N431 Care Plan # 1

Lakeview College of Nursing

Noredia Asia

Demographics (3 points)

Date of Admission 2/19/2023	Client Initials J.L.	Age 94	Gender Female
Race/Ethnicity White	Occupation Retired teacher	Marital Status Divorced	Allergies Metformin - Diarrhea
Code Status DNR	Height 170cm	Weight 52.9 kg	

Medical History (5 Points)

Past Medical History: Diabetes, dementia, GERD, hypothyroidism, rectal bleeding, hyperlipidemia, hypertension, chronic anticoagulation, chronically elevated troponin, right hip fracture, anemia, CAD, recurrent syncope

Past Surgical History: EGD (08/2021), arthroplasty (09/2020), hip fixation (03/2020)

Family History: Not specified by patient and not in chart.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Never smoked, drank alcohol, or used any other substances.

Assistive Devices: Wheelchair/walker

Living Situation: Assisted living center

Education Level: Community college

Admission Assessment

Chief Complaint (2 points): Dizziness/syncope

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

This 94-year-old patient, with a history of recurrent syncope and chronically elevated troponin levels, was brought into the ED for a witnessed syncope episode. Witnesses stated that the morning of the incident, the patient was being assisted in dressing and further informed staff

of a dizzy feeling and was then lowered to the ground. The patient suffered no head trauma or injury. The patient denies chest pain. This patient has suffered from previous syncope episodes at the hospital, and episodes of elevated troponin levels and delirium. The patient's family requested that no aggressive measure be taken and DNR paper were signed. The patient is currently being monitored on telemetry. Other treatment options outside of pharmacological measures have not been well received by the patient, who is refusing most treatment efforts. Also, a nurse reported that the patient was singing a "death song," and when questioned, the patient stated that she "did not want to die." The patient should also be monitored for anxiety and depression.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Syncope

Secondary Diagnosis (if applicable): NSTEMI

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

Non-ST-segment elevation myocardial infarction (NSTEMI) is an acute coronary syndrome (ACS) due to a coronary artery's partial or complete occlusion. This condition is characterized by a sudden decrease in blood flow to the heart muscle, leading to the death of myocardial cells. NSTEMI occurs due to the formation of a thrombus (blood clot) in a coronary artery. This can occur due to the rupture of an atherosclerotic plaque, which causes the release of thrombogenic substances that initiate the clotting cascade (Capriotti, 2020). The thrombus partially occludes the coronary artery, decreasing blood flow to the heart muscle. This causes ischemia and hypoxia, which can lead to myocardial cell death. The cardiovascular system experiences decreased blood flow leading to arrhythmias, reduced cardiac output, and ultimately

heart failure. The respiratory system experiences respiratory distress and hyperventilation due to decreased cardiac output and hypoxemia. The renal system experiences decreased renal perfusion leading to potential acute kidney injury. The gastrointestinal system experiences decreased gastrointestinal motility, decreased blood flow to the gastrointestinal tract, and potential ischemic injury to the intestinal mucosa. Finally, the nervous system experiences anxiety, restlessness, and increased heart rate and blood pressure due to sympathetic nervous system activation (*NSTEMI: Causes, Symptoms, Diagnosis, Treatment & Outlook*, n.d.). Overall, the pathophysiology of NSTEMI can have serious consequences on the body's various systems, and prompt diagnosis and treatment is crucial to prevent life-threatening complications.

The signs and symptoms of NSTEMI are similar to those of other types of ACS, including chest pain or discomfort, shortness of breath, nausea, vomiting, diaphoresis, fatigue, and anxiety (Capriotti, 2020). The expected vital signs in a patient with NSTEMI are an elevated heart rate, elevated blood pressure, and possibly an elevated respiratory rate (*NSTEMI: Causes, Symptoms, Diagnosis, Treatment & Outlook*, n.d.). Laboratory findings may include elevated cardiac biomarkers such as troponin and creatinine kinase-MB, indicating myocardial cell death.

