N441 Care Plan

Lakeview College of Nursing

Name: Kati Davis

Demographics (3 points)

Date of Admission 01/16/2023	**Client Initials** R. T	**Age** 68	**Gender** Female
Race/Ethnicity Caucasion - Non-Hispanic/Latino	**Occupation** Unemployed	**Marital Status** Widowed	**Allergies** Penicillin Reaction: Unknown
Code Status FULL	**Height** 5’ 4”	**Weight** 113 lb 7oz	

Medical History (5 Points)

Past Medical History: The patient has a past medical history of acute renal failure (5/11/2018,) alcoholism, anemia, convulsions, dementia associated with alcoholism, major depressive disorder, gastroesophageal reflux disease, high cholesterol, hypertension, kidney disease, pseudobulbar affect, seizures, stroke, and weight los**s.**

Past Surgical History: The patient has a past surgical history that includes carotid endarterectomy, upper gastrointestinal endoscopy (5/15/2018), upper gastrointestinal endoscopy (05/20/2020), and ankle fracture surgery (L)(12/05/2022).

Family History: The mother has a history of major depressive disorder and panic disorder.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient reports that she has quit smoking. Her smoking use included cigarettes (½ pack a day). She has never used smokeless tobacco. The patient reports that she does not currently use alcohol. The patient has never used illicit drugs.

Assistive Devices: Wheelchair

Living Situation: The patient resides at Arcadia Care in Danville, IL.

Education Level: Some college

Admission Assessment

Chief Complaint (2 points): Bleeding/Bruising

History of Present Illness – OLD CARTS (10 points): The patient is a 68-year-old female who presented to the ER on 01/16/2023 around 5 pm with reports of rapid heart rate (HR) and bruising. The patient noticed her heart rate to be elevated a couple of hours prior to arriving at the ED (3 pm). The raised HR was abnormal enough for the patient to notice and the bruising was "worse than ever." The elevated heart rate was constant, nothing seemed to relax her. Moving her left leg elevated her HR even more. Her left ankle is broken, and she is supposed to be on a strict non-weight-bearing order. The patient did not take any OTC medications prior to arrival for chief complaint.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Atrial fibrillation

Secondary Diagnosis (if applicable): N/A

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

Atrial fibrillation, sometimes called A-fib, is a type of cardiac rhythm disorder that can lead to blood clots in the heart due to its erratic and frequently very rapid rhythm (Mayo Clinic, 2021). The most common type of cardiac arrhythmia is atrial fibrillation. During atrial fibrillation, the atria experience chaotic electrical activity—they quiver rather than contract as a unit (Hinkle et al., 2022). If a person has a-fib, the SA node is not controlling the electrical rhythm of the heart. The atria, on the other hand, suffer from this fast, erratic beat because of several impulses firing quickly and simultaneously. The atria cannot then contract or pump blood into the ventricles efficiently. This rapid, irregular heartbeat is caused by abnormal ventricular contraction.

Some people with a-fib are asymptomatic. However, if the ventricles begin to beat faster, signs and symptoms such as irregular heart rhythm, chest tightness, shortness of breath, dizziness, palpitations, and extreme fatigue can occur (Cleveland Clinic, 2022).

After the initial assessment, if a-fib is suspected, the doctor will most likely order an EKG or echocardiogram to confirm the diagnosis. This information from an echocardiogram may be useful in determining the conditions that cause a-fib, the risk of recurrent a-fib after cardioversion, and the hemodynamic benefit of maintaining sinus rhythm. Although blood draws reveal some imbalances that can lead to a-fib, laboratory blood tests are primarily used to help determine the best drug to prescribe based on the individual kidney and liver functions. Managing the heart rate and restoring a normal rhythm are priorities in the treatment of a-fib. For treatment, rate control medications may be prescribed. The patient is prescribed Cardizem; Cardizem is prescribed to patients presenting with a-fib to relax the blood vessels in the body and heart and lower the heart rate. Blood thinners may also be prescribed. When medication fails to control a-fib, a procedure may be required. A permanent pacemaker or electrical cardioversion may be considered (Cleveland Clinic, 2022).

There are modifiable risk factors to consider if one is concerned about developing a-fib. A heart-healthy diet can include a variety of fruits, vegetables, and whole grains. Smoking cessation and alcohol consumption restrictions can be implemented. Tracking these healthy lifestyle choices can lead to additional advantages such as weight loss and higher nutritional cholesterol levels (Cleveland Clinic, 2022). If a person is concerned about their heart health, they can seek advice and answers from their primary care physician.

