N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 02/28/22	**Client Initials** S.D.	**Age** 64 years old	**Gender** Female
Race/Ethnicity White/Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** Ragweed – sinus congestion Latex – contact dermatitis
Code Status Full Code	**Height** 177.8 cm	**Weight** 89.5 kg	

Medical History (5 Points)

Past Medical History: Patient has a past medical history of obstructive sleep apnea, GERD, anemia, knee osteoarthritis, chronic neck pain, benign colon polyps, restless leg syndrome, and numbness in both legs.

Past Surgical History: Patient has a past surgical history of a cholecystectomy on 09/22/20.

Family History: Patient has a past family history of Alzheimer's disease, breast cancer, diabetes mellitus, stroke, colon cancer, hypertension, and hyperlipidemia on the maternal side. Patient has a past family history of heart attacks on the paternal side.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient is a current alcohol user 1-2 times per month for the past 30+ years. Patient denies drug use. Patient is a former 1 pack a week smoker who started at 16 years of age and stopped at 45 years of age.

Assistive Devices: This patient uses a CPAP/BIPAP machine at home. Patient does not wear glasses or use a walker or wheelchair.

Living Situation: Patient lives at home with her husband in Charleston, Illinois.

Education Level: This patient has no learning barriers.

Admission Assessment

Chief Complaint (2 points): Patient complains of chest palpitations.

History of Present Illness – OLD CARTS (10 points): Patient is a 64-year-old female who presented to the Sarah Bush Lincoln Memorial hospital emergency department on 02/28/22 complaining of chest palpitations that started that morning while she was sleeping. Patient states that this is normal and happens all the time, but this time it felt like her heart was “fluttering”. She also states that she “sometimes has chest discomfort that radiates to her left arm”. She did not attempt any relieving factors. An EKG was performed and she was found to be in atrial fibrillation with rapid ventricular response. In the emergency room she was given diltiazem and digoxin. Her labs showed an elevated d-dimer and a CT shows no pulmonary embolism. She was then admitted to 2 East.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): N/A

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

Atrial fibrillation is a type of dysrhythmia. Atrial fibrillation results from abnormal impulse formation when structural or electrophysiological abnormalities alter the atrial tissue (Hinkle & Cheever, 2018). The alteration causes a rapid, disorganized, and uncoordinated twitching of the atrial musculature. The extrinsic (central) and intrinsic cardiac autonomic nervous system (CANS) play an essential part in the continuance of atrial fibrillation. The CANS consists of an intertwined network of autonomic ganglia and nerve cell bodies within the epicardium (Hinkle & Cheever, 2018). Hyperactive ganglia play a significant role in atrial fibrillation, resulting in impulses initiated from the pulmonary veins and conducted through the

AV node. Atrial fibrillation presents with a ventricular rate between 120 and 200 bpm and an atrial rate of 300 to 600 bpm (Capriotti, 2020). This patient currently does not experience these vital signs. The ventricular and atrial rhythms are highly irregular. This patient had an irregular heart rate that showed on her first electrocardiogram. The rapid and irregular ventricular response reduces the time for ventricular filling, causing a smaller stroke volume (Hinkle & Cheever, 2018). Rapid ventricular response indicates the heart is beating at a rate higher than 100 bpm. Due to the loss in atrial and ventricular response, the atrial kick is lost. It causes patients to experience palpitations and manifestations of heart failure such as shortness of breath, hypotension, and fatigue. This patient presented with palpitations. A 12-lead electrocardiogram is performed to verify the atrial fibrillation rhythm. This patient had an electrocardiogram performed upon arrival to the emergency room. A chest x-ray may also be performed to evaluate pulmonary vasculature in a patient suspected of having pulmonary hypertension. This patient had a chest x-ray performed to rule out a pulmonary embolism. Troponin labs may be evaluated to rule out myocardial infarction. This patient had a troponin lab evaluated. Strategies for both rhythm and rate control are primary treatments for atrial fibrillation. Antithrombic medications are indicated for patients with atrial fibrillation because they reduce stroke risk (Hinkle & Cheever, 2018). The patient is taking aspirin for this reason. Antiarrhythmic medications are also given to treat dysrhythmias. The patient is taking diltiazem to treat and prevent atrial dysrhythmia.

