

**Medications**

**Sotalol (Sorine)** 80mg PO BID  
Pharmacological class: Antiarrhythmics  
Why patient is taking: Improves heart rhythm by acting on the heart muscle. The patient has atrial fibrillation and a pacemaker.  
Nursing assessment: Rate and rhythm of apical pulse.

**Carvedilol (Coreg)** 6.25mg PO BID  
Pharmacological class: Beta blocker  
Why patient is taking: hypertension and heart failure  
Nursing assessment prior to administration: Blood pressure and apical pulse.

**Warfarin (Coumadin)** 6mg PO HS  
Pharmacological class: Anticoagulant  
Why patient is taking: Blood thinner to prevent clots.  
Nursing assessment: Signs of bleeding and hemorrhage, PT/INR

**Atorvastatin (Lipitor)** 40mg PO HS  
Pharmacological class: HMG-CoA reductase inhibitors (statins)  
Why patient is taking: Treats high cholesterol and triglycerides to reduce the risk of stroke, angina, and heart related problems.  
Nursing assessment prior to administration: Cholesterol and triglyceride levels. Monitor liver function tests.

**Lisinopril (Zestril)** 5mg PO HS  
Pharmacological class: Ace Inhibitor  
Why patient is taking: Hypertension and heart failure  
Nursing assessment prior to administration: Blood pressure, apical pulse, BUN, creatinine, and potassium.

(Jones & Bartlett Learning, 2020)

**Lab Values/Diagnostics**

Calcium – 8.3 (L)  
- Normal: 8.6 – 10.3 mg/dL  
- Osteoporosis can cause calcium to be low. The patient has osteoporosis.

PT – 24.9 (H)  
- Normal: 11.9 – 15.0 seconds  
- Warfarin can increase PT. The patient is currently taking warfarin.

INR – 2.16 (H)  
- Normal: 0.86 – 1.14  
- Warfarin can Increase INR. The patient is currently taking warfarin.

Platelets – 144 (L)  
- Normal: 149 – 393 K/mcL  
- Statins decrease platelet counts. The patient is currently taking atorvastatin.

Neutrophils – 35.9 (L)  
- Normal: 45.3% - 79.0%  
- Antihypertensive medications can lower neutrophils. The patient is currently taking antihypertensive medications.

Diagnostic tests showed no abnormalities.

(Sara Bush Lincoln Health Center, 2021)

**Demographic Data**

**Date of Admission:** 11/28/21  
**Admission Diagnosis/Chief Complaint:** Transient ischemic attack (TIA)  
**Age:** 80-year-old  
**Gender:** Female  
**Race/Ethnicity:** Caucasian  
**Allergies:** Antihistamines. Reaction: Tachycardia  
**Code Status:** Full  
**Height in cm:** 160 cm  
**Weight in kg:** 67.7 kg  
**Psychosocial Developmental Stage:** Ego Integrity vs. Despair  
**Cognitive Developmental Stage:** Formal Operational  
**Braden Score:** 20  
**Morse Fall Score:** 45  
**Infection Control Precautions:** Standard precautions

**Admission History**

On 11-28-21 an 80-year-old female Caucasian arrived by ambulance to the emergency department with a history of atrial fibrillation with a pacemaker and hypertension. She stated that on the morning of 11-28-2021 around 0600 she had an episode of diarrhea with no melena or hematochezia after she ate lunch. She stated that she was not in any pain from the diarrhea. While cleaning up the diarrhea she stated that she had an episode of blurry vision that lasted for about 5 minutes and then it went away. She denies any aggravating factors but stated that it could be because she has been more stressed because she is the main caretaker for her husband that has dementia. She stated there was nothing to alleviate her symptoms because it happened so fast.

**Medical History**

**Previous Medical History:** The patient has a past medical history of atrial fibrillation (Afib), hypertension, and osteoporosis.

**Prior Hospitalizations:** N/A

**Previous Surgical History:** Cardiac ablation using fluoroscopy guidance; Cardiac pacemaker; Cataract extraction; Arthroplasty of left knee; Tonsillectomy. Dates were not available.