Pathophysiology References (2) (APA):

Cleveland Clinic. (2022). *Atrial fibrillation (AFIB): Causes, symptoms and treatment*. Cleveland Clinic. Retrieved January 20, 2023, from https://my.clevelandclinic.org/health/diseases/16765-atrial-fibrillation-afib

Hinkle, J. L., Cheever, K. H., & Overbaugh, K. (2022). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.

Mayo Clinic. (2021, October 19). *Atrial fibrillation*. Mayo Clinic. Retrieved January 21, 2023, from https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624

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	3.80-5.30	2.87 (L)	2.95 (L)	Low RBC can be caused by malnutrition. The patient states that she does not eat very well at her nursing facility because eating causes stomach pain.
Hgb	12.0-15.8	7.8 (L)	8.0 (L)	The HGB is low because the RBCs are low. RBC carries the HGB which carries O2 throughout the body.
Hct	36.0-47.0	28.7(L)	25.0 (L)	HCT reflects the percentage of blood volume that makes up the RBC. Just as above, the lack of nutrition due to her upset stomach could be triggering slight anemia.
Platelets	140-440 10(3)/mcL	383	393	

WBC	4.00-12.00 10(3)/mcL	12.50 (H)	10.00	The patient was (+) for occult blood. This could indicate a gastrointestinal infection. Infection causes WBC levels to increase (Pagana et al., 2020).
Neutrophils	47.0-73.0%	N/A	62.8	
Lymphocytes	18.0-42.0%	N/A	23.2	
Monocytes	4.0-12.0%	N/A	10.7	
Eosinophils	0.0-5.0%	N/A	2.7	
Bands	N/A	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	141	145	
K+	3.5-5.1 mmol/L	4.1	3.7	
Cl-	98-107 mmol/L	118 (H)	120 (H)	Elevated levels of chloride may be a sign of kidney disease (Pagana et al., 2020). The patient has a previous medical history of acute renal failure.
CO2	22-30 mmol/L	9 (L)	12 (L)	Atrial fibrillation causes a loss of "atrial kick," resulting in a decrease in heart output. As a result, the organs instruct the brain to send more O2 and the lungs to work harder. This may present as heavy, fast breathing. During this change in breathing the patient may have been exhaling more than he could inhale which would result in lowered CO2 levels (Pagana et al., 2020).
Glucose	**70-99 mg/dL**	126 (H)	101 (H)	This is a slight elevation. These levels are not necessarily concerning. Glucose levels can elevate in moments of stress; the patient may be stressed from being inpatient in the hospital.

BUN	**10-20 mg/dL**	23 (H)	19	An elevated BUN reading may indicate the presence of renal damage or illness (Pagana et al., 2020). The patient has a history of hypertension - this could be causing said damage.
Creatinine	0.60-1.00 mg/dL	1.32 (H)	1.13 (H)	High blood pressures can harm the kidney's blood vessels, impairing kidney function and resulting in high creatinine levels (Pagana et al., 2020). The patient has a medical history of hypertension.
Albumin	3.5-5.0 g/dL	3.6	N/A	
Calcium	8.7-10.5 mg/dL	10.2	N/A	
Mag	1.6-2.6 mg/dL	1.6	N/A	
Phosphate	N/A	N/A	N/A	
Bilirubin	0.2-0.8 mg/dL	N/A	N/A	
Alk Phos	34-104 U/L	99	N/A	
AST	13-39 U/L	N/A	N/A	
ALT	7-52 U/L	N/A	N/A	
Amylase	N/A	N/A	N/A	
Lipase	N/A	N/A	N/A	
Lactic Acid	0.7-2.0 mmol/L	N/A	N/A	
Troponin	0.000-0.040 ng/mL	< 0.030	N/A	
CK-MB	N/A	N/A	N/A	
Total CK	N/A	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	0.8-1.1	2.2 (H)	1.1	This patient was started on heparin at the time of admission; this can elevate PT/INR values.
PT	10.1-13.1 seconds	24.9 (H)	12.3	This patient was started on heparin at the time of admission; this can elevate PT/INR values.
PTT	25-36 seconds	N/A	N/A	
D-Dimer	0-622 ng/mL	N/A	N/A	
BNP	0-100 pg/mL	198 (H)	N/A	There is not a specific lab to watch for that determines A Fib. But, if a patient has atrial fibrillation, it could weaken their heart if it persists. An elevated BNP could detect heart muscle damage that transpired from the episode of A-fib when the heart was not pumping in the way it needed to (Pagana et al., 2020).
HDL	N/A	N/A	N/A	
LDL	N/A	N/A	N/A	
Cholesterol	N/A	N/A	N/A	
Triglycerides	N/A	N/A	N/A	
Hgb A1c	N/A	N/A	N/A	
TSH	0.270-4.200 mlU/L	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	Colorless-yellow	N/A	N/A	
pH	5.0-9.0	N/A	N/A	

