzymes	Hepatotoxicity, thrombocytopenia

Nursing Considerations (2)	This medication can cause hypotension so monitor the patient's blood pressure. This medication may precipitate nephrolithiasis and patient's BUN and creatinine are not within the normal range (Jones & Bartlett, 2020).	Monitor the patient's alanine aminotransferase (ALT) and aspartate aminotransferase (AST) levels. Give fluids if the patient experiences hypovolemia.	Flush the intravenous line with D5W normal saline solution or lactated Ringer's solution before and after giving the drug. Monitor the patient's prothrombin time (PT) or international normalized ratio (INR) during therapy since the patient takes an oral anticoagulant (Jones & Bartlett, 2020).	Monitor for signs of hypersensitivity to ondansetron, including bronchospasm and anaphylaxis. Monitor the patient's electrocardiogram as this medication can prolong the QT interval and can result in life-threatening arrhythmias (Jones & Bartlett, 2020).	Use cautiously in patients with hepatic impairment or alcoholism. Monitor the patient for blood or albumin in urine as this may indicate nephritis and decreased urine may indicate kidney failure (Jones & Bartlett, 2020).
Key Nursing Assessment(s) /Lab(s) Prior to Administration	Assess the patient's blood pressure before and after the medication is given. Assess the patient's potassium levels (Jones & Bartlett, 2020).	Assess the patient's glucose levels as this medication can cause hypoglycemia. Assess the patient's sodium and potassium as this medication can cause hypernatremia and hypokalemia (Jones &	Assess the patient's PT and INR levels. Assess the patient's magnesium and sodium.	Assess the patient's blood pressure for hypotension. Assess the patient's ALT and AST levels as this medication can elevate their liver enzymes.	Monitor the patient's blood urea nitrogen (BUN) and creatinine to assess their kidney function as this medication can be toxic to the kidneys. Monitor the patient's liver labs (ALT and AST) as this medication can affect the liver (Jones & Bartlett, 2020).

		Bartlett, 2020).			
Client Teaching needs (2)	Teach the patient to take their blood pressure at home. Take this medication in the morning so the patient does not have nocturia (Jones & Bartlett, 2020).	Take lactulose with food or dilute with juice as this medication has a very sweet taste. Tell the patient to report abdominal distension or severe diarrhea (Jones & Bartlett, 2020).	Notify the provider if the patient experiences blood in his urine. Do not take over the counter medications or herbal supplements without talking to the provider (Jones & Bartlett, 2020).	Report any allergic signs to the provider, such as a rash. Teach patient to monitor their blood pressure as an adverse effect of this medication is hypotension (Jones & Bartlett, 2020).	Teach the patient about signs of hepatotoxicity, such as bleeding, malaise, and bruising. Do not exceed the recommended amount of the medication (Jones & Bartlett, 2020).

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). 2020 Nurse's Drug Handbook (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented to year, place, person, and reason for visit x4. He appears to be well-nourished and in no apparent/noticeable distress. He is cooperative and appropriately dressed for the weather and is well-groomed.

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Patient's skin is usual for ethnicity, warm, dry, intact, and slightly pink in all areas of his body with no rashes, abrasions, bruises, or wounds present. Patient has no clubbing or cyanosis. Patient has elastic skin as it falls back into place immediately after being pinched and manipulated. Patient's Braden score is 14, which means there is a moderate risk for pressure ulcers or impaired skin integrity due to decreased lower extremity mobility.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is round and bilaterally equal with no obvious contusions or abnormalities. Patient is negative for headaches and has no lymphadenopathy. Patient's ears are free of discharge, are symmetrical and bilaterally placed on the side of the head, and tympanic membranes are a pearly, grey color. The patient's eyes are placed in the center of the face, symmetrical without them being too far apart or too close to each other. The pupils are equal, round, and reactive to light and accommodation. The patient's sclera is white, and the conjunctiva is a bright red. The patient was not wearing any glasses. Patient's nares are bilaterally equal and has no deviated septum. There is no pain or discomfort noted from patient upon palpitation of sinuses. No drainage noted from the nares. Patient's gums are a pale pink, firm, and moist. The patient's teeth were stained yellow, has 2 bottom teeth missing, and no dental carries. Rise and fall of the soft pallet were observed and the tonsils and the uvula are pink and moist and are placed centrally in the patient's mouth with no deviation to one side or the other. .
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:**	.S1 and S2 sounds were heard in the aortic, pulmonic, Erb's point, tricuspid, and mitral locations with no detected murmurs or S3 gallops or masses. Patient has a pulse of 59 beats per minute which were equal and bilaterally