Pathophysiology References (2) (APA):

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

Hinkle, J. L., & Cheever, K. H. (2018). *Textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

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	3.8 – 5.4 x 10^6/mcL	4.94 x 10^6/ mcL	4.87 x 10^6/mcL	
Hgb	11.3 – 15.2 g/ dL	14.8 g/dL	14.6 g/dL	
Hct	33.2 – 45.3 %	42.7 %	42.3 %	
Platelets	149 – 393 kg/ mcL	253 kg/mcL	229 kg/ mcL	
WBC	4.0 – 11.7 kg/ mcL	7.7 kg/mcL	6.3 kg/ mcL	
Neutrophils	45.3 – 79.0 %	45.7 %	58.9 %	
Lymphocytes	11.8 – 45.9 %	39.6 %	27.1 %	
Monocytes	4.4 – 12.0 %	12.0 %	10.1 %	
Eosinophils	0.0 – 6.3 %	3.6 %	3.2 %	
Bands	0.0 – 6.0 %	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-	136 – 145 mmol/L	140 mmol/ L	141 mmol/L	
K+	3.5 – 5.1 mmol/L	3.6 mmol/L	4.2 mmol/L	
Cl-	98 – 107 mmol/L	107 mmol/ L	107 mmol/L	
CO2	21 – 31 mmol/L	23 mmol/L	25 mmol/L	
Glucose	74 – 109 mg/dL	96 mg/dL	89 mg/dL	

BUN	7 – 25 mg/dL	21 mg/dL	22 mg/dL	
Creatinine	0.60 – 1.20 mg/dL	0.90 mg/dL	0.82 mg/dL	
Albumin	3.5 – 5.2 g/dL	4.5 g/dL	N/A	
Calcium	8.6 -10.3 mg/dL	9.7 mg/dL	9.8 mg/ dL	
Mag	1.6 – 3.6 mg/dL	N/A	N/A	
Phosphate	2.5 – 4.5 mg/dL	N/A	N/A	
Bilirubin	0.3 – 1.0 mg/dL	0.5 mg/dL	N/A	
Alk Phos	34 – 104 unit//L	60 unit/L	N/A	
AST	13 – 39 unit/ L	21 unit/L	N/A	
ALT	7 – 52 unit/ L	25 unit/L	N/A	
Amylase	60 – 120 U/ L	N/A	N/A	
Lipase	0 – 160 U/L	N/A	N/A	
Lactic Acid	0.5 – 2.2 mEq/L	N/A	N/A	
Troponin	0.0 – 0.03 ng/mL	< 0.010 ng/ mL	N/A	
CK-MB	3 – 5 %	N/A	N/A	
Total CK	22 – 198 U/ L	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	0.9 – 1.1 seconds	N/A	N/A	
PT	10.1 – 13.1	N/A	N/A	

	seconds			
PTT	25 – 36 seconds	N/A	N/A	
D-Dimer	0.00 – 0.62 mcg/mL	1.17 mcg/ mL (H)	N/A	An elevated d-dimer indicates recent clotting activity. Atrial fibrillation increases the risk for clots due to the stasis of the blood in the heart chamber (Capriotti, 2020).
BNP	>100 pg/mL	N/A	N/A	
HDL	>60 mg/dL	N/A	N/A	
LDL	<130 mg/dL	N/A	N/A	
Cholesterol	<200 mg/dL	N/A	N/A	
Triglycerides	<150 mg/dL	N/A	N/A	
Hgb A1c	<5.7 %	N/A	N/A	
TSH	0.45 – 5.33 mcIU/mL	1.74 mcIU/mL	N/A	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. NO LABS PERFORMED

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow, clear	N/A	N/A	
pH	5.0 – 9.0	N/A	N/A	
Specific Gravity	1.003 – 1.035	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	< 5 /mcL	N/A	N/A	
RBC	0 – 3	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. NO LABS PERFORMED

