N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9-20-21	RP	57	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Express employment professionals.	Married	Cephalexin—The patient breaks out in hives.
Code Status	**Height**	**Weight**	
Full code	5’9”	246 pounds	

Medical History (5 Points)

Past Medical History: The patient has a past medical history of diabetes (type II), hypertension, and dysrhythmia.

Past Surgical History: The patient has a past surgical history of a valve replacement with a mechanical valve (2017).

Family History: The patient's maternal grandmother and mother had diabetes. The patient's sister had a valve replacement. The patient's father had cancer and is deceased, and the patient's brother had bypass surgery.

Social History (tobacco/alcohol/drugs): The patient does not drink alcohol, smoke, or do drugs.

Assistive Devices: The patient wears glasses, but other than that, he has no assistive devices.

Living Situation: The patient lives with his wife in Danville, Illinois.

Education Level: The patient has a high school diploma.

Admission Assessment

Chief Complaint (2 points): The patient called EMS with the complaint of sweating and chest pain.

History of present Illness (10 points): Onset: the patient called EMS on 9-20-21 with the complaint of sweating and chest pain. Location: chest. Duration: over the last hour before calling EMS. Characteristics: the patient stated, "My chest feels full." Associated manifestations: Sweating and just "not feeling right." Relieving factors: The patient took an Advil, and the pain did not go away. Treatment: The patient has not sought out treatment until calling EMS.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Ventricular fibrillation.

Secondary Diagnosis (if applicable): A first-degree heart block.

Pathophysiology of the Disease, APA format (20 points): Ventricular fibrillation occurs when the PVC falls on the T wave of a previous impulse. The T wave indicates repolarization for the refractory period of the ventricle (Capriotti and Frizzell, 2016). This causes a lack of the refractory period and causes the heart to quiver (Capriotti and Frizzell, 2016). When the heart is quivering, blood is not being pumped through the heart and throughout the body. Before ventricular fibrillation occurs, the patient may experience chest pain, a fast heart rate, dizziness, nausea, and shortness of breath (Mayo Clinic, 2021). A patient who is about to experience ventricular fibrillation may experience a fast pulse and high blood pressure. An EKG would be the most common test performed after or during ventricular fibrillation. An EKG measures the electrical activity of the patient's heart, and ventricular fibrillation would be present (Mayo Clinic, 2021). After ventricular fibrillation has occurred, cardiac catheterization is done to check the patient's coronary arteries (Mayo Clinic, 2021). This test can reveal a blockage in the heart. A comprehensive

medical panel and complete blood count would be drawn as well as troponin, prothrombin time, and INR (Mayo Clinic, 2021). Troponin refers to a group of proteins in the heart. The patient was defibrillated in the ambulance (which is the treatment for ventricular fibrillation). An EKG was performed, which confirmed the ventricular fibrillation diagnosis. Once the patient arrived at the hospital, labs were drawn, indicating elevated troponin, INR, and prothrombin time. The higher the PT and INR are, the longer it takes for the patient's blood to clot. The patient also went down for a cardiac catheterization which confirmed a blockage in the heart. Three stents were put in the patient's heart. Stents help improve blood flow that is lost from the blockage.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). ***Pathophysiology: Introductory concepts and clinical perspectives*****. F.A. Davis Company.**

Mayo Foundation for Medical Education and Research. (2021, June 2). ***Ventricular fibrillation.*** **Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/ventricular-fibrillation/symptoms-causes/syc-20364523.**

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. *Normal lab values per epic system at OSF in Urbana*

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.40-5.80	**4.90**	**NA**	
Hgb	13.0-16.5	**14.4**	**NA**	
Hct	38.0-50%	**41.9%**	**NA**	
Platelets	140-440	**238**	**NA**	

WBC	4.00-12.0	**10.90**	**NA**	
Neutrophils	47-73	**41.0%**	**NA**	
Lymphocytes	18-42%	**41.0%**	**NA**	
Monocytes	4-12%	**0.65%**	**NA**	
Eosinophils	0-5%	**0.46%**	**NA**	
Bands	0.0-1.0%	**NA**	**NA**	