Diagnostic testing for NSTEMI includes an electrocardiogram (ECG) and cardiac biomarker testing. The ECG may show ST-segment depression or T-wave inversion, indicating myocardial ischemia (*NSTEMI: Causes, Symptoms, Diagnosis, Treatment & Outlook*, n.d.). Laboratory tests for NSTEMI include cardiac biomarkers such as troponin and creatinine kinase-MB, which will confirm the diagnosis of NSTEMI.

The treatment of NSTEMI includes medical therapy and, in some cases, invasive procedures such as percutaneous coronary intervention (PCI) or coronary artery bypass graft (CABG) surgery (Capriotti, 2020). Medical treatment includes antiplatelet agents such as aspirin

and P2Y12 inhibitors, anticoagulants such as heparin or low-molecular-weight heparin, beta-blockers, and nitroglycerin. PCI or CABG may be necessary for patients with significant coronary artery disease (*NSTEMI: Causes, Symptoms, Diagnosis, Treatment & Outlook*, n.d.). This patient was given aspirin as an antiplatelet and Lovenox.

Pathophysiology References (2) (APA):

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

NSTEMI: Causes, Symptoms, Diagnosis, Treatment & Outlook. (n.d.). Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/22233-nstemi-heart-attack

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	**3.8-5.41**	**3.73**	**3.89**	**NSTEMI can cause anemia caused from decreased oxygen-carrying capacity of the blood.**
Hgb	**11.3-15.2**	**11.0**	**11.6**	**Anemia caused from decreased oxygen-carrying capacity of the blood.**
Hct	**33.2-45.3**	**33.0**	**35.0**	**Anemia caused from decreased oxygen-carrying capacity of the blood.**
Platelets	**149-393**	**248**	**308**	**NSTEMI can cause platelet activation and aggregation, which can lead to thrombosis and decreased platelet counts.**

WBC	**4.0-11.7**	**9.9**	**11.3**	**N/A**
Neutrophils	**45.3-79.0**	**72**	**77**	**N/A**
Lymphocytes	**11.8-45.9**	**20.7**	**13.6**	**N/A**
Monocytes	**4.4-12.0**	**5.6**	**6.7**	**N/A**
Eosinophils	**0.0-6.3**	**0.9**	**2.1**	**N/A**
Bands	**0.0-0.1**	**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**	**138**	**139**	**N/A**
K+	**3.5-5.1**	**4.0**	**3.7**	**N/A**
Cl-	**98-107**	**107**	**106**	**N/A**
CO2	**21-31**	**24**	**28**	**N/A**
Glucose	**74-109**	**74**	**59**	**The patient has a medical history of diabetes and NSTEMI can cause stress-induced hypoglycemia.**
BUN	**7-25**	**31**	**25**	**The decrease in blood floe to the kidneys during a NSTEMI can lead to a decreased renal perfusion and increase BUN levels.**
Creatinine	**0.60-1.20**	**0.80**	**0.64**	**N/A**
Albumin	**3.5-5.2**	**2.4**	**2.5**	**NSTEMI can cause hypoalbuminemia due to inflammation and fluid shifts.**
Calcium	**8.6-10.3**	**8.3**	**8.5**	**NSTEMI can cause hypocalcemia due to decreased myocardial contractility and decreased release of calcium.**
Mag	**1.6-2.4**	**2.0**	**2.0**	**N/A**

