

N321 Care Plan # 1  
Lakeview College of Nursing  
Noredia Asia

**Demographics (3 points)**

<b>Date of Admission</b> 3/7/22	<b>Client Initials</b> J.N.	<b>Age</b> 68	<b>Gender</b> Female
<b>Race/Ethnicity</b> White	<b>Occupation</b> Unemployed	<b>Marital Status</b> Single	<b>Allergies</b> Ibuprofen – rash, swelling Gabapentin – rash, swelling Losartan – rash, swelling
<b>Code Status</b> FULL	<b>Height</b> 5'5	<b>Weight</b> 329lbs	

**Medical History (5 Points)**

**Past Medical History:** A-fib, arthritis, HTN, seizures, sleep apnea, CAD, hyperlipidemia, GERD, hypothyroidism, UTI, depression, anxiety

**Past Surgical History:** Angioplasty, colonoscopy, hysterectomy, ovarian cyst removal, appendectomy

**Family History:** Mother: pancreatitis, diabetes, HTN, CHF; Father: diabetes, HTN, CHF; Maternal Mother: arthritis; Sister: arthritis, HTN; Brother: diabetes, HTN, stroke

**Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):**

Smoked a little tobacco in college; no other drug use

**Assistive Devices:** Walker, wheelchair

**Living Situation:** Rehabilitation center

**Education Level:** Diploma

**Admission Assessment**

**Chief Complaint (2 points):** Confusion

**History of Present Illness – OLD CARTS (10 points):** Patient presents to the ED with complaints of confusion with a recent ED visit on 2/27/22 for fall complaints and denied hitting

her head or any loss of consciousness. Negative results in imaging for head trauma. The patient has had numerous previous UTI's as well. The patient could not tell the events that lead up to the hospitalization or location of events. Patient hallucinations are present without details of what the patient sees or hears.

### **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 (AF) is the most commonly encountered arrhythmia in the clinical setting, with the highest prevalence within the elderly population. AF is present in almost 30% of those aged 80 to 89 years and complicates MI in 5% to 10% of cases. It is defined as the absence of coordinated, rhythmic atrial contractions. Multiple irregular fibrillatory P waves are seen on the ECG representing multiple, rapid reentrant impulses moving around in the atrial chamber. The multiple irregular P waves may or may not stimulate a concomitant irregular, rapid ventricular response.

The normal working heart is composed of two types of chambers namely – two atria and two ventricles. Located in the right atrium is the sinus node, a group of cells tagged as the heart's natural pacemaker. The sinus node is where the signal is produced that starts each heartbeat. In atrial fibrillation, the signal pathways in the atria are garbled. Possible causes can be coronary artery disease, heart attack, hypertension, sleep apnea, and viral infections. Risk factors to atrial fibrillation include age, heart diseases, alcohol use, and obesity.

Signs and symptoms of atrial fibrillation include the presence of palpitations characterized by fast and pounding heartbeats, chest pain, dizziness, fatigue, lightheadedness, shortness of breath, weakness, and decreased ability to physical activity. Atrial fibrillation can be diagnosed in many ways including a chest x-ray which shows the imaging of the heart that can help evaluate any complications such as fluid in the lungs that may contribute to the condition. This specific diagnostic imaging was done on this patient. Other diagnostic tests is an ECG which measures the electrical activity of the heart through the use of electrodes properly placed on the chest.

Therapeutic management of for atrial fibrillation depends on the duration of the condition, clinical manifestations and predisposing and precipitating factors of the condition. The goals of treatment for atrial fibrillation include retuning the heart rhythm, regulating the heart rate, and avoiding blood clot development that can lead to a stroke. Treatment commonly involved medications such as beta-blockers which slow the heart at rest and during activity and blood thinners which reduce the risk for stroke. This patient is currently taking blood thinners and beta-blockers.