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**	**126**	**NA**	**Decreased heart function can cause a low sodium level (Capriotti and Frizzell, 2016).**
K+	3.5-5.1	**3.7**	**NA**	
Cl-	98-107	**94**	**NA**	
CO2	21-31	**21**	**NA**	
Glucose	70-99	**283**	**NA**	**This patient has diabetes, which causes an increased glucose level (Capriotti and Frizzell, 2016).**
BUN	6-20	**19**	**NA**	
Creatinine	0.50-1.00	**1.00**	**NA**	
Albumin	3.5-5.7	**4.2**	**NA**	
Calcium	8.8-10.2	**9.5**	**NA**	
Mag	1.6-2.6	**1.9**	**NA**	
Phosphate	3.4 – 4.5	**NA**	**NA**	
Bilirubin	0.2 – 1.3	**0.5**	**NA**	

Alk Phos	38 – 126	**53**	**NA**	
AST	14 – 36	**46**	**NA**	**Elevated AST levels can indicate heart issues (Capriotti and Frizzell, 2016).**
ALT	0 – 34	**65**	**NA**	**Elevated ALT levels can indicate inflammation, infection, and heart issues (Capriotti and Frizzell, 2016).**
Amylase	30 - 110	**NA**	**NA**	
Lipase	0 - 160	**NA**	**NA**	
Lactic Acid	0.5-2.5	**NA**	**NA**	
Troponin	0 – 0.4	**0.075**	**7.0**	**An elevated troponin indicates heart injury (Capriotti and Frizzell, 2016).**
CK-MB	5 - 25	**NA**	**NA**	
Total CK	22- 128	**NA**	**NA**	

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	0.8-1.1	**3.0**	**NA**	**An elevated INR can indicate your blood is taking longer to clot (Capriotti and Frizzell, 2016).**
PT	10.1-13.1 seconds	**37.6**	**NA**	**An elevated PT can indicate your blood is taking longer to clot (Capriotti and Frizzell, 2016).**
PTT	25-36 seconds	**35 Seconds**	**NA**	
D-Dimer	0-622 ng/ml	**NA**	**NA**	
BNP	0-100	**86**	**NA**	
HDL	>40	**NA**	**NA**	
LDL	Less than 130	**NA**	**NA**	

Cholesterol	<200	**NA**	**NA**	
Triglycerides	<150	**NA**	**NA**	
Hgb A1c	4.0-6.0%	**NA**	**NA**	***This test was collected, but no result yet***
TSH	0.270-4.200	**2.536**	**NA**	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. *Not collected*

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Colorless and clear.	**NA**	**NA**	
pH	4.5 - 8	**NA**	**NA**	
Specific Gravity	1.005 – 1.035	**NA**	**NA**	
Glucose	Negative	**NA**	**NA**	
Protein	Negative	**NA**	**NA**	
Ketones	Negative	**NA**	**NA**	
WBC	Negative	**NA**	**NA**	
RBC	Negative	**NA**	**NA**	
Leukoesterase	Negative	**NA**	**NA**	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. *Not collected*

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35 – 7.45	**NA**	**NA**	

PaO2	75 - 100	**NA**	**NA**	
PaCO2	38 - 42	**NA**	**NA**	
HCO3	22 - 28	**NA**	**NA**	
SaO2	95% - 100%	**NA**	**NA**	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. *Not collected*

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Clean catch, no growth	**NA**	**NA**	
Blood Culture	No growth after 3 days	**NA**	**NA**	
Sputum Culture	Negative	**NA**	**NA**	
Stool Culture	The stool should appear brown, soft, and well-formed in consistency with no blood, mucus, bacteria, or fungi.	**NA**	**NA**	

Lab Correlations Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). ***Pathophysiology: introductory concepts and clinical perspectives.*** **Philadelphia: F.A. Davis Company.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray, Cardiac catheterization.