Capillary refill: **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	bounding in both carotid, brachial, radial, posterior tibial, popliteal, femoral, and dorsalis pedis pulse sites. Patient has 2+ weak pulses in radial, posterior tibial, dorsalis pedis, and brachial arteries. Patient has adequate capillary refill as it took less than 3 seconds for color/blood to return to the patient's nail bed on his fingers and toes. Patient has no neck vein distension. No pitting edema or swelling was noted in any of the patient's extremities or centrally on his body.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations were even, nonlabored, and clear/free of fluid both anteriorly and posteriorly in both lobes of the left lung and all three lobes of the right. Patient was averaging 18 breaths a minute, which is an average rate. Patient has no stridor, rales, coarse rhonchi, wheezes, or chest wall tenderness. No accessory muscles were being used to help the patient breathe.
GASTROINTESTINAL (2 points): **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:**	Patient is on a regular diet at home, but he is on a mechanical and thickened liquid diet at the hospital as he is at risk for dysphagia when consuming thin liquids. Height: 171 cm Weight: 84.5 kg Bowel sounds auscultated are active in all 4 quadrants with approximately 18 clicks and gurgles per minute. Patient had 1 loose, moderate amount of brown stool at 1346. Patient did not experience any pain or tenderness upon light or deep palpation. Patient has no abdominal distension, masses, scars, drains, or wounds.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒**	Urine was pale yellow and clear with no foul odor notes. Patient voided a total of 300 mL of urine during my clinical rotation. According to the patient, the patient did not experience pain with urination and did not note burning, hesitancy, incontinence, or urgency.

Inspection of genitals: **Catheter: Y ☐ N ☒** **Type:** **Size:**	I did not inspect the patient's genitals at the patient's request and no catheter was present.
MUSCULOSKELETAL (2 points): **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** ☐ **X** **Needs support to stand and walk** ☐**X**	Patient is up with 1 assisted and a gait belt. Patient needs assistance to the bathroom in the hospital but does not need help at home with activities of daily living. Patient's range of motion is within normal limits. He has bilaterally equal strength and grip in both his feet and hands. Patient's strength is 3/5 during hip flexion, hip abduction, and hip adduction. Morse fall risk score of 95 puts the patient at a high fall risk.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is oriented to person, place, time and situation. His cognition is normal. His speech is gargled. Patient is alert and responds to light and deep stimuli.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient used to drink to cope, now he drinks less and plays video games on his laptop to cope. He is a high school graduate with a forklift certification. He forms fully structured sentences. He is not religious and does not "believe in a god". He lives at home by himself. He has capability of making a fully informed consent.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0735	68 bpm	126/83 mmHg	18 breaths/minut e	37.3 Celsius	94%

1129	59 bpm	116/75 mmHg	18 breaths/minute	37.3 Celsius	98%

Vital Sign Trends: Patient's vitals continue to improve throughout the shift, including an improvement of blood pressure, and oxygen saturation. This can be attributed to the metoprolol medication and an improvement of symptoms from the amiodarone treating the atrial fibrillation. Patient's pulse is slight low but this may be from the metoprolol and the patient is not consuming a lot of calories since he's on a restricted diet.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0747	Numerical	N/A	0/10	N/A	N/A
1134	Numerical	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Patient has a 20-gauge intravenous catheter in his left forearm which was placed on 05/29/21 in the medical surgical unit-as indicated by tape by the insertion site. The intravenous catheter was patent as it flushed and aspirated easily and without any resistance. There was no drainage, swelling/edema, discoloration, warmth to the touch, or redness noticed. The transparent dressing was dry and intact. The catheter was saline locked.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
Patient consumed 200 milliliters (mL) of thickened liquids during the shift. Patient received 50 mL of magnesium sulfate. Patient received 10 mL of gadobutrol. Patient received a total of 260 mL.	Patient voided 300 mL of urine during my clinical rotation.

Nursing Care

Overview of care: I administered medications, helped the patient to the commode, ordered food, and completed a head-to-toe assessment on my patient. The patient did not have any procedures completed during my clinical rotation on 06/08/2021, but had a chest x-ray on 06/05/2021, an MRI on 06/06/2021, and a CT scan on 06/07/2021. The patient complained about the water thickening giving him nausea since he was on a nectar liquid diet and he had to take lactulose with the water thickening. We administered ondansetron for his nausea. His vitals were stable, although his blood pressure improved slightly. The patient is also on a mechanical soft diet and needs assistance with one person and a gait belt. The patient will continue taking metoprolol, amiodarone, and aspirin when he is discharged. The metoprolol and amiodarone will treat his arrhythmia, while the aspirin will prevent him from clotting.

Future plans for the patient include discharging to the inpatient rehabilitation unit at OSF Heart of Mary Medical Center in Urbana and continuing to improve his withdrawal process from alcohol. There are no home health needs and equipment needs until the patient is assessed after rehabilitation. Follow up plans include meeting with the provider every week to assess the

improvement of rehabilitation and medication therapy. Education needs include continuing to take prescribed medications and improving his health in the rehabilitation unit.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Decreased cardiac output related to alterations in cardiac rhythm as evidenced by electrocardiogram showing atrial fibrillation with rapid ventricular response.	Decreased cardiac output is the top priority because this can increase the risk of a thrombus or a clot.	1.Auscultate the apical pulse and asses the heart rate and rhythm every 4 hours during the assessment. 2.Note the heart sounds during the assessment every 4 hours.	1.The patient showed normal sinus rhythm and a pulse of 59 beats per minute during the assessment. 2.The heart sounds heard were S1 and S2 both times the patient was assessed every 4 hours.
2. Risk for decreased cardiac perfusion related to reduced cardiac contractility as evidenced by an abnormal atrial rhythm (atrial fibrillation).	This diagnosis is chosen because the patient is at risk for decreased perfusion to the extremities and organs.	1.Assess the patient's capillary refill status every 4 hours. 2.Palpate the pulses (radial, femoral, dorsalis pedis, and carotid) every 4 hours to assess tissue	**1.** Patient has a capillary refill of less than 3 seconds, indicating his extremities are being perfused both times the patient was assessed every 4 hours. 2.Patient has 2+ weak pulses in radial, posterior tibial, dorsalis pedis, and femoral arteries both