### **Pathophysiology References (2) (APA):**

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

Ellis, M. E. (2018, September 29). *Afib with RVR: What You Need to Know*. Healthline. Retrieved March 14, 2022, from <https://www.healthline.com/health/atrial-fibrillation/rvr#diagnosis>

### **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	3.5-5.2	4.27	3.55	N/A
Hgb	11-16	11.3	9.4	Obesity
Hct	34-47	35.8	30.3	Vitamin deficiency
Platelets	140-400	242	260	N/A
WBC	4-11	22.99	18.06	UTI
Neutrophils	1.6-7.70	18.97	15.86	Chronic UTI
Lymphocytes	1-4.9	1.16	1.73	N/A
Monocytes	0-1.110	2.09	0.54	Chronic infection present
Eosinophils	0-0.510	0.02	0.0	N/A
Bands	0-10	N/A	1.7	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	139	135	N/A
K+	3.5-5.1	3.9	4.3	N/A
Cl-	98-107	105	103	N/A
CO2	22-29	28	28	N/A
Glucose	60-99	115	102	Diabetes
BUN	10-20	20	20	N/A
Creatinine	0.55-1.02	0.79	0.64	N/A
Albumin	3.4-4.8	1.8	N/A	Kidney disease

<b>Calcium</b>	8.9-10.6	8.9	9.0	N/A
<b>Mag</b>	1.6-2.6	1.6	2.0	N/A
<b>Phosphate</b>	N/A	N/A	N/A	N/A
<b>Bilirubin</b>	0.2-1.2	1.9	N/A	N/A
<b>Alk Phos</b>	40-150	209	N/A	N/A
<b>AST</b>	5-34	17	N/A	N/A
<b>ALT</b>	0-55	13	N/A	N/A
<b>Amylase</b>	25-115	N/A	N/A	N/A
<b>Lipase</b>	73-393	N/A	N/A	N/A
<b>Lactic Acid</b>	0.5-2.20	1.39	N/A	N/A

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Lab Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>INR</b>	0.9-1.1	2.3	2.1	N/A
<b>PT</b>	11.7-13.8	24.9	22.9	N/A
<b>PTT</b>	22.4-35.9	>200	41.2	N/A
<b>D-Dimer</b>	<500	N/A	N/A	N/A
<b>BNP</b>	0-100	N/A	N/A	N/A
<b>HDL</b>	40-60	N/A	N/A	N/A
<b>LDL</b>	<100	N/A	N/A	N/A
<b>Cholesterol</b>	0-200	N/A	N/A	N/A

<b>Triglycerides</b>	<150	N/A	N/A	N/A
<b>Hgb A1c</b>	4-6	N/A	N/A	N/A
<b>TSH</b>	0.350-4.940	3.884	N/A	N/A

**Urinalysis Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Lab Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Reason for Abnormal</b>
<b>Color &amp; Clarity</b>	Colorless-yellow; Clear	Amber; Clear	Dark yellow; Clear	UTI; dehydration
<b>pH</b>	5.0-7.0	5.0	5.0	N/A
<b>Specific Gravity</b>	1.003-1.035	1.015	1.015	N/A
<b>Glucose</b>	Neg	Neg	Neg	N/A
<b>Protein</b>	Neg	Neg	Neg	N/A
<b>Ketones</b>	Neg	Neg	Neg	N/A
<b>WBC</b>	0-25	539	148	UTI
<b>RBC</b>	0-20	59	18	UTI
<b>Leukoesterase</b>	Neg	Large	Large	UTI

**Cultures Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Explanation of Findings</b>
<b>Urine Culture</b>	Neg	>100,000 cfu/mL of E.coli	Neg	Susception of UTI
<b>Blood Culture</b>	Neg	23 cfu/mL of Gram positive cocci	Neg	MRSA
<b>Sputum Culture</b>	Neg	N/A	N/A	N/A

<b>Stool Culture</b>	Neg	N/A	N/A	N/A
----------------------	-----	-----	-----	-----

**Lab Correlations Reference (1) (APA):**

Kee, J. L. F. (2017). *Pearson Handbook of Laboratory & Diagnostic Tests with Nursing implications* (8th ed.). Pearson.