Diagnostic Test Correlation (5 points):

The chest X-ray indicated normal findings and the same as his last one in 2017. The cardiac catheterization confirmed a blockage in the heart. (Stents were placed).

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). ***Pathophysiology: introductory concepts and clinical perspectives.*** **Philadelphia: F.A. Davis Company.**

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

Home Medications (5 required)

Brand/Generic	**Losartan / Cozaar**	**Protonix / Pantoprazole**	**Spironolactone / carospir**	**Furosemide / Lasix**	**Clopidogrel / Plavix**
Dose	**100mg**	**40 mg**	**25mg**	**20mg**	**75mg**
Frequency	**1X daily**	**1X daily**	**1X daily**	**1X daily**	**1X daily**
Route	**Oral**	**oral**	**Oral**	**Oral**	**Oral**
Classification	**Angiotensin II receptor blocker (ARB)/ Antihypertensive**	**Proton pump inhibitor, antiulcer.**	**Potassium-sparing diuretic, diuretic.**	**Loop diuretic, antihypertensive.**	**Platelet aggregation inhibitor**
Mechanism of Action	**Blocks binding of angiotensin II to receptor sites in many tissues, including**	**Interferes with gastric acid secretion by inhibiting**	**Spironolactone competes with aldosterone for these receptors,**	**Inhibits sodium and water reabsorption in the loop of Henle and increases**	**Binds to adenosine diphosphate (ADP) receptors on the**

	adrenal glands and vascular smooth muscles.	**the hydrogen-potassium-adenosine-triphosphate enzyme system, or proton pump, in gastric parietal cells.**	**thereby preventing sodium and water reabsorption and causing their excretion through the distal convoluted tubules.**	**urine formation.**	**surface of activated platelets.**
Reason Client Taking	**The patient is taking for hypertension.**	**The patient is taking for stomach upset.**	**The patient is taking to reduce fluid because of heart issues.**	**The client is taking for hypertension.**	**The patient is taking to reduce the risk of a stroke.**
Contraindications (2)	**Concurrent aliskiren therapy (in patients with diabetes or renal impairment), hypersensitivity to losartan or its components.**	**Hypersensitivity to pantoprazole, concurrent therapy with rilpivirine containing products.**	**Acute renal insufficiency, Addison's disease.**	**Anuria, hypersensitivity to furosemide or its components.**	**Active pathological bleeding, hypersensitivity to clopidogrel.**
Side Effects/Adverse Reactions (2)	**Hypotension, angioedema.**	**Pancreatitis, Hepatic failure.**	**Hypotension, gastric bleeding.**	**Arrhythmias, thromboembolism.**	**Fatal intracranial bleeding, acute liver disease.**
Nursing Considerations (2)	**Know that in some cases, losartan may be given with other antihypertensives. Be aware that**	**Monitor the patient for bone fracture, especially in patient receiving more than**	**Be aware that for patients who have trouble swallowing, pharmacist**	**Be aware that patients who are allergic to sulfonamides may also be allergic to furosemide. Prepare drug**	**Expect to give aspirin with clopidogrel in patient with acute coronary syndrome.**

	patients who have renal artery stenosis or severe heart failure may experience acute renal failure from losartan therapy.	**1 dose. Be aware that a symptomatic response to the drug does not rule out the presence of gastric tumor.**	**may crush—mix with flavored syrup, and dispense as a suspension. Stop drug for several days, as prescribed, before patient undergoes adrenal vein catheterization to measure serum aldosterone level and plasma renin activity.**	**for infusion with normal saline solution, lactated ringers, or D5W.**	**Use cautiously in patients with severe hepatic or renal disease, risk of bleeding from surgery or trauma, or conditions that predispose to bleeding.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Assess the patients' blood pressure before giving losartan. Monitor the patient's serum potassium level to detect hyperkalemia.**	**Monitor PT and INR if the patient takes an anticoagulant.**	**Monitor the patient's serum potassium level, and monitor patient's renal function.**	**Obtain patients weight before and periodically during furosemide therapy due to fluid loss. Expect the patient to have periodic hearing tests. Monitor labs for hypokalemia.**	**Obtain a blood cell count to check for a hematologic issue. Monitor patient who takes aspirin closely because the risk of bleeding is increased.**
Client Teaching needs (2)	**Warn the patient to tell all prescribers of losartan**	**Advise patient to expect relief of symptoms**	**Instruct the patient to take with meals or milk.**	**Instruct the patient to take furosemide at the same time**	**Instruct patient not to discontinue abruptly or**

