N441 Care Plan

Lakeview College of Nursing

Emily Clark

Demographics (3 points)

Date of Admission 3/21	**Client Initials** S.E.	**Age** 41	**Gender** M
Race/Ethnicity White/Caucasian	**Occupation** Unemployed	**Marital Status** Single	**Allergies** NKDA
Code Status Full	**Height** 6'0"	**Weight** 302 lbs.	

Medical History (5 Points)

Past Medical History: Asthma**,** Obesity, Diverticulitis

Past Surgical History: None

Family History: Paternal – fatal MI at 60 years old.

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

Denies any use of tobacco, smokeless tobacco, or drugs. Patient reports casual drinking, consuming 1-3 beers per week, for the last 20 years.

Assistive Devices: None

Living Situation: S.E. lives at home alone.

Education Level: Some college. No learning barriers present.

Admission Assessment

Chief Complaint (2 points): Chest pain and shortness of breath

History of Present Illness – OLD CARTS (10 points):

The patient arrives to the ED via EMS for chest pain and shortness of breathing that became constant over the last few hours. S.E. states that the chest pain is near the center of his chest and is accompanied by a lot of pressure; he rates this pain a 6/10. The patient states the pain does not radiate, but any time he gets up he starts to "feel the room spin around him" and the pressure

becomes more intense. The pain and pressure does not go away with rest. S.E. called 911 because his apple watch notified him that his heart rate was in the 190s. The 911 operator instructed him to chew an aspirin while waiting for help. In the ED, an EKG was performed and revealed SVT with a rate of 180. He was given 3 separate does of 6mg adenosine IV with no relief, so he was cardioverted with 100 joules. After cardioversion, another EKG was done and revealed sinus tachycardia. S.E. was admitted for observation and further diagnostic testing**.**

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Supraventricular tachycardia (SVT)

Secondary Diagnosis (if applicable): N/A

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

Supraventricular tachycardia is an irregular or erratic heart rhythm (Hinkle & Cheever, 2018). Tachycardia is a heart rate greater than 100 beats per minute, while supraventricular tachycardia is greater than 150 beats per minute (Hinkle & Cheever, 2018). The change in rate is related to an electrical firing at the SA node (Capriotti, 2020). SVT causes the heart to become weak and tired, especially if it is prolonged or goes untreated. A weak heart may lead to heart failure, changes in cardiac muscles and could end with poor perfusion (Hinkle & Cheever, 2018). Patients with SVT may be asymptomatic, but if symptoms are present, they may include heart or chest palpitations described as a “fluttering” feeling, fatigue, chest pain, shortness of breath, and sweating or diaphoresis (Capriotti, 2020). SVT may be caused by heart and lung conditions, infection, stress, lack of sleep, and drug or alcohol use (Hinkle & Cheever, 2018). Supraventricular tachycardia is diagnosed with an electrocardiogram (EKG). An EKG shows how the electrical signals in the heart affect the heart rate and rhythm. SVT can be identified on

an EKG strip by looking at the rate the heart is beating, and often, a p-wave is not identifiable because of how fast the heart is beating (Capriotti, 2020). The most common ways to treat SVT include medications such as adenosine to restart and regulate the electrical signals in the heart or cardioversion in an attempt to shock the heart rhythm back to normal (Hinkle & Cheever, 2018). This patient presented to the ED with chest pain and shortness of breath. He stated he felt a fluttering and a lot of pressure in his chest before coming in to be seen. An EKG was used to diagnose his supraventricular tachycardia. The EKG monitor showed a rate greater than 150 beats per minute, and the p-wave was not immediately identifiable. Return of normal sinus rhythm was not possible with adenosine, but sinus tachycardia was achieved after cardioversion.

Pathophysiology References (2) (APA):

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

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's 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	4.0-5.8	5.1	5.65	
Hgb	12-16	15.4	16	
Hct	35-52%	43.7	49.1	
Platelets	150-400	260	312	
WBC	4.5-11	8.70	10.2	
Neutrophils	1.6-7.7	73	73.7	The patient presented with cold and flu symptoms such as runny nose, sore throat, and body aches. His COVID-19 test was negative.