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):**

XR Chest AP – No grossly evident large infiltrate or pleural effusion apparent on this exam. No grossly evident discernable pneumothorax. Heart likely normal in size.

XR Shoulder Right – No evidence for acute fracture or discoloration. Stable mild degenerative changes of glenohumeral and acromioclavicular joints. Stable mild superior migration of humeral head which can be seen with underlying rotator cuff pathology.

**Diagnostic Test Correlation (5 points):**

The chest XR was given to assess the lungs and any effects from the atrial fibrillation and if any fluid was sitting in or around the lungs. The XR of the patients right shoulder was given due to that being the area in which the patient fell and is experiencing extreme pain and discomfort from.

**Diagnostic Test Reference (1) (APA):**

Kee, J. L. F. (2017). *Pearson Handbook of Laboratory & Diagnostic Tests with Nursing implications* (8th ed.). Pearson.

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

**Home Medications (5 required)**

<b>Brand/Generic</b>	Apixaban/ Eliquis	Aripiprazole/ Abilify	Citalopram/ Celexa	Ertapenem/ Invanz	Hydrocodone/ Narco
<b>Dose</b>	5mg	15mg	20mg	1g	325mg
<b>Frequency</b>	Bid	Daily	Daily	Daily	Q6h PRN
<b>Route</b>	PO	PO	PO	IVPB	PO
<b>Classification</b>	Anticoagulant	Antipsychotics	SSRI	Carbapenem antibiotic	Opioid analgesic
<b>Mechanism of Action</b>	Inhibits free and clot-bound FXa, and prothrombinase activity	Lowering dopaminergic neurotransmission in the mesolimbic pathway	Inhibits the serotonin reuptake in the synaptic cleft	Bind penicillin binding proteins that weaken or interfere with cell wall formation	Binds to the mu opioid receptor with the highest affinity followed by the delta opioid receptors
<b>Reason Client Taking</b>	Nonvalvular A- fib	Bipolar/ Schizophrenia	Panic disorder	UTI	Pain
<b>Contraindications (2)</b>	Edoxaban; Rivaroxaban	Amisulpride; Bromperidol	QT-prolonging agents; Dapoxetine	Cholera vaccine; Probenecid	Naltrexone; Fusidic acid
<b>Side Effects/Adverse Reactions (2)</b>	Hemorrhage; Nausea	Decreased HDL cholesterol; Increased serum glucose	Hyponatremia; Drowsiness	Diarrhea; A-fib	Bradycardia; Anxiety
<b>Nursing Considerations (2)</b>	Monitor for signs and symptoms of bleeding; Grape fruit juice can increase	Monitor for depression or suicidal ideation; Check ordered labs for abnormalities	Assess mental status prior to admin of med; Taper dosage to discontinue	Obtain baseline renal function test; Assess neurological status	Do not exceed 4g per 24 hours; Assess patient for history of

	effects of medication				liver disease or ethanol abuse
--	-----------------------	--	--	--	--------------------------------

**Hospital Medications (5 required)**

<b>Brand/Generic</b>	Levetiracetam/ Keppra	Levothyroxine/ Levoxyl	Lidocaine 5%/ Lidoderm	Metoprolol/ Tartrate	Nystatin/ Nyata
<b>Dose</b>	250mg	150mg	1 patch	25mg	100,000 U/g
<b>Frequency</b>	Bid	Daily	On 12hrs, Off 12hrs	Q12hrs	Q12hrs
<b>Route</b>	PO	PO	Transdermal	PO	Topical
<b>Classification</b>	Anticonvulsants	Thyroid hormones	Topical local anesthetics	Beta-adrenergic blocking agents	Topical antifungals
<b>Mechanism of Action</b>	Modulation of synaptic neurotransmitter release through binding to the synaptic vesicle protein in the brain	Increases metabolic rate of cells of all tissues in the body	Blockade of voltage gated sodium channels leading to reversible block of action potential propagation	Blocks beta1- receptors with minimal or no effects	Binds to ergosterol
<b>Reason Client Taking</b>	Seizures	Hypothyroidism	Pain	HTN	Fungal infection
<b>Contraindications (2)</b>	Paraldehyde; Kratom	Sodium Iodide; Lanthanum	Dapsone; Nitroxide	Fexinidazole; Etofylline	Progesterone (ONLY)
<b>Side Effects/Adverse Reactions (2)</b>	CNS depression; Hypertension	Tachycardia; Angina	Erythema; Petechia	Bradycarrhythmias; Pruritus	Hypersensitivity; Contact dermatitis
<b>Nursing Considerations (2)</b>	Monitor for CNS depression; Monitor for therapeutic response	Take before meal; Monitor glucose levels closely in diabetic patients	Remove patch for 12 hrs; Do not exceed 1 patch	Hold if SBP<90 or HR<50; Discontinue med slowly	Determine cause of infection is fungal; Avoid skin contact when applying to patient