Phosphate	**2.5-5.0**	**2.6**	**N/A**	**N/A**
Bilirubin	**0.3-1.0**	**0.5**	**N/A**	**N/A**
Alk Phos	**34-104**	**77**	**N/A**	**N/A**
AST	**13-39**	**19**	**N/A**	**N/A**
ALT	**7-52**	**13**	**N/A**	**N/A**
Amylase	**40-140**	**N/A**	**N/A**	**N/A**
Lipase	**0-160**	**N/A**	**N/A**	**N/A**
Lactic Acid	**Less than 2**	**N/A**	**N/A**	**N/A**
Troponin	**0.000-0.030**	**0.108**	**0.124**	**Elevated troponin levels diagnose NSTEMI and are a response to myocardial injury.**
CK-MB	**0.60-6.3**	**1.99**	**N/A**	**N/A**
Total CK	**30-223**	**82**	**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	**0.86-1.14**	**1.48**	**N/A**	**The lab is elevated due to the activation of the coagulation system post NSTEMI.**
PT	**11.9-15.0**	**18.0**	**N/A**	**The lab is elevated due to the activation of the coagulation system post NSTEMI.**
PTT	**22.6-35.3**	**29.4**	**N/A**	**N/A**
D-Dimer	**0.00-0.62**	**Less than 0.27**	**N/A**	**N/A**
BNP	**0-100**	**130**	**245**	**This is elevated due to the lack of circulation from high troponin levels and decreased cardiac**

				output.
HDL	**Above 60**	**N/A**	**N/A**	**N/A**
LDL	**100-129**	**N/A**	**N/A**	**N/A**
Cholesterol	**Below 200**	**N/A**	**N/A**	**N/A**
Triglycerides	**Less than 150**	**N/A**	**N/A**	**N/A**
Hgb A1c	**5.7-6.4**	**N/A**	**N/A**	**N/A**
TSH	**0.45-5.33**	**1.97**	**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	**Yellow & clear**	**Yellow & cloudy**	**N/A**	**The patient is possibly contracting a UTI.**
pH	**5.0-8.0**	**5.5**	**N/A**	**N/A**
Specific Gravity	**1.005-1.034**	**1.022**	**N/A**	**N/A**
Glucose	**Normal**	**Normal**	**N/A**	**N/A**
Protein	**Negative**	**Negative**	**N/A**	**N/A**
Ketones	**Negative**	**Traced**	**N/A**	**NSTEMI can cause decreased renal perfusion and ketones show possible injury.**
WBC	**Less than 5**	**37**	**N/A**	**The patient is possibly contracting a UTI.**
RBC	**0-3**	**1**	**N/A**	**N/A**
Leukoesterase	**Negative**	**4+**	**N/A**	**NSTEMI can cause decreased renal perfusion and urinary retention leading to a UTI.**

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	N/A
PaO2	90-100	N/A	N/A	N/A
PaCO2	35-45	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A
SaO2	80-100	N/A	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	Gram negative bacteria	N/A	The NSTEMI can cause decreased renal perfusion and urinary retention which can grow bacteria.
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/AN	N/A	N/A

Lab Correlations Reference (1) (APA):

Sarah Bush Hospital

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

EKG was taken to assess the possibility of myocardial ischemia due to the elevated troponin levels, and there were significant abnormal findings. CT scan of the brain and head was taken to rule out any injuries or trauma from the fall subsequent to the syncope episode.

Diagnostic Test Correlation (5 points):

The purpose of the EKG is to visualize the electrical activity of the heart and helps diagnose the cardiac conditions such as a myocardial infarction and ischemia that can happen as a result to a NSTEMI. The purpose of the CT scan is to visualize abnormalities within the body that could quickly assess the extent of damage caused by injury or disease. A CT scan was needed for this patient because it's easy for elderly people to attain serious injuries after falls.

Diagnostic Test Reference (1) (APA):

Van, A. M. (2021). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications* (9th ed.). F. A Davis Company.