Specific Gravity	1.003-1.030	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0-5	N/A	N/A	
RBC	0-2/ hpf	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	7.35	N/A	
PaO2	85-105 mmHg	104	N/A	
PaCO2	35-45 mmHg	18 (L)	N/A	The patient could have had heavy/fast breathing from her A fib. This pace of breathing is an overall increase in ventilation which could cause a decreased PaCO2 (Pagana et al., 2020).
HCO3	22.0-26.0 mmol/L	9.5 (L)	N/A	I am unable to find an explanation of the finding correlating it to the patient's diagnosis.
SaO2	94-100%	98	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	No growth	N/A	N/A	
Blood Culture	No growth	N/A	N/A	
Sputum Culture	No growth	N/A	N/A	
Stool Culture	No growth	(+) occult blood	N/A	The (+) result of this test means there has been blood found in the stool. This could indicate causes such as peptic ulcers or inflammatory bowel disease.

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2020). *Mosby's Diagnostic and Laboratory Test Reference* (15th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

(1) CT Head or brain without contrast

(2) CT Chest, abdomen, pelvis without contrast

Diagnostic Test Correlation (5 points):

(1) The patient had this diagnostic test done because of a change in mental status. The CT found a small right frontal chronic subdural hematoma. A hyperdense area was noted posterior to the left frontal bone, this could indicate a mass. An MRI is suggested to further evaluate.

(2) The patient had this diagnostic test done because of complaints of abdominal pain after eating. This test is going to be used to assess for bleeding - the patient presented with very high INR levels. To diagnose conditions like appendicitis, pyelonephritis, or infected fluid collections, often called abscesses, CT scans of the abdomen are performed (John Hopkins, 2021).

Diagnostic Test Reference (1) (APA):

John Hopkins. (2021, August 8). *Computed Tomography (CT or cat) scan of the abdomen*. Johns Hpkins Medicine. Retrieved January 21, 2023, from https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/computed-tomography-ct-or-cat-scan-of-the-abdomen

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

Home Medications (5 required)

Brand/Generic	**ferrous sulfate (Fer-In-Sol)**	**Calcium carbonate (Tums)**	**sertraline (Zoloft)**	**mirtazapine (Remeron)**	**acetaminophen (Tylenol)**
Dose	325mg	500mg	25mg	15mg	650 mg
Frequency	BID	TID	Nightly	Nightly	Every 4 hours PRN
Route	Oral	Oral	Oral	Oral	Oral
Classification	<u>Pharmacologic class:</u> Hematinic <u>Therapeutic class:</u> Antianemic	<u>Pharmacologic class:</u> Calcium salts <u>Therapeutic class:</u> Antacid	<u>Pharmacologic class:</u> Selective serotonin reuptake inhibitor (SSRI) <u>Therapeutic class:</u> Antianxiety,	<u>Pharmacologic class:</u> Tetracyclic antidepressant <u>Therapeutic class:</u> antidepressant	<u>Pharmacologic class:</u> Nonsalicylate, para-aminophenol derivative <u>Therapeutic class:</u> Antipyretic

			antidepressant		, nonopioid analgesic
Mechanism of Action	Acts to normalize RBC production by binding with hemoglobin or by being oxidized and stored as hemosiderin or aggregated ferritin in reticuloendothelial cells of the bone marrow, liver, and spleen.	Increases levels of intracellular and extracellular calcium, which is needed to maintain homeostasis, especially in the nervous and musculoskeletal systems.	Inhibits reuptake of the neurotransmitter serotonin by CNS neurons, thereby increasing the amount of serotonin available in nerve synapses**.**	This drug works by increasing the amount of mood enhancing chemicals called noradrenaline and serotonin in the brain.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.
Reason Client Taking	Patient's RBC, HGB and HCT counts are low.	To provide antacid effects.	The patient has a history of depression.	Treats depression and sometimes OCD and anxiety	Mild pain or more severe pain if the patient requests.
Contraindications (2)	1. hemochromatosis 2. hemolytic anemias	1. Hypercalcemia 2. Renal calculi	1. Concurrent use of disulfiram (oral solution) or pimozide 2. Hypersensitivity to sertraline or its components	1. High cholesterol 2. Low amounts of sodium in the blood	1. Hypersensitivity to acetaminophen or its components 2. severe hepatic impairment
Side Effects/Adverse Reactions (2)	1. Dizziness 2. Stool discoloration	1. Hypotension 2. Hypercalcemia	1. cerebrovascular spasm 2. suicidal ideation	1. Cerebral ischemia 2. Serotonin syndrome	1) Agitation/anxiety 2) Hepatotoxicity
Nursing Considerations (2)	1. Give iron tablets and capsules with a full glass of juice or water 2. Do not crush enteric coated tablets or open capsules	1. Store at room temperature, and protect from heat, moisture, and direct light. Do not freeze 2. Monitor	1. Be aware that sertraline should not be given to patients with bradycardia, congenital long QT syndrome,	1. Use this drug cautiously in elderly patients and in those receiving concurrent medication	1) Use cautiously in patients with hepatic impairment or active hepatic disease,