				Neutrophils increase with any type of infection, and with stress (Pagana, 2021).
Lymphocytes	1-4.9	23	20.4	
Monocytes	0-1.1	7	5.2	
Eosinophils	0-0.5	0.4	0.2	
Bands	0	0	0	

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	136	139	
K+	3.5-5	4.6	3.7	
Cl-	98-108	106	106	
CO2	22-28	20	24	
Glucose	70-99	96	82	
BUN	7-25	7	9	
Creatinine	0.6-1.3	0.81	0.82	
Albumin	3.5-5.2	4	3.6	
Calcium	8.6-10	8.9	9.1	
Mag	1.6-2.6	1.9	1.7	
Phosphate	2.4-4.5	3	4.1	
Bilirubin	< 1.5	0.5	0.5	
Alk Phos	39-104	91	87	
AST	10-30	29	27	

ALT	10-40	20	23	
Amylase	23-85	27	28	
Lipase	0-160	80	74	
Lactic Acid	0.5-2.2	0.9	0.8	
Troponin	0.0-0.04	0.140	0.160	Increased troponin shows cardiac damage, such as sustained SVT (Pagana, 2021).
CK-MB	5-25	17	21	
Total CK	22-198	102	141	

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	2-3	N/A	N/A	
PT	9.6-11.8	N/A	N/A	
PTT	30-40	N/A	N/A	
D-Dimer	< = 250	N/A	N/A	
BNP	< 100	N/A	N/A	
HDL	> 60	N/A	N/A	
LDL	< 130	N/A	N/A	
Cholesterol	< 200	N/A	N/A	
Triglycerides	< 150	N/A	N/A	
Hgb A1c	4-5.6 non-diabetic	N/A	N/A	
TSH	0.5-5	N/A	N/A	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Straw-dark yellow, clear-hazy	N/A	N/A	
pH	4.5-8	N/A	N/A	
Specific Gravity	1.005-1.035	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	Negative	N/A	N/A	
RBC	Negative	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.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	N/A	N/A	
PaO2	80-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-28	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.

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):

K.P., T.P., & T.P. (2020). *Mosby's® Diagnostic and Laboratory Test Reference* (15th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest x-ray: 3/21 at 2359 – Normal heart size, no pulmonary congestion or infiltrates noted in the lungs.

EKG: 3/21 at 2300 (arrival) – SVT with a rate of 180

EKG: 3/22 0110 (post cardioversion) – Sinus tachycardia without ST elevation, with a rate of 120

EKG: 3/22 0500 – Normal sinus rhythm with a rate of 80

Diagnostic Test Correlation (5 points):

A chest x-ray was performed based on the patients complains of chest pain, shortness of breath, and also several days' worth of runny nose, sore throat, and body aches. It was done to examine the size of the heart and lungs, and to eliminate disease process.

3 separate EKGs were done to examine the heart rhythm and its irregularities. Initially, the EKG was done to see if the patient was having a myocardial infarct. After ruling out an MI, the EKG

was done to examine the effectiveness of the cardioversion, and to continue to monitor for changes in the heart rhythm.

Diagnostic Test Reference (1) (APA):

K.P., T.P., & T.P. (2020). *Mosby's® Diagnostic and Laboratory Test Reference* (15th ed.). Mosby.

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

Home Medications (5 required) *The patient is only take 3 home medications at this time*

Brand/Generic	**Tylenol Acetaminophen**	**Benadryl Diphenhydramine**	**ProAir Albuterol inhaler**	N/A	N/A
Dose	650mg	25mg	2 puffs	N/A	N/A
Frequency	Every 8 hours PRN	Every 4-6 hours PRN	Every 4-6 hours PRN	N/A	N/A
Route	PO	PO	PO	N/A	N/A
Classification	Antipyretic, nonopioid analgesic	Antihistamine	Bronchodilator	N/A	N/A
Mechanism of Action	Blocks prostaglandin production, interfering with pain impulse generation	Competes with histamine at the central and peripheral H1 receptors. By doing this, it inhibits respiratory and vascular smooth muscle contraction, and decreases capillary permeability to reduce itching and wheals.	Converts ATP to cAMP to decrease intracellular calcium levels. This relaxes bronchial smooth muscle and inhibits histamine release.	N/A	N/A
Reason Client Taking	Pain	Seasonal allergies	Asthma	N/A	N/A
Contraindications (2)	Severe hepatic impairment. Severe acute liver disease	Breastfeeding. Hypersensitivity.	Hypersensitivity. Hypokalemia.	N/A	N/A