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

Home Medications (5 required)

Brand/Generic	**Levothyroxine/ Eltoxin**	**Apixaban/Eliquis**	**Furosemide/Lasix**	**Tramadol/ Ultram**	**Aspirin**
Dose	**25mcg**	**5mg**	**20mg**	**50mg**	**81mg**
Frequency	**Daily**	**BID**	**Daily**	**Q6H**	**Daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**

Classification	**Synthetic thyroxine; Thyroid hormone replacement**	**Factor Xa inhibitor; anticoagulant**	**Loop diuretic; Diuretic**	**Opioid agonist; opioid analgesic**	**Salicylate; NSAID**
Mechanism of Action	**This replaces endogenous thyroid hormone, which may exert its physiologic effects by controlling DNA transcription and protein synthesis.**	**Inhibits free and clot-bound factor Xa and prothrombinase activity and decreases thrombin generation and thrombus development**	**Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation**	**Binds with mu receptors and inhibits the reuptake of norepinephrine and serotonin**	**Blocks the activity of cyclooxyge the enzym needed for prostaglan synthesis. Platelet aggregatio inhibited b interfering productio thromboxa A2.**
Reason Client Taking	**Hypothyroidism**	**DVT**	**Edema**	**Pain**	**Anti-platel aggregate**
Contraindications (2)	**Hypersensitivity to levothyroxine (ONLY).**	**Active bleeding; hypersensitivity to apixaban**	**Anuria; hypersensitivity to furosemide**	**Asthma; alcohol intoxication**	**Active bleeding; current or recent GI bleeds**
Side Effects/Adverse Reactions (2)	**Arrhythmias, heart failure**	**Hypotension; excessive bleeding**	**Thromboembolism ; hypokalemia**	**Respiratory depression; adrenal insufficiency**	**GI bleedin prolonged bleeding ti**
Nursing Considerations (2)	**Use cautiously in elderly patients; Monitor for signs and symptoms of overtreatment of levothyroxine**	**Do not give with patients with severe hepatic dysfunction; monitor for bleeding**	**Administer slowly over 1-2 minutes; monitor for hypokalemia**	**Monitor for respiratory depression; monitor for serotonin syndrome symptoms**	**Ask about tinnitus; d crush unle advised**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**PT; blood glucose**	**INR; blood pressure**	**Potassium labs; obtain weight prior to administering**	**Assess respirations;**	**PT/INR; temperatu**
Client Teaching Needs (2)	**Take separate from antacids;**	**Report unusual bleeding to**	**Change positions slowly to minimize**	**Avoid hazardous**	**Take with food; avoi**

	take 30 minutes before breakfast	**provider; avoid razors**	**orthostatic hypotension; limit sodium intake**	**activities; Do not consume alcohol without prescriber knowledge**	**using with alcohol**

Brand/Generic	**Citalopram/ Celexa**	**Famotidine/ Pepcid**	**Atorvastatin/ Lipitor**	**Enoxaparin/ Lovenox**	**Insulin Aspart/ Novolog**
Dose	**10mg**	**20mg**	**80mg**	**50mg**	**10 units**
Frequency	**Daily**	**BID**	**Daily at bedtime**	**Q12H**	**TID**
Route	**PO**	**PO**	**PO**	**SubQ**	**SubQ**
Classification	**SSRI; Antidepressant**	**Histamine-2 blocker; antiulcer agent**	**HMG-CoA reductase inhibitor; antihyperlipidemic**	**Low-molecular-weight-heparin; anticoagulant**	**Human insulin; antidiabetic**
Mechanism of Action	**Blocks serotonin reuptake by adrenergic nerves which increases serotonin levels and elevate mood and reduce depression**	**Reduces HCL formation by preventing histamine from binding with H2 receptors on the surface or parietal cells**	**Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL to enhance uptake**	**Potentiates the action of antithrombin 3 and inactivates clotting factors.**	**Lowers blood glucose levels by stimulation peripheral glucose uptake by fat and skeletal muscle and by inhibiting hepatic glucose produciton**
Reason Client Taking	**Anxiety/ Depression**	**GERD**	**Hyperlipidemia**	**Anticoagulation**	**Diabeted**
Contraindications (2)	**Hypersensitivity to citalopram; use within 14**	**Hypersensitivity to famotidine (ONLY)**	**Active hepatic disease; hypersensitivity**	**HIT; hypersensitivity to enoxaparin**	**Chronic lung disease; hypersensiti**