		serum calcium levels, as ordered, and evaluate therapeutic response by assessing for Chvostek's and Trousseau's signs, which should not appear.	hypokalemia or hypomagnesemia, recent acute myocardial infarction, or uncompensated heart failure because of increased risk of prolonged QT interval and torsades de pointes. 2. Monitor patient closely for evidence of serotonin syndrome, such as agitation, coma, diarrhea, hallucinations, labile blood pressure, nausea, tachycardia, and vomiting.	known to cause hyponatremia because drug may lower the serum sodium level in patients. 2. Do not give drug within 14 days of an MAO inhibitor or concurrent therapy with serotonin-precursors such as L-tryptophan and oxitriptan to avoid serious, possibly fatal, serotonin syndrome reaction.	alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment 2) Monitor renal function in patient on long-term therapy.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1. check RBC, HGB, and HCT levels 2. Be sure to monitor patient's BP as this can cause hypotension	1. Check calcium levels 2. It would not hurt to monitor BP as an adverse reaction is hypotension.	1. Potassium levels should be checked as this should not be given to patients with hypokalemia 2. Heart rate should be monitored as this should not be given to patients with bradycardia.	1. Assess dizziness and drowsiness 2. Check sodium levels as this may cause hyponatremia	1. Liver function tests – ALT, AST 2. Check pain level before administering.
Client Teaching needs (2)	1. Do not chew any solid form of iron except for chewable tablets 2. Urge patient	1. Urge patient to chew chewable tablets thoroughly before	1. Advise patient that drug may cause mild pupillary dilation,	1. Take this before bed. 2. Advise patient to avoid alcohol and other CNS	1. Take exactly as directed on the package label

	to eat chicken, fish, lean red meat, and turkey, as well as foods rich in vitamin C to improve iron absorption.	swallowing and to drink a glass of water afterward. 2. Instruct the patient to dissolve calcium citrate effervescent tablets in water and drink immediately.	which may lead to an episode of acute closure glaucoma. 2. Inform patient that the oral solution contains alcohol and should not be taken with disulfiram.	depressants during therapy and for up to 7 days after drug is discontinued.	2. Do not take more Tylenol or take it more often than directed even if fever and pain are still present.

Hospital Medications (5 required)

Brand/Generic	**atorvastatin (Lipotor)**	**busPIRone (Buspar)**	**cefTRIAXone (Rocephin)**	**dilTIAZem (cardizem)**	**pantoprazole (Protonix)**
Dose	10mg	10mg	2g	30mg	40mg
Frequency	Nightly	TID	Every 24 hours	Four times daily	BID
Route	Oral	Oral	Intravenous	Oral	Intravenous
Classification	Pharmacologic class: HMG-CoA reductase inhibitor Therapeutic class: Antihyperlipidemic	Pharmacologic class: Azaspirone Therapeutic class: Anxiolytic	Pharmacologic class: Third-generation cephalosporin Therapeutic class: antibiotic	Pharmacologic class: Calcium channel blocker Therapeutic class: Antianginal, antiarrhythmic, antihypertensive	Pharmacologic class: Proton pump inhibitor Therapeutic class: antiulcer
Mechanism of Action	Reduces plasma	Suppresses serotonergic	Interferes with bacterial cell	Inhibits calcium	Interferes with gastric acid