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35 – 7.45	N/A	N/A	
PaO2	10.3 – 23.3	N/A	N/A	
PaCO2	35.0 – 45.0	N/A	N/A	
HCO3	22.0 – 26.0	N/A	N/A	
SaO2	92 – 100 %	N/A	N/A	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format. NO LABS PERFORMED

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (1) (APA):

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

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

02/28 at 0135 Electrocardiogram (EKG): shows atrial fibrillation with rapid ventricular response and ST and T wave abnormality, irregular heart rate, consider anterolateral ischemia.

02/28 Chest x-ray: shows a mildly enlarged heart, no pneumothorax, no effusion, linear opacities in the base that appear to represent overlying vasculature, no definite acute abnormality.

02/28 Electrocardiogram (EKG): shows normal sinus rhythm that has replaced the atrial fibrillation when compared to the EKG at 0135, ST and T wave abnormality also shown.

02/28 CT angio chest pulmonary with contrast: shows no evidence of pulmonary embolisms or aortic dissection, multiple bibasilar lung nodules, left hepatic cysts, post cholecystectomy, and degenerative changes.

03/01 EC Echo complete without contrast: shows mild left ventricular hypertrophy, ejection fraction is 55-60%, there is grade 1 diastolic dysfunction, right atrium is mildly dilated, aortic valve is mildly calcified with mild aortic regurgitation.

Diagnostic Test Correlation (5 points):

The first electrocardiogram (EKG) was performed due to the chest palpitations. The second EKG was performed routinely due to the first EKG results. An EKG is used to visualize the electrical activity of the heart. The chest x-ray was performed due to the chest discomfort that has been experienced and due to the chest palpitations. An x-ray is used to visualize the cardiac shadow and pulmonary fields along with bone structure. The CT of the lungs was performed due to pain, chest pressure, increased d-dimer, atrial fibrillation, and chest palpitations. A CT is used for a specific cross-sectional visualization of the body and can identify many different pathological conditions, such as abscesses, tumors, pleural effusion, pulmonary embolisms, and many more. The echocardiogram was performed due to the new onset atrial fibrillation. Echocardiograms are

noninvasive sonograms that can show the activity and structures of the heart. They are commonly used to look at the size and function of the ventricles, valve structure, and valve function.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required) Patient only had one home medication.

Brand/Generic	Pantoprazole (Protonix)
Dose	40 mg
Frequency	Daily
Route	Oral
Classification	Pharmacological: Proton-pump inhibitor Therapeutic: Antiulcer agent
Mechanism of Action	Binds to an enzyme in the presence of acidic gastric pH, preventing the final transport of hydrogen ions into the gastric lumen.
Reason Client Taking	GERD
Contraindications (2)	Hypersensitivity to proton pump inhibitors. Should only be used during pregnancy if clearly needed.
Side Effects/Adverse Reactions (2)	Headache Pseudomembranous colitis
Nursing Considerations (2)	Monitor bowel function, diarrhea, abdominal pain, fever, and bloody stools should be reported to provider as a sign of pseudomembranous colitis. May be administered with or without food.
Key Nursing Assessment(s)/Lab(s) Prior to	Assess patient routinely for epigastric or abdominal pain. This medication may cause abnormal liver function tests such as increased AST, ALT, alkaline phosphate, and bilirubin. May also cause

Administration	hypomagnesemia.
Client Teaching needs (2)	Instruct patient to take medication as directed for the full course of therapy, even if they are feeling better. Advise patient to avoid alcohol, products containing aspirin or NSAIDS, and foods that may cause an increase in GI irritation.