		perfusion.	times the patient was assessed every 4 hours.
3. Risk for falls related to decreased mobility in lower extremities as evidenced by a Morse fall score of 95.	This diagnosis is chosen because the patient only has 3/5 on the lower extremity strength scale and needs assistance with one person and a gait belt.	1.Respond to call light as soon as possible when the patient needs assistance. 2.Move items the patient needs easily within reach, such as the liquids, food, telephone, laptop, and call light.	1.Patient did not get out of bed without assistance as the patient was attended to as soon as the call light went off. 2. Patient always had necessities within reach to prevent him from getting out of bed to reach these items.
4. Activity Intolerance related to decreased cardiac output as evidenced increased respiratory rate with activity.	This diagnosis is chosen as the patient cannot perform activities without breathing heavily, causing him not to be able to perform his daily needs.	1.Observe and document response to activity any time patient gets out of bed. 2. Assess the patient's nutritional status every time he consumes food.	1.The patient's respirations increased from 18 to 22 respirations per minute upon rising from the bed to get to the commode. The patient's respirations only increased from 18 to 20 respirations per minute the second time he stood up from the bed to get to the commode. 2.The patient only consumed 40% of his breakfast and 50% of his lunch. Patient needs calories and protein to heal and to increase his energy stores.

Other References (APA):

Concept Map (20 Points)

Subjective Data

Patient presented with syncope after fainting and "falling on the sidewalk" while outside at his job. The patient described his syncope as "feeling really dizzy and weak." The patient did not express any other symptoms besides a "very light headache" but still reported a score of 0 on the numerical pain scale during the symptoms.

Nursing Diagnosis/Outcomes

eased cardiac output related to alterations in cardiac rhythm as evidenced by electrocardiogram showing atrial fibrillation apid ventricular response.
The patient showed normal sinus rhythm and a pulse of 59 beats per minute during the assessment.
The heart sounds heard were S1 and S2 both times the patient was assessed every 4 hours.
Risk for decreased cardiac perfusion related to reduced cardiac contractility as evidenced by an abnormal atrial rhythm (atrial fibrillation).
Patient has a capillary refill of less than 3 seconds, indicating his extremities are being perfused both times the patient was assessed every 4 hours.
Patient has 2+ weak pulses in radial, posterior tibial, dorsalis pedis, and femoral arteries both times the patient was assessed every 4 hours.
Risk for falls related to decreased mobility in lower extremities as evidenced by a Morse fall score of 95.
Patient did not get out of bed without assistance as the patient was attended to as soon as the call light went off.
Patient always had necessities within reach to prevent him from getting out of bed to reach these items.
Activity Intolerance related to decreased cardiac output as evidenced increased respiratory rate with activity.
The patient's respirations increased from 18 to 22 respirations per minute upon rising from the bed to get to the commode. The patient's respirations only increased from 18 to 20 respirations per minute the second time he stood up from the bed to get to the commode.
The patient only consumed 40% of his breakfast and 50% of his lunch. Patient needs calories and protein to heal and to increase his energy stores.

Objective Data

The abnormal labs show the following:
RBC: 4.01 (10^6/mcL)
BUN: 5 (mg/dL)
Magnesium: 1.5 (mg/dL)
Glucose: 100 (mg/dL)

The assessment shows the patient has 2+ weak pulses in radial, carotid, dorsalis pedis, posterior, popliteal, femoral, and brachial arteries, has 3/5 strength during hip flexion, abduction, and adduction, and has a Morse fall score of 95.

The chest shows slight cardiomegaly and mild pulmonary edema.

Patient Information

A 53-year-old Caucasian male was a history of acute heart failure with preserved ejection fraction, alcoholism, hypertension, thrombocytopenia, dehydration, lactic acidosis is admitted with a chief complaint of syncope related to atrial fibrillation.

Nursing Interventions

1. Auscultate the apical pulse and asses the heart rate and rhythm every 4 hours during the assessment.
2. Note the heart sounds during the assessment every 4 hours.
3. Assess the patient's capillary refill status every 4 hours.
4. Palpate the pulses (radial, femoral, dorsalis pedis, and carotid) every 4 hours to assess tissue perfusion.
5. Respond to call light as soon as possible when the patient needs assistance.
6. 2.Move items the patient needs easily within reach, such as the liquids, food, telephone, laptop, and call light.
7. Observe and document response to activity any time patient gets out of bed.
8. Assess the patient's nutritional status every time he consumes food.