**Social History:** The patient denies any history of alcohol consumption, smoking, or drug usage.

**Pathophysiology**

**Disease process:** A transient ischemic attack (TIA) happens when there is a blockage or a reduction of blood flow to the brain. A blood clot is usually the cause of the obstruction. The obstruction will be resolved after a short time frame and blood will begin to flow again. Once the blood is flowing all symptoms will be resolved as well. A TIA can be a warning sign for a future stroke (Capriotti, 2020).

**S/S of disease:** Sudden severe headache with no known cause, confusion, weakness or numbness of the arm, leg, and/or face, difficulty speaking, vision changes, difficulty walking, loss of coordination or balance, and dizziness (Capriotti, 2020).

**Method of Diagnosis:** Diagnosis of TIA can consist of a physical exam, neurological exam, risk factors assessment, ultrasonography, computerized tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), echocardiography, and arteriography (Hinkle & Cheever, 2018).

**Treatment of Disease:** TIA can be a warning for a stroke. Once the cause of the TIA has been determined, the goal is to prevent a stroke by correcting the abnormality. Medications such as anti-platelets and/or anticoagulants can be prescribed to reduce the risk of having a stroke. A surgical angioplasty might also be performed (Capriotti, 2020).

**Active Orders**

- Heart Healthy Diet:
  - Helps lower LDL and triglycerides in the blood and raise HDL which will help control hypertension.
- Fall Risk Precautions:
  - To prevent injury while in the hospital. The patient had blurred vision and a Morse fall risk score of 45.
- Vitals Every 4 Hours:
  - Assess for signs and symptoms of infection, blood pressure for hypertension or hypotension after administering antihypertensives, heart rate and rhythm, atrial fibrillation, and change in oxygenation.
- 2L/min continuous O2 via Nasal Canula:
  - Supplemental oxygen needed to maintain adequate oxygen saturation.

(Sara Bush Lincoln Health Center, 2021)

## Physical Exam/Assessment

**General:** Patient is alert and oriented x 4. Identifies self and is oriented to place, time, and situation. The patient is in no acute distress. The patient is calm and cooperative, well groomed, and has a clean appearance with appropriate affect. The patient maintains appropriate eye contact, demonstrates articulate speech, and responds to questions.

**Integument:** Skin color usual for ethnicity and warm to the touch on the upper and lower extremities. The skin has areas of dryness on her elbows and knees. Skin turgor has elasticity with no rashes, bruises, or wounds. There are no drains. The patient has a Braden score of 20.

**HEENT:** Head/Neck: Normocephalic atraumatic, active range of motion, supple, non-tender, no carotid bruits, no jugular venous distention (JVD), no lymphadenopathy, and no thyromegaly. There is no obvious abnormalities or contusions on the patient's head.

Ears: The right and left ear are symmetrical and bilaterally placed. They are clear with ability to hear out of both ears. Tympanic membrane is a pearly gray color in the right and left ear. There is no drainage or cerumen present inside of the ears (right and left).

Eyes: For the right and left eye, pupil size 3mm, pupils equal, round, and reactive to light and accommodation (PERLA), extraocular movements intact (EOMI), conjunctiva has no abnormalities, no scleral icterus.

**Cardiovascular:** The patient has a pacemaker. S1 and S2 heard with normal sinus rhythm from the aortic, pulmonic, Erb's point, tricuspid, and mitral locations of the heart. There are no friction rubs, murmurs, or gallops detected or heard on S3 and S4. Pulses equal and +3 in all extremities. Capillary refill less than 3 seconds for the upper and lower right and left extremities. The patient has no signs of edema and no neck vein distention.

**Respiratory:** Breath sounds were clear to auscultation and percussion (inspiratory and expiratory) on the right and left lungs. Respirations were non-labored, regular, and accessory muscle not used. Lung aeration was equal.

**Genitourinary:** Voids without difficulty or pain in the toilet. Unable to assess amount. Urine is clear, yellow, and without odor. No dialysis and no catheter.

**Musculoskeletal:** Nails are smooth without pits or grooves. They are uniform in consistency and in color. They are free of discoloration and spots. The skin is warm to the touch on the upper and lower right and left extremities. Patient shows equal strength and has active range of motion on her upper and lower right and left extremities. Patient has a gait belt and is up with one assist. Patient has a fall risk with a score of 45 (Morse Fall Score). Safety needs managed per basic protocol.