	cholesterol and lipoprotein levels by inhibiting HG-CoA reductase and cholesterol synthesis in the liver band by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown	activity while enhancing dopaminergic and noradrenergic cell firing. This mediates anxiety.	wall synthesis by inhibiting cross-linking of peptidoglycan strands. Peptidoglycan makes the cell membrane rigid and protective. Without it, bacterial cells rupture and die.	movement into coronary and vascular smooth-muscle cells by blocking slow calcium channels in cell membrane.	secretion by inhibiting the hydrogen-potassium-adenosine triphosphatase enzyme system, or proton pump, n gastric parietal cells.
Reason Client Taking	A-fib patients are prescribed statin treatments to help recover sinus rhythm and electrical cardioversion.	To manage anxiety	To treat an infection.	This controls hypertensio n.	PPIs are often prescribed to acute inpatient stays due to increased stress during hospitalization and its potential impact on the GI tract.
Contraindicatio ns (2)	1. Active hepatic disease 2. unexplained persistent rise in serum transaminase level.	1. Hypersensitivi ty to buspirone or its components 2. Severe hepatic or renal impairment.	1. Hypersensitivi ty to ceftriaxone 2. intravenous administration of ceftriaxone solutions containing lidocaine	1. Acute MI 2. Pulmonary edema	1) concurrent therapy with rilpivirine – containing products 2) hypersensitivit y to pantoprazole
Side Effects/Adverse Reactions (2)	1. Arrhythmias 2. Hypoglycemia	1. Serotonin syndrome 2. Angioedema	1. Seizures 2. Acute renal failure	1. Atrial flutter 2. Bradycardia	1. Hepatic failure 2. Hepatoxicity
Nursing Considerations (2)	1. Know that this is used in patients with homozygous familial hypercholester olemia as an	1. Use buspirone cautiously in patients with hepatic or renal impairment.	1. Be aware that calcium-containing products must not be given I.V within 48 hours of	1. Monitor patient's BP, heart rate/rhythm by continuous ECG, and	1. Nurses should inform the patient to inform the prescriber if they have a history of liver

	adjunct to other lipid-loweing treatments or alone only if other treatments are not available. 2. Be aware that this may be used with colestipol or cholestyramine for additive antihyperlipidemic effects.	2. Institute safety precautions because of possible adverse CNS reactions.	ceftriaxone, including solutions given through a different I.C. line and at a different site. 2. Use cautiously in patients who are hypersensitive to penicillin because cross-sensitivity has occurred in about 1% to 3% of such patients.	pulse rate as appropriate during therapy 2. Assess patient for signs and symptoms of heart failure.	disease. 2. Nurses should inform patient to tell their physician if they are allergic to any kind of proton pump inhibitor.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	1. Liver function tests 2. Lipid panel	1. Check their medication history to ensure they are not also taking a drug with MAO inhibitor activity. This can cause an elevated BP 2. Check to see if they are on other CNS depressants or antihistamines. This may make the patient drowsy or less alert.	1. Double check if patient has ever had an allergic reaction to other antibiotics. 2. Obtain culture and sensitivity results, if possible and as ordered, before giving drug.	1. Liver function tests 2. Monitor HR and this can cause bradycardia.	Assess the patient for signs and symptoms of stomach pain, heart burn, stomach upset, and N/V
Client Teaching needs (2)	1. Advise the patient to take drug at the same tie each day to maintain its effects. 2. Instruct patient to take a missed dose as soon as	1. Advise patient to take consistently either always with or always without food. 2. Caution patient to avoid drinking large amounts of grapefruit	1. Urge patient to report watery, bloody stools to prescriber immediately, even up to 2 months after drug therapy has ended. 2. Tell patient	1. Explain to the patient that capsules and E.R. tablets mut be swallowed whole. 2. Tell patient that stopping	1. Advise patient to take before meals 2. Advise patient to not crush

	possible. If it is almost time for her next dose, she should skip the missed dose. Tell patient not to double the dose.	juice.	to report evidence of blood dyscrasia or superinfection to prescriber immediately.	drug suddenly may have life-threatening effects.	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *Nurse's Drug Handbook 2021*. Jones & Bartlett Learning.

(Original work published 2021)

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and oriented to name only. The patient is very pleasant and does answer some yes or no questions. She expresses she has pain in (L) leg but does not appear in acute distress. The patient is cooperative and pleasant.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 19** **Drains present: Y☐ N ☐** **Type:**	Skin is white, intact, and dry without jaundice Patient has cast on the left lower leg due to a fall. Skin color surrounding cast is appropriate for ethnicity, skin is warm with no tingling, no numbness or pain. Pressure wound on coccyx. Patient has bruises all over body in various stages of healing
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Normocephalic, white sclera, moist mucous membranes, no oral lesions. The head and neck are symmetrical. Trachea is midline without deviation. Oral cavity pink moist and clear. Auricles are bilateral no visible deformities. The septum is midline no visible bleeding. Teeth are natural with some missing.

CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	(-) for chest pain at the time of assessment. Rate and rhythm S1, S2 are normal without murmur, click, rub, or gallops. Capillary refill < 2 seconds. No neck vein distension. (-) for edema at time of assessment in upper and lower bilateral extremities.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Breath sounds are unlabored and regular in high fowler's position. Lung expansion is symmetrical. Anterior and posterior chest walls have no tenderness, masses, or crepitus upon palpation. Breath sounds clear without wheezing or crackles. No ET tube
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:**	Home diet is considered normal adult diet with a low appetite. Current diet in hospital setting is NPO until she received GI consult bc of (+) occult blood. Height: 5' 4" Weight: 113 lb 7oz Last BM: 1/17/22 Bowel sounds normoactive in all four quadrants. The abdomen is soft, flat, and non-tender. The patient is using bedside commode with assist. She is on a strict non-weight-bearing order because of her fractured (L) ankle. The patient has had 2 voids during my clinical hours and 1 BM.
GENITOURINARY: **Color:**	The patient is continent and able to control her bladder and bowel of their own accord.

Character: **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	The urine is yellow and clear. (-) for pain during urination.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score: 50** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Observed the presence of cranial nerve 1. The patient smelled other patients' lunch coming back and expressed, "I wish I could eat, that smells alright." The patient is currently in a wheelchair because of her fractured ankle and needs assistance while using the restroom. Decreased active range of motion. Pain associated with (L) leg with movement. The patient is a fall risk with a score of 50. She is under high risk fall prevention intervention procedures.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient is alert and awake. She can use senses as they are intact. The patient wears glasses. The patient is alert to name only. Strength unequal in legs due to left ankle fracture.
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):**	The patient states she has several family members nearby in the community near her short-term nursing facility. She copes by cherishing those relationships with her family. No specific religion is practiced. Her developmental level would be categorized as normal adult.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0815	93	103/63	31	98.0	95
1215	80	102/58	23	97.6	96

Vital Sign Trends/Correlation:

Vital signs remained stable during my clinical shift except for respiratory rate. Her HR upon admission was rapid and respirations continued to be elevated during my clinical shift. They did improve before I left for the day but were still considered abnormal.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0815	Numeric Scale	(L) leg	Severe 8/10	Aching	Told nurse, Autumn, her pain rating. She was going to give her a pain pill shortly after this assessment.
1230	Numeric Scale	(L) leg	4/10	moderate	Pain is diminished from early. No interventions currently.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	20 G Peripheral IV on left wrist Date: 01/16/2023 No redness, tenderness, or swelling. The access is clean, dry, and intact.
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:**	N/A

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)**
50 mL (IV Piggyback) 1338.8 mL (IV)	Continent x 2 void

Nursing Care

Summary of Care (2 points)

Overview of care: During this clinical time, I was able to assist the nurse with med passing, assessment, and ambulating. Although the patient rested quite a bit because of her sore leg/ankle, she permitted me to be involved in patient care during my clinical hours.

Procedures/testing done: No procedures or testing was done during my clinical hours.

Complaints/Issues: The only complaints were pain from the patient during position changes and ambulation.

Vital signs (stable/unstable): Vital signs remained stable during my clinical hours. Respiration rate became elevated at times, but it eventually trended back to “normal”.

Tolerating diet, activity, etc.: The patient is NPO; she is tolerating this fine currently. Activity including slight ambulation is painful for the client. She became agitated and tired any time she had to move her left leg.

Physician notifications: No updated physical notes during these clinical hours.

Future plans for client: Future plans for this client include a GI consult because of her (+) occult stool culture. The physician noted, “we have to get her up and moving,” so it is imperative to also get a consult from physical therapy and an occupational therapist.

Discharge Planning (2 points)

Discharge location: Potential inpatient rehabilitation facility due to her fractured ankle. If the patient is not discharged to inpatient rehab, she will be discharged to Arcadia Care in Danville, IL.

Home health needs (if applicable): The patient is not being discharged home. Currently, there are no home health needs.

Equipment needs (if applicable): The patient is not being discharged home. At this time, no additional equipment is needed.

Follow up plan: The patient should follow up with her primary care provider after discharge. It is also encouraged to follow up with physical therapy/occupational therapy after discharge also.

Education needs: It is imperative to educate the patient and any support person on the importance of following up with PT/OT.