Side Effects/Adverse Reactions (2)	Hepatotoxicity, Stevens-Johnson syndrome	Arrythmias. Sedation	Hypokalemia. Arrythmias.	N/A	N/A
Nursing Considerations (2)	Monitor liver function. Do not mix with OTC cold medications.	Report palpitations. Monitor respiratory function.	Use cautiously in patients with cardiac disorders. Be aware that drug tolerance can develop.	N/A	N/A
Key Nursing Assessment(s)/Lab(s) Prior to Administration	LFT. Assess health history and note if patient is taking blood thinners.	Monitor blood pressure. Monitor neuro status to establish a baseline.	Monitor serum potassium levels. Monitor blood pressure.	N/A	N/A
Client Teaching needs (2)	Avoid taking OTC cold medications while taking this medication. Ask your provider if this is safe to take while taking other medications.	Do not take this medication while driving or using machinery. Take this medication with food to avoid GI upset.	Instruct the patient to place the mouthpiece between their lips, press down on the device, inhale and hold their breath for 10 seconds before exhalation. Clients should be taught to rinse their mouth after administration to avoid developing thrush.	N/A	N/A

Hospital Medications (5 required)

Brand/Generic	**Coreg Carvedilol**	**Lopressor Metoprolol**	**Aspirin Acetylsalicylic acid**	**Dyrenium Triamterene hydrochlorothiazide**	**Adenocard adenosine**
Dose	6.25 mg	50mg	81 mg	37.5-25mg	6mg
Frequency	Twice daily	BID	Daily	Daily	PRN
Route	PO	PO	PO	PO	IV
Classification	Nonselective beta blocker	Beta blocker	NSAID	Potassium sparing diuretic	Nucleoside, antiarrhythmic
Mechanism of Action	Reduces cardiac output, tachycardia,	Inhibits stimulation of beta1-receptor	Inhibits prostaglandin production, interfering	Inhibits sodium reabsorption to promote sodium and water	Slows conduction at AV node, or interrupt AV

	and causes vasodilation to decrease peripheral vascular resistance. This in turns, lower blood pressure.	sites, decreasing cardiac excitability. This relieves angina, and symptoms of heart failure.	with inflammation response, thus decreasing swelling and localized pain. This medication also inhibits platelet aggregation and causes peripheral vasodilation.	excretion.	node pathways to restore normal sinus rhythm.
Reason Client Taking	Hypertension	Hypertension	MI preventative	Hypertension	SVT
Contraindications (2)	Bronchospastic conditions. Second- or third-degree heart block. Heart failure.	Cardiogenic shock. Heart beat lesser than 45bpm. Third degree AV block.	Active bleeding. Coagulation disorders. GI bleed. Pregnancy.	Anuria. Hyperkalemia.	Third degree heart block. Hypersensitivity
Side Effects/Adverse Reactions (2)	Bradycardia. Angina.	Arrhythmias including bradycardia. Cardiac arrest. Cardiogenic shock	Prolonged bleeding time. Diarrhea, heart burn, stomach pain. GI bleed. Bronchospasm.	Hyperkalemia. Elevated BUN levels.	Atrial fibrillation. Bradycardia. Hypotension.
Nursing Considerations (2)		Expect to decrease the dose if a patient with heart failure develops symptomatic bradycardia. This medication may aggravate peripheral vascular disease.	Do not crush this medication. Do not give this medication to children.	Do not give to a patient with decreased renal function. Monitor laboratory results to assess sodium, potassium, and creatinine levels.	A single dose should not excess 6mg. Do not give the medication if the solution is not clear.
Key Nursing Assessment(s)/Lab (s) Prior to Administration	Blood pressure. Heart rate and rhythm.	Complete a baseline EKG prior to starting this medication. Full cardiovascular	Coagulation times (aPTT, PT, INR). Assess for bleeding. Monitor stools for GI bleed.	Review potassium levels. Monitor heart rate.	Heart rate. Blood pressure. EKG.