**Medications Reference (1) (APA):**

Jones & Bartlett Learning. (2021). *Nurse's Drug Handbook* (12th ed.).

**Assessment**

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

<p><b>GENERAL:</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p>Appears alert to person                  Disoriented to place, time, and situation                  No acute distress                  Well groomed</p>
<p><b>INTEGUMENTARY:</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds:</b>  <b>Braden Score:</b>  <b>Drains present:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Type:</b></p>	<p>Skin is white with yellow undertones                  Normal distribution, quantity, and texture, of hair across all regions                  Skin warm and dry upon palpation                  Skin turgor normal mobility                  No rashes                  No bruising                  Minor wounds and abrasion on the sole of feet and near big toe</p>
<p><b>HEENT:</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>Head and neck are symmetrical, trachea is midline without deviation                  Ears bilateral auricles with no visible or palpable deformities, increased hearing difficulty with Whisper test conducted bilaterally                  PERRLA bilaterally, EOMs intact bilateral, Bilateral sclera white, bilateral cornea clear, no visible drainage from eyes                  Septum is midline, bilateral frontal sinuses are nontender to palpation                  Dentition is good</p>
<p><b>CARDIOVASCULAR:</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Location of Edema:</b></p>	<p>Tachycardia; irregular rhythm                  Clear S1 and S2 without murmurs, gallops, or rubs                  Peripheral pulses 2+ throughout bilaterally                  Capillary refill less than 3 seconds fingers and toes bilaterally</p>
<p><b>RESPIRATORY:</b>  <b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Breath Sounds: Location, character</b></p>	<p>Lungs sounds clear throughout anterior/posterior bilaterally, no wheezes, crackles, or rhonchi noted</p>

<p><b>GASTROINTESTINAL:</b>  <b>Diet at home:</b> Diabetic  <b>Current Diet:</b> Diabetic  <b>Height:</b> 5'5  <b>Weight:</b> 329lbs  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b> 3/7/22  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>              <b>Distention:</b> None              <b>Incisions:</b> None              <b>Scars:</b> None              <b>Drains:</b> None              <b>Wounds:</b> None  <b>Ostomy:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Nasogastric:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>              <b>Size:</b>  <b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>              <b>Type:</b></p>	<p>Bowel sounds positive, signs suggestive of lower abdominal wall panniculitis present, tenderness at the area of panniculitis          Abdomen is soft, tender, no organomegaly or masses noted upon palpation of all four quadrants</p>
<p><b>GENITOURINARY:</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Dialysis:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>Inspection of genitals:</b>  <b>Catheter:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>              <b>Type:</b>              <b>Size:</b></p>	<p>Pt. having urinary retention, so catheter was inserted upon arrival to hospital</p>
<p><b>MUSCULOSKELETAL:</b>  <b>Neurovascular status:</b>  <b>ROM:</b>  <b>Supportive devices:</b> Wheelchair, walker  <b>Strength:</b>  <b>ADL Assistance:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Fall Risk:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Fall Score:</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib)</b> <input type="checkbox"/>  <b>Needs assistance with equipment</b> X  <b>Needs support to stand and walk</b> <input type="checkbox"/></p>	<p>Tested cranial nerves intact          All extremities have full range of motion          Hand grips and pedal pushes and pulls demonstrate equal strength in all extremities (5 out of 5)          Patient placed on bed rest so gait could not be accurately assessed          High risk for falls</p>