**Neurological:** MAEW, PERLA, alert and oriented to person, place, time, and situation, answers questions appropriately, normal cognition, clear and understandable, has sensation that is equal on the right and left upper and lower extremities, equal strength on the right and left upper and lower extremities.

**Most recent VS (include date/time and highlight if abnormal):**

- Date: 11/29/2021 Time: 0900
- BP: 177/75 HR: 77 bpm RR: 16 Temp: 36.8 degrees C O2Sat: 90%

**Pain and pain scale used:** The patient rated her pain a 0 out of 10 using the numeric pain scale. The time was 0900.

<p style="text-align: center;"><b>Nursing Diagnosis 1</b></p> <p>Risk for ineffective cerebral tissue perfusion related to hypertension as evidenced by a diagnosed history of high blood pressure and a current blood pressure of 177/75.</p>	<p style="text-align: center;"><b>Nursing Diagnosis 2</b></p> <p>Risk for falls related to impaired mobility as evidenced by Morse Fall Score of 45 and episodes of blurred vision.</p>	<p style="text-align: center;"><b>Nursing Diagnosis 3</b></p> <p>Ineffective coping related to situational crisis as evidenced by inability to cope due to being the main caretaker for her husband who has dementia.</p>
<p style="text-align: center;"><b>Rationale</b></p> <p>I chose this nursing diagnosis due to the patient having a history of hypertension which is the leading cause for stroke. The patient is currently admitted for a possible TIA which is a warning sign for a stroke.</p>	<p style="text-align: center;"><b>Rationale</b></p> <p>I chose this nursing diagnoses due to the patient having episodes of blurred vision and a score of 45 on the Morse Fall Risk Scale. This puts her at the high end of being a moderate risk for falling. A few more points and she would be considered high risk for falling.</p>	<p style="text-align: center;"><b>Rationale</b></p> <p>I chose this nursing diagnosis because the patient is stressed out from taking care of her husband who has dementia which leaves her no time to be caring for herself correctly. She stated that she decided to get checked out but should be at home caring for her husband instead.</p>
<p style="text-align: center;"><b>Interventions</b></p> <p><b>Intervention 1:</b> Administer antihypertensives as prescribed per physician's orders.</p> <p><b>Intervention 2:</b> Educate the patient on the importance of taking her antihypertensive medications as directed to keep her hypertension under control.</p>	<p style="text-align: center;"><b>Interventions</b></p> <p><b>Intervention 1:</b> Educate the patient on safety hazards that could cause a potential fall such as extension cords across walkways, throw rugs, poor lighting, unstable chairs or tables, and clutter.</p> <p><b>Intervention 2:</b> Educate the patient to push the call light and wait for assistance before getting out of the hospital bed or chair.</p>	<p style="text-align: center;"><b>Interventions</b></p> <p><b>Intervention 1:</b> Encourage the patient to express feelings such as depression, anger, hostility, and disconnectedness.</p> <p><b>Intervention 2:</b> Encourage the patient to try stress relieving techniques through cognitive behavioral relaxation such as music therapy, meditation, or guided imagery.</p>
<p style="text-align: center;"><b>Evaluation of Interventions</b></p> <p>Antihypertensives given as prescribed by the physician. After educating the patient on the importance of taking her antihypertensive medications as directed, the patient was able to teach back the amount and times that her medications are to be taken once she is discharged and at home again.</p>	<p style="text-align: center;"><b>Evaluation of Interventions</b></p> <p>The patient was able to point at and verbalize different items that might be a potential safety hazard in her home. The patient verbalized the importance of pushing her call light for assistance before standing while in the hospital to prevent the risk of her falling.</p>	<p style="text-align: center;"><b>Evaluation of Interventions</b></p> <p>The patient verbalized that she would express her feelings and will try relaxation techniques whenever she is feeling stressed or overwhelmed. The patient stated that she really thinks that talking to someone would help her as well.</p>

**References (3) (APA):**

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

Hinkle, J. L. & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14<sup>th</sup> ed.). Wolters Kluwer

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

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