		assessment including heart rate and blood pressure.			
Client Teaching needs (2)	Stand or change positions slowly as this medication may cause dizziness or orthostatic hypotension. Notify provider for signs of heart failure such as sudden and rapid weight gain, shortness of breath with activity, and swelling of the legs.	Always measure pulse before administration of this medication and call provider if less than 60 bpm. Do not stop taking this medication abruptly.	Take this medication with food and a full glass of water. Report black, tarry stools.	Do not take this medication with milk or food. Drink plenty of water and avoid excessive heat to prevent dehydration.	Report chest pain, difficulty breathing, or heart palpitation. Patient may experience temporary flushing, nausea, or dizziness during administration.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2020 Nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: The patient appears calm, pleasant, and accepting of care **Alertness:** A&O x4 **Orientation:** person, time, place, situation **Distress:** none **Overall appearance:** fair	S.E. is alert and oriented to self, place, time, and situation. He appears calm, pleasant, and accepting of care. He does not appear to be in any distress. S.E. appears well groomed and his stated age.
INTEGUMENTARY: **Skin color:** pale (white) **Character:** dry **Temperature:** warm **Turgor:** quick to return to normal state **Rashes:** none **Bruises:** none **Wounds:** none **Braden Score:** 20 **Drains present: Y☐ N ☒** **Type:**	Skin is warm, dry, pale in color, and quick to return to normal state. Skin is free of any rashes, bruises, or wounds. Braden score: 20 Sensory- without impairment (4) Moisture – without moisture (4) Activity – walks occasionally (3) Mobility – slightly limited (3) Nutrition – adequate (3) Friction/shear – no apparent problem (3)
HEENT: **Head/Neck:** supple and symmetrical**,** thyroid nonpalpable**,** no tracheal deviation **Ears:** without drainage, warm, pale, and dry **Eyes:** PERRLA bilaterally **Nose:** small amounts of clear to yellow drainage **Teeth:** normal dentition	Head and neck are symmetrical, without tracheal deviation. PERRLA bilaterally, normal dentition. External ears are warm, pale, and dry, and are free of drainage. Small amounts of clear to yellow drainage present at bilateral nostrils.
CARDIOVASCULAR: **Heart sounds:** S1 and S2 are auscultated without any murmurs or gallops. **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** Most recent EKG showed normal sinus rhythm with a rate of 80 **Peripheral Pulses:** All peripheral pulses are 2+ bilaterally **Capillary refill:** < 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	S1 and S2 are auscultated without difficulty. Heart sounds are free of gallops or murmurs. EKG shows a rhythm of normal sinus rhythm. All peripheral pulses are palpable bilaterally. Capillary refill is noted to be <3 seconds. There is no neck vein distension or edema throughout.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** Breath sounds are clear to auscultation	Breath sounds are clear to auscultation without rhonchi or wheezing throughout. There is no accessory muscle use. Patient is breathing spontaneously.

without any rhonchi or wheezing throughout. **ET Tube:** N/A **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	
GASTROINTESTINAL: **Diet at home:** Regular **Current Diet:** NPO for testing **Height:** 6'0" **Weight:** 302 pounds **Auscultation Bowel sounds:** normoactive in all four quadrants **Last BM:** 3/21 **Palpation: Pain, Mass etc.:** light and deep palpation performed without any note of mass, patient denies pain during palpation. **Inspection:** **Distention:** none **Incisions:** none **Scars:** none **Drains:** none **Wounds:** none **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Patient is currently NPO for testing and diagnostic imaging- he is tolerating this well without complaints. Bowel sounds are present and normoactive in all four quadrants. Patient denies pain during light and deep palpating. There is no mass or building felt during palpation. Inspection of the abdomen is performed and there is no distension, incisions, scars, drains, or wounds present.
GENITOURINARY: **Color:** yellow **Character:** clear **Quantity of urine:** 600mL since admission **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: N/A** **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	Patient is spontaneously voiding adequate amounts of clear, yellow urine. Urine output since admission is 600mL.
MUSCULOSKELETAL: **Neurovascular status:** intact	Patient is up as tolerated independently without difficulty. S.E. does not require any assistance