<p><b>NEUROLOGICAL:</b>  <b>MAEW:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/>  <b>PERLA:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/>  <b>Strength Equal:</b> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -  <b>Legs</b> <input type="checkbox"/> <b>Arms</b> <input type="checkbox"/> <b>Both</b> <input type="checkbox"/>  <b>Orientation:</b> Disoriented  <b>Mental Status:</b> Altered  <b>Speech:</b> Present  <b>Sensory:</b> Intact  <b>LOC:</b> No</p>	<p>Moves all extremities well but limited                  Patient disoriented to person, place, and time                  Mental status altered                  Speech presented                  Sensory normal                  No loss of consciousness</p>
<p><b>PSYCHOSOCIAL/CULTURAL:</b>  <b>Coping method(s):</b>  <b>Developmental level:</b>  <b>Religion &amp; what it means to pt.:</b>  <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>Patient does not handle emotions well and tries to practice remaining calm                  Appropriate developmental level for age                  Christianity is important to patient                  Patient feels well supported by family, friends, and environment</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0740	107	116/53	22	98.5F	96
1230	102	110/57	22	98.3F	93

**Pain Assessment, 2 sets (2 points)**

Time	Scale	Location	Severity	Characteristics	Interventions
0740	0-10	Right shoulder	8	Constant; chronic	Care clustered; relaxation techniques; quiet environment facilitated; medicated

1230	0-10	Right shoulder	7	Constant; chronic	Care clustered; relaxation techniques; quiet environment facilitated; medicated
------	------	----------------	---	-------------------	---

**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> 20G <b>Location of IV:</b> Breast <b>Date on IV:</b> 3/7/22 <b>Patency of IV:</b> Patent <b>Signs of erythema, drainage, etc.:</b> None <b>IV dressing assessment:</b> Intact, dry, clean; dressing in place	No infusion pump No fluid Saline lock in place

**Intake and Output (2 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
100% in food	150mL – weighted diaper
360mL of water	Incontinent of urine x1 void
1mL of Ertapenem	Incontinent of stool x1 bowel movements

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care:** Patient refused turns, meals, and overall cooperation with staff, however, was compliant once activities were activated; patient took medications well and slept throughout shift

**Procedures/testing done:** None

**Complaints/Issues:** Patient complained of pain (8/10 by the end of shift; right shoulder; difficulty moving; medications were given) and too much movement by staff, requested to be left alone majority of shift

**Vital signs (stable/unstable):** Stable

**Tolerating diet, activity, etc.:** Diabetic diet; up with 2 assistants; bed rest otherwise

**Physician notifications:** None

**Future plans for client:** Anticipate client will require home health/rehabilitation continuation upon discharge

**Discharge Planning (2 points)**

**Discharge location:** Patients sister would like to return patient to university rehab

**Home health needs (if applicable):** Nurse aid

**Equipment needs (if applicable):** Hoyer Lift

**Follow up plan:** ROM Appointments; extended care facility

**Education needs:** Medication reconciliation, increasing activity, weight loss, diet, heart health, signs of stroke or MI

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

<b>Nursing Diagnosis</b>	<b>Rationale</b>	<b>Interventions (2 per dx)</b>	<b>Outcome Goal (1 per dx)</b>	<b>Evaluation</b>
<ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> <li>• Listed in order by priority – highest priority to lowest</li> </ul>	<ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>			<ul style="list-style-type: none"> <li>• How did the client/family respond to the nurse’s actions?</li> <li>• Client response, status of goals and outcomes,</li> </ul>