	therapy. Instruct the patient to avoid salt substitutes.	within 2 weeks of starting therapy. Instruct patient to notify prescriber if diarrhea occurs and becomes prolonged or severe.	Tell patients who can't swallow tablets that drug is available as a suspension.	every day for therapeutic effect. Emphasize the importance of weight and diet control, especially limiting sodium intake.	without first consulting prescriber. Caution patient that bleeding may continue longer than usual.

Hospital Medications (5 required)

Brand/ Generic	Amiodarone/ Cordarone	Aspirin / Bayer *newly prescribed to patient*	Fentanyl / Fentora	Heparin / Hepalean	Versed / Midazolam
Dose	360mg	81 mg	25 mcg	5,000 units	2 mg 1X 1mg 1X 1mg 1X 4mg total
Frequency	Continuous IV infusion	1X daily	1X	1X	1X
Route	IV	oral	IV	Subcutaneous	IV
Classification	Class III antiarrhythmic	Antiplatelet, antipyretic.	Opioid analgesic	Anticoagulant	Benzodiazepine, sedative-hypnotic
Mechanism of Action	Acts on cardiac cell membranes, prolonging repolarization and the refractory	Aspirin blocks the activity of cyclooxygenase, the enzyme needed for	Binds to opioid receptor	Binds with antithrombin III, enhancing antithrombi	May exert sedating effect by increasi

	period and raising ventricular fibrillation threshold.	**prostaglandin synthesis.**	**sites in the CNS, altering perception of and emotional response to pain by inhibiting ascending pain pathways.**	**n III's inactivation of the coagulation enzymes thrombin and factors Xa and Xia.**	**ng activity of Gamma-aminobutyric acid, a major inhibitory neurotransmitter in the brain.**
Reason Client Taking	**The patient is taking to prevent ventricular fibrillation.**	**The patient is taking to reduce the risk of a stroke.**	**The client had a single dose for pain.**	**The patient is taking heparin to decrease the risk of embolism and to prevent clots.**	**The patient was given versed before their cardiac catheterization.**
Contraindications (2)	**Bradycardia that causes syncope, cardiogenic shock.**	**Active bleeding or coagulation disorders, current or recurrent GI bleed or ulcers.**	**Respiratory depression, hypersensitivity to fentanyl.**	**Severe thrombocytopenia, and uncontrolled active bleeding.**	**Coma, shock.**
Side Effects/ Adverse	**Thyroid cancer, pancreatitis.**	**CNS depression, GI bleeding.**	**Seizures, hypot**	**Thrombosis, Asthma.**	**Cardiac arrest, airway**

Reactions (2)			**ension.**		**obstruction.**
Nursing Considerations (2)	**Use an in-line filter during I.V. administration of amiodarone. Know that infusion of up to 0.5mg/min may be continued for 2-3 weeks, regardless of patient's age, left ventricular function, or renal function.**	**Don't crush time released or controlled release aspirin unless directed, ask about tinnitus.**	**Use cautiously in patients at risk for opioid abuse, such as those with mental illness or personal or family history of abuse. Expect the blood fentanyl level to be prolonged if patient chews or swallows the trans**	**Avoid injecting any drugs by I.M. route during heparin therapy, to decrease the risk of bleeding. Alternate injection sites and watch for signs of bleeding and hematoma.**	**Determine whether patient consumes alcohol or takes antibiotics, antihypertensive, or protease inhibitors because these substances can produce an intense and prolonged sedative effect when taken with midazolam. Be aware that recovery time is usually 2 hours but may be up to 6 hours.**