ROM: Active ROM performed **Supportive devices:** none **Strength:** equal, 4+ bilaterally **ADL Assistance:** **Y☐ N ☒** **Fall Risk:** **Y ☐ N☒** **Fall Score: 4** **Activity/Mobility Status:** as tolerated **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	from staff or supportive devices in transfers and ambulation. S.E. performed active ROM without difficulty. Fall risk: 4 3 for cardiovascular medications 1 for male gender
NEUROLOGICAL: **MAEW:** **Y ☐ N☒** **PERLA:** **Y ☐ N☒** **Strength Equal:** **Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** A&O x4 **Mental Status:** good **Speech:** normal **Sensory:** perceptive to pain, touch, and temperature **LOC:** alert	Neuro assessment performed without any immediate needs for intervention. Patient has equal strength bilaterally. S.E. is A&O x4 and has no slurring of his speech. Patient is perceptive to pain, touch, and temperature. Patient reports this is his baseline neurological function.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** family, significant other, prayer **Developmental level:** mature **Religion & what it means to pt.:** Patient reports that he is Christian and that he does not have any worries as "God will always take care of me when I need" **Personal/Family Data (Think about home environment, family structure, and available family support):** family and significant other support available as needed.	Patient reports that between his family and significant other, he feels supported in both medical and personal needs. Patient is a Christian and states "I do not worry because I know God will provide when I need him to".

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	87	172/110	20	98.6 F	94% RA
1100	90	160/104	18	97.4 F	96% RA

Vital Sign Trends/Correlation: S.E. has ongoing hypertension. He denies previous hypertension. All other vital signs are stable on room air. This student reviewed different lifestyle changes and stress management techniques to help lower blood pressure. S.E. plans to follow up with his PCP to discuss this issue. SVT and sinus tachycardia appears resolved.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	Numeric	Denies	0	Denies	None
1100	Numeric	Denies	0	Denies	None

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20g **Location of IV:** Left AC **Date on IV:** 3/21 **Patency of IV:** flushes without difficulty **Signs of erythema, drainage, etc.:** free of redness and drainage **IV dressing assessment:** IV dressing is clean, dry, and intact.	Saline Locked
Other Lines (PICC, Port, central line, etc.) None **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)
100 mL – Patient is NPO, meds with sips	600 mL of urine

Nursing Care

Summary of Care (2 points)

Overview of care: S.E. was admitted for observation and further diagnostic imaging. During this admission, S.E. had a cardiology consult where EKGs were ordered to be done q6 hours during the remainder of his stay. Cardiology also requested an echocardiogram to be completed this morning. If testing comes back normal, S.E. will be discharged and instructed to follow up outpatient to manage his new hypertension.

Procedures/testing done: Routine lab work, a chest x-ray, and 3 EKGs.

Complaints/Issues: None

Vital signs (stable/unstable): Persistent hypertension, but otherwise stable.

Tolerating diet, activity, etc.: Patient is NPO and tolerating without complaints. Patient reports no difficulty with ambulation.

Physician notifications: Echocardiogram ordered.

Future plans for client: Echocardiogram to be completed today 3/22, and then pending discharge.

Discharge Planning (2 points)

Discharge location: Home with significant other.

Home health needs (if applicable): None

Equipment needs (if applicable): None

Follow up plan: Follow up with cardiology team outpatient to manage hypertension.

Education needs: Education has been started on lifestyle changes to be made to reduce blood pressure including weight loss, stress management, and a change in dietary habits.