Hospital Medications (5 required)

Brand/Generic	Aspirin (Excedrin)	Diltiazem (Cardizem)	Famotidine (Pepcid)	Calcium-Carbonate (Tums)	Ondansetron (Zofran)
Dose	81 mg	30 mg	20 mg	500 mg	4 mg
Frequency	Daily	TID	BID	Q6 PRN	Q6 PRN
Route	Oral	Oral	Oral	Oral	IV push
Classification	**Pharmacological:** Salicylates **Therapeutic**: Antipyretics, nonopioid analgesics	**Pharmacological:** Calcium channel blockers **Therapeutic**: antianginals, antiarrhythmics, antihypertensives	**Pharmacological:** Histamine H2 antagonists **Therapeutic**: Antiulcer agent	**Pharmacological:** Antacids **Therapeutic**: Mineral and electrolyte replacements/ supplements	**Pharmacological**: 5-HT3 antagonists **Therapeutic**: Antiemetic
Mechanism of Action	Produces analgesia and reduces inflammation and fever by inhibiting production of prostaglandins. Also decreases platelet aggregation.	Inhibits transport of calcium in myocardial and vascular smooth muscle cells, resulting in inhibition of excitation-contraction coupling and subsequent contraction.	Inhibits the action of histamine at the H2-receptor site located primarily in gastric parietal cells, resulting in inhibition of gastric acid secretion.	Acts as a activator in the transmission of nerve impulses and contraction of cardiac, skeletal, and smooth muscle.	Blocks the effects of serotonin at 5-HT3 receptor sites located in vagal nerve terminals and the chemoreceptor trigger zone in the CNS.

Reason Client Taking	Atrial fibrillation, helps reduce the risk for stroke	Atrial fibrillation, helps with heart rate control	GERD and ulcer prevention	Heartburn	Nausea/Vomiting
Contraindications (2)	Hypersensitivity to aspirin. Bleeding disorders or thrombocytopenia.	Hypersensitivity to diltiazem. 2nd or 3rd-degree AV block.	Hypersensitivity to famotidine. Alcohol should be avoided.	Hypercalcemia. Ventricular fibrillation.	Hypersensitivity to ondansetron. Congenital long QT syndrome.
Side Effects/Adverse Reactions (2)	GI bleeding Anemia	Arrhythmias Heart failure	Aplastic anemia Arrhythmias	Constipation Nausea/ Vomiting	Headache Constipation
Nursing Considerations (2)	Use cautiously in patients with a history of GI bleeds or ulcer disease. Assess for rash periodically during therapy.	Monitor intake and output ratios and daily weight. Monitor for signs and symptoms of heart failure.	Assess for epigastric or abdominal pain. Assess geriatric patients routinely for confusion and report promptly.	Assess for heartburn, indigestion, and abdominal pain. Inspect abdomen and auscultate bowel sounds.	Assess patient for nausea, vomiting, abdominal distention, and bowel sounds prior to and following administration. Assess for extrapyramidal effects (involuntary movements, facial grimacing, rigidity, and trembling of hands)
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Assess platelets, RBC, Hgb, and Hct prior to administration. Assess pain before and after administration. Monitor hepatic function through	Monitor blood pressure before and during therapy. Monitor AST, ALT, bilirubin, albumin, and protein. Also monitor for hyperkalemia. Lastly,	Monitor CBC with differential periodically during therapy.	Monitor serum calcium, chloride, sodium, potassium, magnesium, albumin, and parathyroid hormone prior to administration.	Monitor serum bilirubin, AST, and ALT levels prior to administration.

	AST, ALT, and alkaline phosphate. Also monitor prothrombin time.	obtain an EKG prior to administration.			
Client Teaching needs (2)	Instruct patient to take with a full glass of water and remain in an upright position for 15 – 30 minutes after administration. Report tinnitus, unusual bleeding of gums, bruising, black, tarry stools, or fever lasting longer than 3 days.	Advise the patient to take the medication at the same time each day. Advise the patient to avoid large amounts of grapefruit juice during therapy.	Instruct patient to take medication as directed for the full course of therapy. Inform patient that smoking interferes with the action of histamine antagonists and encourage them to quit.	Instruct patient not to take enteric-coated tablets within 1 hour of calcium carbonate this will result in premature dissolution of the tablets. Advise patients that calcium carbonate may cause constipation and review methods of preventing constipation.	Instruct patient to take medication exactly as directed. Advise patient to notify health care professional immediately if symptoms of irregular heart beat or involuntary movement of eyes, face, or limbs occur.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert and responsive Oriented to person, place, time, and situation. Shows no signs of distress or discomfort. Appears to be clean and well kept, appropriate.