			mucosal form because drug is absorbed slowly from GI tract.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor continuous ECG, monitor vital signs and oxygen. Monitor liver enzymes as ordered.**	**Assess for bleeding disorders, or hypersensitivity to aspirin.**	**Monitor the patient's respiratory status, monitor blood glucose levels with diabetic patients.**	**Check hematocrit and platelet count before and during heparin therapy.**	**Assess the level of consciousness frequently. Assess blood pressure.**
Client Teaching needs (2)	**Explain that the patient will need frequent monitoring and laboratory tests during treatment. Instruct the patient to report abnormal bleeding or bruising.**	**Tell patient not to take aspirin if it has a strong vinegar like odor, instruct patient to take aspirin with food or after meals because it may cause GI upset if taken on an empty stomach.**	**Instruct patient to avoid alcohol and other CNS depressants including benzo**	**Explain that heparin can't be taken orally. Advise patient to wear or carry appropriate medical identification.**	**Inform patient that he may not remember the procedure because midazolam produces amnesia.**

			diazepines during fentanyl therapy. Warn patient not to take more drug than prescribed and not to take it longer than needed because excessive use can lead to abuse.		**Advise patient to avoid hazardous activities until the drugs CNS effects, such as dizziness and drowsiness, have worn off.**

Medications Reference (1) (APA):

Jones & Bartless Learning. (2020). 2020 Nurse's drug handbook (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient is alert and oriented X4** **The patient does not seem to be in any distress, but seems to have mild anxiety.** **The patients overall appearance is within normal limits.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 21** **Drains present: Y☐ N ☒** **Type:**	 **The patient's skin is dry and intact.** **The skin is white and warm.** **Normal turgor: 2+** **The patient does not have any rashes, bruises, or wounds.** **Braden score: 21** **No drains present.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**The patients head is symmetrical (midline with no deviations).** **The patient's hair is dark brown with no patches or balding.** **The patient's ears are clear and pink with no drainage.** **The tympanic membrane is visible and is pearly grey.** **PEERLA is present.** **The patient does not have nasal deviation.** **The oral mucosa is pink and moist.** **The patient wears glasses.** **The patient's teeth are in good condition.** .
CARDIOVASCULAR (2 points):	**The patient had a normal sinus rhythm with**

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:**	**first degree heart block.** **No S1, S2, S3, S4, Or murmur is present.** **The patient's radial and pedal pulses are palpable.** **There is no peripheral edema.** **Normal capillary refill: less than 3 seconds.** **The patient has no neck vein distension.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	**The patient's breath sounds are clear and equal bilaterally.** **The patient is not using accessory muscles.** **The patient does not have an ET tube.**
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:**	**The patient is on a regular diet at home.** **The patient is on a cardiac diet here at the hospital.** **Height: 5'9"** **Weight: 246 pounds** **Normoactive bowel sounds heard in all four quadrants.** **Last BM: 9-19-21 in the afternoon.** **There is no distension, incisions, scars, drains, or wounds.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:**	**The patient's urine is clear and yellow.** **The patient is voiding regularly.** **The patient reports no pain or trouble with urination.**

Pain with urination: Y ☐ N ☒ **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	**The patient's genitals are clean and intact.**
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 ☐** **Needs support to stand and walk☐**	**The patient is not experiencing any weakness.** **The patient has a normal ROM.** **The patient does not use supportive devices (wears glasses).** **The patient's strength is equal on both sides.** **The patient ambulates independently.** **Fall score: 5 (not a 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:**	**The patients grip strength is equal bilaterally.** **PERLA is present.** **The patient is oriented and mental status is normal.** **The patient has normal speech and is actively speaking.** **No LOC.**
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):**	**The patient practices Christianity.** **The patient's developmental level is within normal range for age.** **The patient's support system is his wife. They are very close and they go to church together.** **The patient watches baseball (cubs specifically) as a coping method.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
08:45am	**67**	**151/88**	**22**	**97.5 F**	**99% RA**

				oral	
12:00pm	**60**	**127/89**	**18**	**97.9 F** **Oral**	**99% RA**

Vital Sign Trends/Correlation:

The patient's vital signs are consistent and stable. During the 08:45am vitals, the patient was slightly anxious and had an increased respiratory rate.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
08:00am	**0-10**	**NA**	**The patient denies pain.**	**NA**	**NA**
12:00pm	**0-10**	**NA**	**The patient denies pain.**	**NA**	**NA**

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:**	**Size: 18 gauge** **Location of IV: peripheral IV in the medial cubital vein.** **Date on IV: 9-20-21** **The patient is receiving a continuous amiodarone infusion (0.5 mg/mg). The patient has also received IV push fentanyl and versed.** **Patency: IV is patent and there is no signs of erythema or drainage.** **IV dressing is intact and no sign of infiltration**

Other Lines (PICC, Port, central line, etc.)	No other lines.
Type: Size: Location: Date of insertion: Patency: Signs of erythema, drainage, etc.: Dressing assessment: Date on dressing: CUROS caps in place: Y ☐ N ☐ CLABSI prevention measures:	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
115 ml IV amiodarone *The patient is NPO for upcoming cardiac cathertization procedure*	500 ml urine

Nursing Care

Summary of Care (2 points)

Overview of care: The patient arrived to the CCU 9-20-21 in the evening. Upon arrival, the patient complained of "chest tightness". The patient is on continuous heart monitoring and on an amiodarone drip. The IV is placed in the patient's medial cubital vein. The patient is NPO because of a cardiac catheterization that will be done in the morning of 9-21-21. The patient is currently stable and reports no pain. Troponin and INR was elevated, which was to be expected because he had experienced ventricular fibrillation.

Procedures/testing done: The patient had a cardiac catheterization.

Complaints/Issues: The patient complained of chest tightness upon arrival, but has no complaints at this time.

Vital signs (stable/unstable): The patient's vital signs are stable.

Tolerating diet, activity, etc.: The patient is currently NPO.

Physician notifications: The physician is referring the patient to see his cardiologist.

Future plans for patient: The patient is expected to follow up with his primary care physician, cardiologist, and attend cardiac rehab.

Discharge planning (2 points)

Discharge location: The patient is discharging home with his wife to Danville, IL.

Home health needs (if applicable): The patient is receiving a home health consult because his wife is not in the best health and he will need rehab.

Equipment needs (if applicable): No equipment needed.

Follow up plan: The patient is expected to follow up with his primary care physican and cardiologist.

Education needs: The patient needs education on proper diet because he is a diabetic. The patient also needs education on an exercise plan / cardiac rehab.

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. Risk for injury related to trauma from a percutaneous puncture as evidence by Bleeding from the catheterization site.	**I chose this nursing diagnosis because the patient just had a cardiac cathertization.**	**1.Keep pressure dressing on the catheterization site and assess every 30 minutes for bleeding.** **2.Maintain bed rest for 6 hours.**	**The patient was willing to maintain bedrest for 6 hours and was cooperative during the assessments for bleeding. Goal: Reduce the risk for injury and bleeding. Outcome: Positive outcome. The patient maintained bedrest and had no injury.**
2. Risk for decreased cardiac output related to hypertension as evidence by ventricular fibrillation.	**The patient experience ventricular fibrillation and has a first degree heart block.**	**1. Teach patient about proper diet/ lifestyle modifications.** **2.Assess the patient's blood pressure frequently.**	**The patient was willing to listen to the teaching. However, he expressed his love for "a fat, juicy burger". The patient was also cooperative in the frequent blood pressure monitoring. Goal: help the patient manage their hypertension. Outcome: positive outcome. The patient listened to what was taught and blood pressure remained stable.**
3**. Risk for unstable blood glucose related to type II diabetes as evidence by a blood sugar of 283.**	**The patient had a blood sugar level of 283.**	**1. Watch for signs of hyperglycemia.** **2 Administer insulin.**	**The patient was willing to receive insulin. Goal: keep a close eye on the patient's blood glucose and maintain the**