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

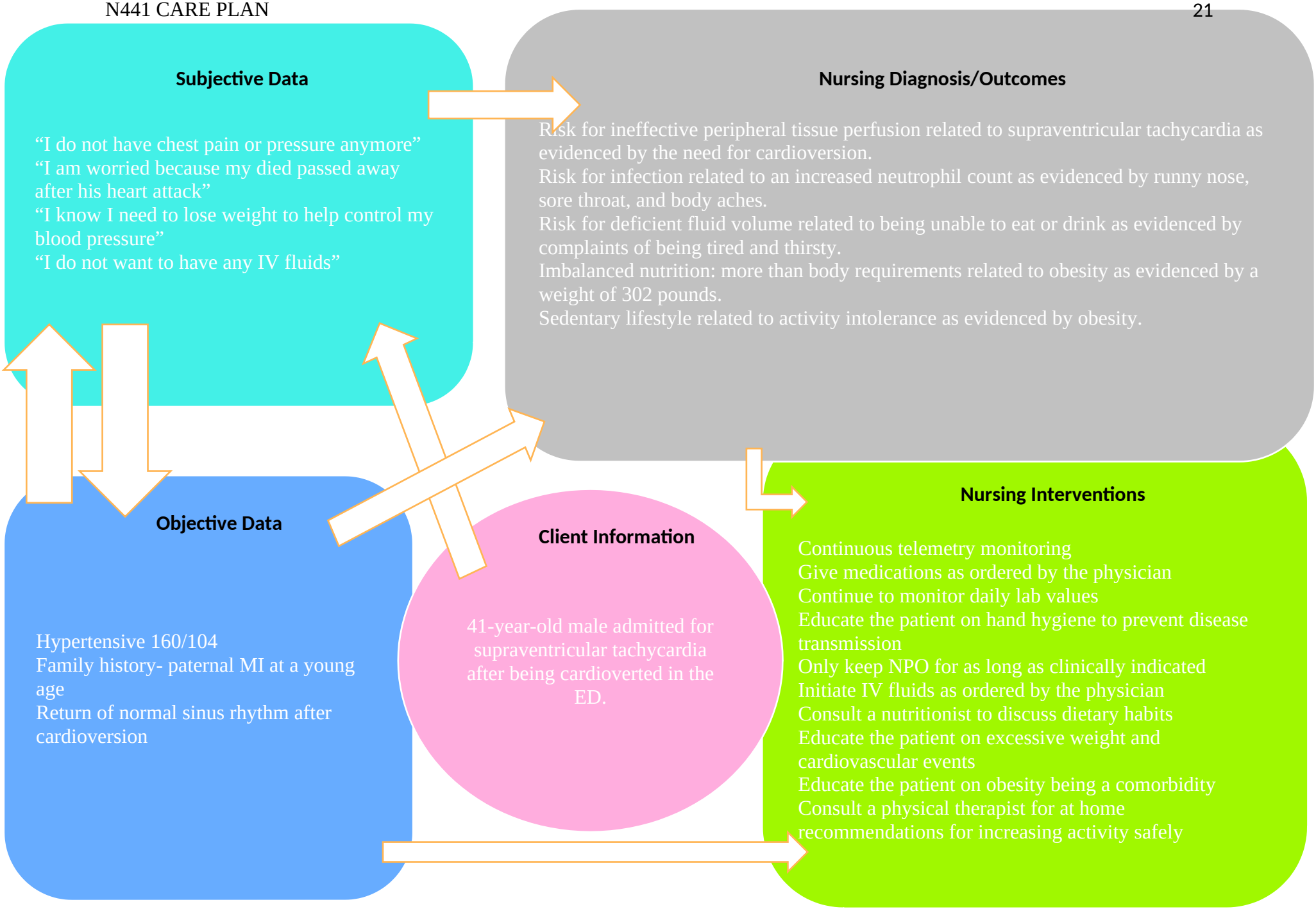
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 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. Risk for ineffective peripheral tissue perfusion related to supraventricular tachycardia as evidenced by the need for cardioversion.	The patient had a heart rate of 180 when arriving to the ED, when the heart is pumping this fast it may get tired and be unable to perfuse as expected.	**1.**Continuous telemetry monitoring. **2.**Give medications as ordered by the physician.	**1.** The patient will continue to be in a normal sinus rhythm.	Continuous telemetry and Q6 hour EKGs continue to show normal sinus rhythm, meaning the cardioversion was successful.
2. Risk for infection related to an increased neutrophil count as evidenced by	One of the only abnormal labs noted was an increase in neutrophils.	**1.** Continue to monitor daily laboratory values. **2.**Educate the patient on hand	**1.** Daily laboratory neutrophil values will decrease.	There is no new data to measure. The patient reports less cold/flu symptoms than prior to