INTEGUMENTARY:	
Skin color:	Usual for ethnicity.
Character:	Dry and intact.
Temperature:	Warm to the touch.
Turgor:	Elastic skin turgor.
Rashes:	No rashes.
Bruises:	No bruises.
Wounds: .	No wounds.
Braden Score:	20
Drains present: Y☐ N ☒	No drains present.
Type:	
HEENT:	
Head/Neck:	Symmetrical appearance of face and skull.
Ears:	No hearing difficulties; external ears clean and even; grey tympanic membrane.
Eyes:	PERRLA; Follows the 6 cardinal fields; White sclera; Moist.
Nose:	Patent; No nasal drainage; Moist mucous membranes.
Teeth:	Pale yellow in color; No cavities.
CARDIOVASCULAR:	
Heart sounds:	
S1, S2, S3, S4, murmur etc.	S1 and S2 heart sounds.
Cardiac rhythm (if applicable):	Normal sinus rhythm.
Peripheral Pulses:	3+ pulse of the left and right radial artery, 3+ pulse of the left and right popliteal artery, 3+ pulse of the left and right femoral artery, 3+ pulse of the left and right dorsalis pedis.
Capillary refill:	Capillary refill < 3 seconds in both the upper and lower extremities
Neck Vein Distention: Y ☐ N ☒	No neck vein distention
Edema Y ☐ N ☒	No edema
Location of Edema:	N/A
RESPIRATORY:	.
Accessory muscle use: Y☐ N ☒	No accessory muscle use.
Breath Sounds: Location, character	Regular, unlabored respirations; Bronchial/vesicular breath sounds present; Clear/ Diminished, equal breath sounds of the right upper lobe, right middle lobe, right lower lobe, left upper lobe, and left lower lobe anteriorly and posteriorly
ET Tube:	N/A – this patient is not intubated
Size of tube:	N/A

Placement (cm to lip): **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	N/A N/A N/A N/A N/A Reduce exposure to mechanical ventilation, provide oral care and subglottic suctioning, promote early mobility, and advocate for adequate nurse staffing and a healthy environment
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	. Regular diet, 3 meals per day Heart healthy diet; 1,800 – 2,000 calories per day, no caffeine 177.8 cm 89.5 kg Active in all four quadrants; RLQ, RUQ, LUQ, LLQ 02/28/22 No pain or masses upon palpation in all four quadrants No distention No incisions No scars No drains No wounds No ostomy No NG tube N/A No feeding tubes/PEF tube N/A
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	 Pale yellow Clear 150 mL No pain with urination No dialysis No swelling or redness, No wounds No catheter present Adhere to hand hygiene, limit the use of duration of urinary catheters, use aseptic technique for

	catheter insertion, adhere to proper catheter care
MUSCULOSKELETAL: **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☐**	. Nail beds are pink; Capillary refill is < 3 seconds in the upper and lower extremities; Extremities are warm and sensitive to touch Active ROM present, Moves extremities well No supportive devices 5 – active motion against full resistance; Equal in upper and lower extremities No ADL assistance Not a fall risk 35 Independent (up and lib)
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	. Yes Yes Equal strength in upper and lower extremities Oriented to person, place, time, and situation Normal cognition; No delays noticed Clear, non-impaired speech Sensitive to touch, sound, hearing, and light. Alert
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):**	. Patient states that she leans on her husband for help when she needs it Can read and write, forms structured sentences, and has the capability of making a fully informed decision Patient states she is not religious Patient lives at home with her husband and has kids that live nearby

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	83 BPM	112/70 mmHg	18 respirations/minute	35.8 C	95% on room air

1100	73 BPM	115/64 mmHg	18 respirations/minute	36.4 C	96% on room air

Vital Sign Trends/Correlation:

The patient's vital signs are all within normal limits. They have continued to be in normal limits with both assessments. The patient's blood pressure and pulse rate have both decreased, but not to a level of concern. The patient remains stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	Numerical	N/A	0/10	N/A	Continued to monitor
1200	Numerical	N/A	0/10	N/A	Continued to monitor

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18 gauge **Location of IV:** Left AC **Date on IV:** 02/28/22 **Patency of IV:** Clear, flushes easily **Signs of erythema, drainage, etc.:** No signs of erythema, infiltration, or drainage. **IV dressing assessment:** Dry, intact, transparent	Saline Lock
Other Lines (PICC, Port, central line, etc.)	
No other lines **Type:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐**	N/A

CLABSI prevention measures: Use of appropriate hand hygiene, maintain a closed system, scrub access ports with antiseptic solution for at least 15 – 20 seconds before access, use intermittent infusion caps of lure-lock design to ensure a secure junction.	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
320 mL of water	150 mL of urine

Nursing Care

Summary of Care (2 points)

During the clinical day from 0700 – 1300, the nursing student and registered nurse provided the patient with basic health needs. Morning medications were given at 0800. An echocardiogram was performed that shows mild left ventricular hypertrophy with a grade 1 diastolic dysfunction. There are no complaints or issues. The patient's vital signs remained stable within normal limits. The patient ate a full meal for breakfast and tolerated it well. The student nurse and registered nurse walked the patient to assess heart rate with activity. The patient tolerated ambulated. The physician was notified of the ambulation results and plans to discharge the patient home with her husband today.

Discharge Planning (2 points)

The patient will be discharging home in Charleston, Illinois with her husband today. She will not need any new home health or equipment needs. However, she will need to continue to use her CPAP/BIPAP at night for her obstructive sleep apnea. Patient will need to follow up with Dr. Katsamakis in the cardiac center in 6 – 8 weeks regarding the new onset atrial fibrillation. Patient will also need to follow up with her primary physician concerning the pulmonary nodules

found. A chest CT is recommended in 3 – 6 months and again at 18 – 24 months. The patient is being discharged on diltiazem, which is a new medication. She will need to be educated on proper medication administration and what the drug is for.

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 • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Decreased cardiac output related to mild left ventricular hypertrophy as evidenced by the echocardiogram.	This nursing diagnosis was chosen as priority because the patient is at risk for poor perfusion due to the mild left ventricular hypertrophy, which can cause further problems with oxygenation.	**1.**Assess the patient's HR, BP, and pulse pressure (Phelps, 2020). **2.**Assess peripheral and central pulses, including capillary refill (Phelps, 2020).	**1.** The nurse will be able to identify early on if there is a perfusion issue occurring within the patient.	The patient responded positively to the assessment actions of the nurse. The patient understood why the assessments were occurring and did not want to change plan of care.
2. Deficient knowledge related to a new diagnosis as evidenced by	This nursing diagnosis was chosen as the second priority	**1.** Teach the patient about the symptoms of atrial fibrillation	**1.** The patient will understand the symptoms and treatment of atrial	The patient responded positively to the teaching of symptoms and

	the patient asking multiple questions.	because the patient has been experiencing chest palpitations and thought it was normal. The patient needs to be further educated on the diagnosis to eliminate potential complications.	(Phelps, 2020). **2.**Teach the patient about approaches to treating atrial fibrillation: rate control versus rhythm control (Phelps, 2020).	fibrillation to prevent further complications of atrial fibrillation.	treatment of atrial fibrillation. She was able to verbally ask questions and teach back what we taught her. The patient understands this is a main goal of her treatment and wants to make no modifications.
3.	Risk for bleeding related to prescribed medications as evidenced by aspirin complications.	This nursing diagnosis was chosen next because the patient is taking a prescribed baby aspirin and aspirin decreases platelet aggregation, placing the patient at risk for bleeding.	**1.**Monitor BP and HR and observe for signs of orthostatic hypotension (Phelps, 2020). **2**Monitor laboratory values for coagulation status as appropriate (Phelps, 2020).	**1.** The nurse will identify the bleed early if it occurs and proper treatment can be given.	The patient responded positively to the monitoring of the vital signs and laboratory values. The patient understands this is a risk and plans to follow the treatment plan.
4.	Risk for anxiety related to a new diagnosis as evidenced by multiple questions being asked about the diagnosis by the patient.	This nursing diagnosis was chosen next because the patient is at risk for anxiety related to the lack of knowledge of the disease	**1.** Acknowledge awareness of the patient's anxiety (Phelps, 2020) **2.** Maintain a calm manner while	**1.** The patient will remain without anxiety while in the hospital and after she is discharged to home with all of her questions answered.	The patient responded positively to the open communication regarding anxiety and curiosity. The patient understand she can speak openly