priority pertinent to this client				modifications to plan.
<p>1. Ineffective breathing pattern related to fatigue, pulmonary congestion, and decreased lung expansion secondary to atrial fibrillation as evidenced by tachypnea.</p>	<p>The patient's heart rate has been over 100 as well as her respirations which may make her breathing more difficult.</p>	<ol style="list-style-type: none"> <li>1. Assess the patient's respiratory rate and depth</li> <li>2. Inspect chest excursion</li> </ol>	<p>1. The patient will demonstrate an effective breathing pattern without causing fatigue.</p>	<p>The patients family was very grateful and responded well to the nurse's actions. The client was agitated to the advances of the nurse but still cooperated. The goal is for the patient's respiratory pattern to be effective without fatigue.</p>
<p>2. Anxiety related to breathlessness from inadequate oxygenation secondary to atrial fibrillations evidenced by verbalizations of uncertainty and decreased concentration.</p>	<p>The patients issues with atrial fibrillation and depression may increase the likelihood of anxiety.</p>	<ol style="list-style-type: none"> <li>1. Assist the patient in taking on ways to control anxiety and avoid uncertain situations.</li> <li>2. Approach and interact with the patient calmly.</li> </ol>	<p>1. The patient will be able to identify strategies to reduce anxiety by utilizing coping patterns.</p>	<p>The patient's family was understanding to the interventions and asked questions on how they could also incorporate these acts in their life. The client was calm and accepting to the interventions when calming her down. The goal is for the patient will identify strategies to reduce anxiety, demonstrate improved concentration, and manage anxiety and coping patterns.</p>

<p><b>3.</b> Acute pain related to decreased myocardial blood flow and increased cardiac workload or oxygen consumption secondary to atrial fibrillation as evidenced by reports of pain.</p>	<p>The patient is under stress and pain due to the fall and may increase due to atrial fibrillation.</p>	<ol style="list-style-type: none"> <li><b>1.</b> Ask the patient to call the nurse's attention immediately when chest pain occurs</li> <li><b>2.</b> Evaluate and monitor the patient's response to medication</li> </ol>	<p><b>1.</b> For the patient to demonstrate pain relief as evidenced by the absence of muscle tension and restlessness, and stable vital signs.</p>	<p>The patient and family's response to the nurse's actions are positive and may negatively impact the client if the pain persists after the medication is given. The client's response can range from stress and frustration to relief dependent upon how quick the medications effect the system. The goal is for the client's pain to be brought down to at least a 5. The client's outcome will demonstrate relief of pain as evidenced by a pain score of 5 out of 10, stable vital signs, and absence of restlessness.</p>
---	--	---	---	--

**Other References (APA):**

**Concept Map (20 Points):**

**Subjective Data**

- 8 out of 10 pain
- No recollection of events prior to hospitalization
- hallucinations

**Nursing Diagnosis/Outcomes**

- Ineffective breathing pattern related to fatigue, pulmonary congestion, and decreased lung expansion secondary to atrial fibrillation as evidenced by tachypnea. The patient will demonstrate an effective breathing pattern without causing fatigue.
- Anxiety related to breathlessness from inadequate oxygenation secondary to atrial fibrillations evidenced by verbalizations of uncertainty and decreased concentration. The patient will be able to identify strategies to reduce anxiety by utilizing coping patterns.
- Acute pain related to decreased myocardial blood flow and increased cardiac workload or oxygen consumption secondary to atrial fibrillation as evidenced by reports of pain. For the patient to demonstrate pain relief as evidenced by the absence of muscle tension and restlessness, and stable vital signs.

**Objective Data**

- T: 98.3F
- HR: 102
- R: 22
- BP: 110/57
- O2: 93
- XR Chest
- XR Right Shoulder
- Packed WBC
- 

**Client Information**

- 68 years old
- Female
- Unemployed
- Full code
- Altered mental status
- HTN, diabetes, CAD
- Single

**Nursing Interventions**

- Assess the patient's respiratory rate and depth
- Inspect chest excursion
- Assist the patient in taking on ways to control anxiety and avoid uncertain situations.
- Approach and interact with the patient calmly.
- Ask the patient to call the nurse's attention immediately when chest pain occurs
- Evaluate and monitor the patient's response to medication