runny nose, sore throat, and body aches.	This increase is likely related to the patient complaints of a runny nose, sore throat, and body aches. The patient is likely developing an infection.	hygiene to prevent disease transmission.		admission.
3. Risk for deficient fluid volume related to being unable to eat or drink as evidenced by complaints of being tired and thirsty.	The patient has been unable to eat or drink since before he arrived to the ED. At the end of my clinical time, the patient voiced feeling "tried and sluggish" and that he thought it was related to being unable to eat or drink.	**1.** Only keep NPO for as long as clinically indicated. **2.** Initiate IV fluids as ordered by the physician.	**1.** Patient will be able to resume a normal diet after diagnostic testing.	Patient remains NPO for testing but is excited to be able to eat and drink following his echocardiogram. He states he did not want IV fluids to be started earlier in admission.
4. Imbalanced nutrition: more than body requirements related to obesity as evidenced by a weight of 302 pounds.	The patient is obese. He consumes more than his recommended calories daily. He is at risk for serious cardiovascular events at this weight.	**1.** Consult a nutritionist to discuss dietary habits. **2.** Educate the patient on excessive weight and cardiovascular events.	**1.** The patient will work with a nutritionist outpatient to reduce his weight and eliminate his cardiovascular risk.	The patient acknowledged the need for weight loss to decrease cardiovascular diseases and hypertension.
5. Sedentary lifestyle related	With the patient's	**1.** Educate the patient on	**1.** The patient will	The patient his acknowledged

to activity intolerance as evidenced by obesity.	obesity and sedentary lifestyle, he has placed himself at risk for cardiovascular events and impaired healing.	obesity being a comorbidity. **2.** Consult a physical therapist for at home recommendations for increasing activity safely.	acknowledge his obesity and how it affects his health.	his obesity and need for weight loss. The patient intends to lose weight to reduce his blood pressure.

Other References (APA):

Concept Map (20 Points):


Subjective Data
"I do not have chest pain or pressure anymore"
"I am worried because my died passed away after his heart attack"
"I know I need to lose weight to help control my blood pressure"
"I do not want to have any IV fluids"
Nursing Diagnosis/Outcomes
Risk for ineffective peripheral tissue perfusion related to supraventricular tachycardia as evidenced by the need for cardioversion.
Risk for infection related to an increased neutrophil count as evidenced by runny nose, sore throat, and body aches.
Risk for deficient fluid volume related to being unable to eat or drink as evidenced by complaints of being tired and thirsty.
Imbalanced nutrition: more than body requirements related to obesity as evidenced by a weight of 302 pounds.
Sedentary lifestyle related to activity intolerance as evidenced by obesity.
Objective Data
Hypertensive 160/104
Family history- paternal MI at a young age
Return of normal sinus rhythm after cardioversion
Client Information
41-year-old male admitted for supraventricular tachycardia after being cardioverted in the ED.
Nursing Interventions
Continuous telemetry monitoring
Give medications as ordered by the physician
Continue to monitor daily lab values
Educate the patient on hand hygiene to prevent disease transmission
Only keep NPO for as long as clinically indicated
Initiate IV fluids as ordered by the physician
Consult a nutritionist to discuss dietary habits
Educate the patient on excessive weight and cardiovascular events
Educate the patient on obesity being a comorbidity
Consult a physical therapist for at home recommendations for increasing activity safely