	she has recently been diagnosed with.	interacting with the patient (Phelps, 2020).		to the healthcare workers.
5. Risk for powerlessness related to lack of knowledge as evidenced by a new disease and medication diagnosis.	This nursing diagnosis was chosen next because the patient has a lack of knowledge in a diagnosis that must be monitored for the rest of her life.	**1.**Assess for feelings of hopelessness, depression, and apathy (Phelps, 2020). **2.**Identify the patient's locus of control (Phelps, 2020).	**1.** The patient will not feel powerless in the situation of the new diagnosis, rather will be open to communication and learning.	The patient responded positively to the open communication regarding the sense of power in this situation. The patient understands this is a learning opportunity.

Other References (APA):

Phelps, L. L. (2020). *Nursing diagnosis: Reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points)

Subjective Data

Patient came in experiencing chest palpitations, feeling like her heart was fluttering. Patient rates her pain a 0/10 during her stay. She appears to be in no distress and is alert and oriented. Patient states she often has chest discomfort that radiates to her left arm.

Objective Data

Patient had an EKG performed upon arrival that showed atrial fibrillation with rapid ventricular response. A chest x-ray was performed that showed mild heart enlargement and no pulmonary embolism present. Patient had a d-dimer of 1.17 upon arrival. No abnormal assessment findings or abnormal vital signs at this time.

Client Information

S.D. is a 64-year-old Caucasian female who is a full code. She is 177.8 cm tall and 89.5 kg. She is allergic to ragweed and latex. She has a history of obstructive sleep apnea, GERD, and benign colon polyps. She is a current alcohol user 1-2 times per week and a former smoker. She has no developmental delays.

Nursing Diagnosis/Outcomes

Decreased cardiac output related to mild left ventricular hypertrophy as evidenced by the echocardiogram.
The nurse will be able to identify early on if there is a perfusion issue occurring within the patient.
Deficient knowledge related to a new diagnosis as evidenced by the patient asking multiple questions.
The patient will understand the symptoms and treatment of atrial fibrillation to prevent further complications of atrial fibrillation.
Risk for bleeding related to prescribed medications as evidenced by aspirin complications.
The nurse will identify the bleed early if it occurs and proper treatment can be given.
Risk for anxiety related to a new diagnosis as evidenced by multiple questions being asked about the diagnosis by the patient.
The patient will remain without anxiety while in the hospital and after she is discharged to home with all of her questions answered.
Risk for powerlessness related to lack of knowledge as evidenced by a new disease and medication diagnosis.
The patient will not feel powerless in the situation of the new diagnosis, rather will be open to communication and learning.

Nursing Interventions

Assess the patient's HR, BP, and pulse pressure.
Assess peripheral and central pulses, including capillary refill.
Teach the patient about the symptoms of atrial fibrillation.
Teach the patient about approaches to treating atrial fibrillation: rate control versus rhythm control.
Monitor BP and HR and observe for signs of orthostatic hypotension.
Monitor laboratory values for coagulation status as appropriate.
Acknowledge awareness of the patient's anxiety.
Maintain a calm manner while interacting with the patient.
Assess for feelings of hopelessness, depression, and apathy.
Identify the patient's locus of control.