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. Ineffective tissue perfusion related to decreased cardiac output as evidenced by the report of rapid heartbeat upon arrival.	I chose this nursing diagnosis because lack of oxygenated blood flow to certain areas of the body should be a priority per ABCs.	**1.** Monitor the client's blood pressure **2.** Keep assessing mental status, LOC, speech, and behavior patterns.	**1.** The patient will demonstrate increased perfusion as evidenced by vital sounds being within parameters.	- The patient was cooperative to nurse visits and frequent vital sign checks. - The patient's BP and respiration rate improved and the O2 level stayed at an appropriate number.
2. Acute pain related to injury to left ankle as evidenced by verbal complaints of discomfort during movement.	This nursing diagnosis was chosen because pain is a major barrier in the client's ability to ambulate. This will be a potential barrier in the patient's success with future PT/OT	1. Maintain immobilization of affected part using bed rest, cast, splint, or traction. 2. Elevate bed covers and keep linens off toes. This will maintain body warmth without discomfort due to	1. The patient will demonstrate ability to participate in activities with minimal complaints of discomfort**.**	- During my clinical shift, I was able to keep immobilization of the left ankle fracture. But the consultation with OT/PT had not been initiated yet. Ideally, the patient would show non-verbal agreement of the plan to move

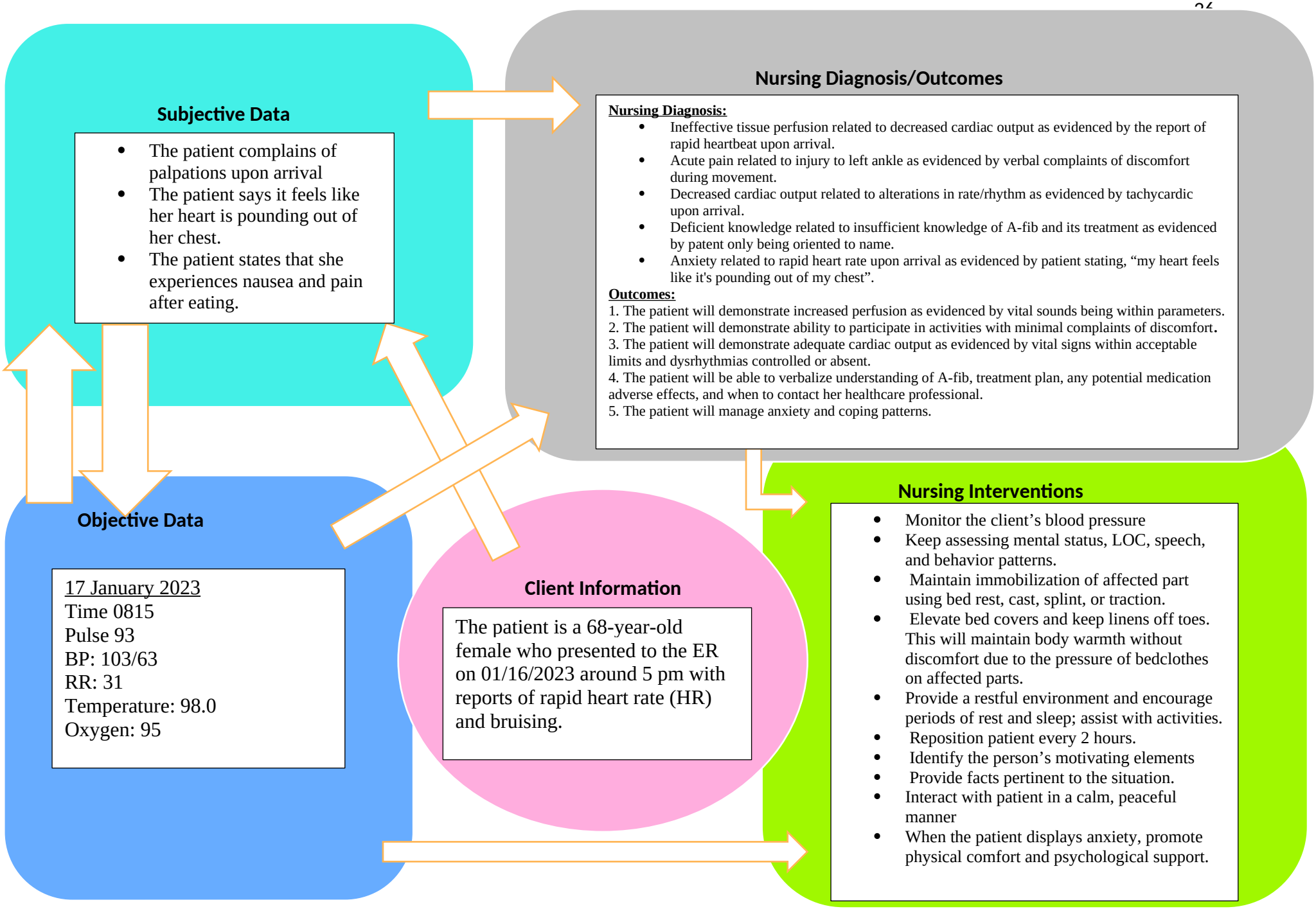
		the pressure of bedclothes on affected parts.		forward with PT/OT and will exhibit pain relief after consistent therapies.
3. Decreased cardiac output related to alterations in rate/rhythm as evidenced by tachycardic upon arrival.	This nursing diagnosis was chosen because of ABC priority. With A-fib, manifests with difficulty circulating blood to all parts of the body, which may cause altered heart rate, rhythm, and potential weakness.	1. Provide a restful environment and encourage periods of rest and sleep; assist with activities. 2. Reposition patient every 2 hours.	1. The patient will demonstrate adequate cardiac output as evidenced by vital signs within acceptable limits and dysrhythmias controlled or absent.	I was able to implement the repositioning every two hours. The patient was accepting of the repositioning to help keep her blood flowing appropriately. The client did experience pain with movement because of her fracture. The physician hopes to have a consult from OT/PT soon to keep her moving and eventually alleviate discomfort.
4. Deficient knowledge related to insufficient knowledge of A-fib and its treatment as evidenced by patent only being oriented to name.	This diagnosis was chosen because deficient knowledge can lead to lack of adherence with a treatment plan and can result in a readmission later on	1. Identify the person's motivating elements 2. Provide facts pertinent to the situation.	1. The patient will be able to verbalize understanding of A-fib, treatment plan, any potential medication adverse effects, and when to contact her healthcare professional.	During my clinical shift, I was unable to implement the suggested interventions. Ideally, the patient will be receptive of the health education and be able to demonstrate behavior and lifestyle modifications to prevent complications of her diagnosis.
5. Anxiety related to rapid heart rate upon arrival as	I chose this diagnosis because anxiety can make it more	1. Interact with patient in a calm, peaceful manner. 2. When the	1. The patient will manage anxiety and coping patterns.	During my clinical shift, I was able to implement interacting peacefully and