			level. **Outcome: insulin was given, and the patient's blood glucose went down to 150. The patient did not show signs of hyperglycemia.**
4. Risk for Ineffective Therapeutic Regimen Management related to type II diabetes as evidence by uncontrolled diabetes and blood glucose levels.	**The patient has an uncontrolled blood glucose and does not follow dietary/medical regimen.**	**1. Provide information of proper diabetes management and how to check blood glucose levels.** **2. Provide information on dietary modifications.**	**The patient was open and willing to learn new information regarding his diabetes management.** **Goal: provide information to the patient about diabetes management (lifestyle modifications and medical regimen).** **Outcome: The patient was engaged in the teaching plan and plans on monitoring his glucose levels and eating better.**
5. Anxiety related to ventricular fibrillation as evidence by restlessness and expressions of anxiety.	**The patient is feeling anxious about his ventricular fibrillation experience and new hospitalization.**	**1. Stay with the patient and answer their questions.** **2. Observe for increasing anxiety and provide a calm environment.**	**The patient was cooperative and open about discussing his feelings.** **Goals: reduce the patient's anxiety and make him feel calm.** **Outcome: after our morning assessment, the patient was calmer. He was not restless, and his respiratory rate went from 22 to 18.**

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2020). ***All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health.*** **St. Louis, MO: Elsevier.**

Concept Map (20 Points):

Subjective Data

The patient is currently not experiencing any pain.
He stated "When I got here my chest felt tight, and it still does on occasion".
The patient also stated "I am feeling anxious and scared about what is going to happen today".
The patient does not smoke, drink, or do drugs.

Nursing Diagnosis/Outcomes

1. Risk for injury related to trauma from a percutaneous puncture as evidence by Bleeding from the catheterization site. Outcome: Positive outcome. The patient maintained bedrest and had no injury.
2. Risk for decreased cardiac output related to hypertension as evidence by ventricular fibrillation. Outcome: positive outcome. The patient listened to what was taught and blood pressure remained stable.
3. Risk for unstable blood glucose related to type II diabetes as evidence by a blood sugar of 283. Outcome: insulin was given, and the patient's blood glucose went down to 150. The patient did not show signs of hyperglycemia.
4. Risk for Ineffective Therapeutic Regimen Management related to type II diabetes as evidence by uncontrolled diabetes and blood glucose levels. Outcome: The patient was engaged in the teaching plan and plans on monitoring his glucose levels and eating better.
5. Anxiety related to ventricular fibrillation as evidence by restlessness and expressions of anxiety. Outcome: after our morning assessment, the patient was calmer. He was not restless, and his respiratory rate went from 22 to 18.

Objective Data

The patient is restless and had an elevated RR of 22--- after intervention RR was 18.
Temperature: 97.9 oral
Blood pressure: 127/89
Pulse: 60
O2: 99% on room air.
Weight: 246 pounds
Height: 5'9"

Patient Information

The patient is a 57 year old male who was admitted to the critical care unit on 9-20-21 in the evening following ventricular fibrillation and defibrillation.
The patient had a cardiac catheterization and three stents were placed.
Full code.
Allergies: Cephalexin—pt breaks out in hives.

Nursing Interventions

1. Keep pressure dressing on the catheterization site and assess every 30 minutes for bleeding. Maintain bed rest for 6 hours.
2. Teach patient about proper diet/ lifestyle modifications. Assess the patient's blood pressure frequently.
3. Watch for signs of hyperglycemia. Administer insulin.
4. Provide information of proper diabetes management and how to check blood glucose levels. Provide information on dietary modifications.
5. Stay with the patient and answer their questions. Observe for increasing anxiety and provide a calm environment.