evidenced by patient stating, “my heart feels like it's pounding out of my chest”.	challenging for patients in the hospital to follow diet exercise and drug use recommendations.	patient displays anxiety, promote physical comfort and psychological support.		being calm and approachable. Ideally, with efforts to promote comfort and support the patient will be able to demonstrate improved concentration and identify strategies to reduce anxiety.

Other References (APA):

Linda Lee Phelps. (2020). *Sparks & Taylor’s Nursing Diagnosis Reference Manual*. Wolters Kluwer Medical.

Concept Map (20 Points):


Subjective Data
The patient complains of palpations upon arrival
The patient says it feels like her heart is pounding out of her chest.
The patient states that she experiences nausea and pain after eating.
Nursing Diagnosis/Outcomes
Nursing Diagnosis:
Ineffective tissue perfusion related to decreased cardiac output as evidenced by the report of rapid heartbeat upon arrival.
Acute pain related to injury to left ankle as evidenced by verbal complaints of discomfort during movement.
Decreased cardiac output related to alterations in rate/rhythm as evidenced by tachycardic upon arrival.
Deficient knowledge related to insufficient knowledge of A-fib and its treatment as evidenced by patent only being oriented to name.
Anxiety related to rapid heart rate upon arrival as evidenced by patient stating, “my heart feels like it's pounding out of my chest”.
Outcomes:
1. The patient will demonstrate increased perfusion as evidenced by vital sounds being within parameters.
2. The patient will demonstrate ability to participate in activities with minimal complaints of discomfort.
3. The patient will demonstrate adequate cardiac output as evidenced by vital signs within acceptable limits and dysrhythmias controlled or absent.
4. The patient will be able to verbalize understanding of A-fib, treatment plan, any potential medication adverse effects, and when to contact her healthcare professional.
5. The patient will manage anxiety and coping patterns.
Objective Data
17 January 2023
Time 0815
Pulse 93
BP: 103/63
RR: 31
Temperature: 98.0
Oxygen: 95
Client Information
The patient is a 68-year-old female who presented to the ER on 01/16/2023 around 5 pm with reports of rapid heart rate (HR) and bruising.
Nursing Interventions
Monitor the client’s blood pressure
Keep assessing mental status, LOC, speech, and behavior patterns.
Maintain immobilization of affected part using bed rest, cast, splint, or traction.
Elevate bed covers and keep linens off toes. This will maintain body warmth without discomfort due to the pressure of bedclothes on affected parts.
Provide a restful environment and encourage periods of rest and sleep; assist with activities.
Reposition patient every 2 hours.
Identify the person’s motivating elements
Provide facts pertinent to the situation.
Interact with patient in a calm, peaceful manner
When the patient displays anxiety, promote physical comfort and psychological support.