	days of MAO inhibitors therapy		**to atorvastatin**		**vity to insulin**
Side Effects/Adverse Reactions (2)	**GI bleeding; decreased PT**	**Bronchospasm; dyspnea**	**Hypoglycemia; pancreatitis**	**Hyperkalemia; A-fib**	**DKA; hypokalemia**
Nursing Considerations (2)	**Monitor for serotonin syndrome; do not give with bradycardia**	**Do not give with patients with PKU; Shake oral suspension vigorously before administering**	**Used cautiously in patients with liver disease; expect to measure lipid levels 2-4 weeks after therapy**	**Expect to give with aspirin in NSTEMI; watch close for bleeding**	**Monitor for hypoglycemia; Do not use to treat DKA**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**HR; PT**	**Respirations; RBC**	**Liver function tests; blood glucose**	**Potassium levels; PT/INR**	**Blood glucose; potassium levels**
Client Teaching Needs (2)	**Do not abruptly stop; may lead to pupil dilation**	**Avoid alcohol and smoking on therapy; Do not take with other acid-reducing products**	**Take drug at the same time each day; take missed dose as soon as possible**	**Easy bruising; report signs of thromboembolism**	**Learn signs of hypoglycemia; avoid performing hazardous activities until effects**

Hospital Medications (5 required)

Medications Reference (1) (APA):

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

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is alert. Patient is oriented A&O X 3. Patient is in no acute distress. Patient is well-groomed.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Skin is dry and intact, no drains noted. Skin warm upon palpation. Skin color is normal for ethnicity. Skin turgor has normal mobility. No rashes or wounds present.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is midline with no deviations. Hair has normal distribution. Trachea is midline. Patient uses glasses regularly. Nose shows no deviation. Oral mucosa is pink and moist with no notable drainage. Dentures noted.**
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:**	**Irregular cardiac rhythm. S1 and S1 sound heard, radial and dorsalis pedal pulses palpable bilaterally.** **Capillary refill less than 3 secs bilaterally.** **No murmur or gallops present.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**The patient is breathing normal, breathe sounds clear bilaterally without the use of accessory muscles.** **The chest moves equally with respirations.** **There are no chest wall deformities.** **On palpation, chest expansion is equal on both sides.**
GASTROINTESTINAL: **Diet at home: Regular**	**Patient's abdomen is soft and non-tender. Normoactive bowel sounds in all 4 quadrants.**

Current Diet: Limited fried food and caffeine free beverages **Height: 170cm** **Weight: 52.9kg** **Auscultation Bowel sounds:** **Last BM: 02/20/2023** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N X** **Nasogastric: Y ☐ N X** **Size:** **Feeding tubes/PEG tube Y ☐ N X** **Type:**	**No abdominal tenderness, pain, or masses palpable.** **No distention, incision, scars, drains, or wounds.** **Patient is incontinent to bowel movements.**
GENITOURINARY: **Color: Yellow** **Character: Clear** **Quantity of urine: Small** **Pain with urination: Y ☒ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: External cathether** **Size: Small**	**Genitals are without rashes, lesions, and bumps. Genitals are clean, dry, and without abnormal discoloration.** **Patient has an external catheter in place due to incontinence episodes.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 17** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment X** **Needs support to stand and walk☐**	**Reflexes intact** **Full and functioning ROM is attainable for all extremities.** **Upper and lower extremities are 5 out of 5 in strength bilaterally.** **Peripheral pulses +2 and present** **Patient on bed rest** **Patient is a high fall risk; fall risk precautions include lowered bed, 3 bed rails raised, bed alarm activated, fall wrist band on, and room close to nurses station**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -**	**Oriented to person, place, and situation. Lacks orientation to date and time.** **Patient has calm and aware mental status.** **Patient's speech is clear.**

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Patient's sensory responses are intact and functioning properly.** **Patient is alert.**
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient stated that she had "no coping methods." Development level is age appropriate The patient is no longer religious for reasons unspecified. The patient's support system are friends; the patient stated that she "has no family."

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	64	135/83	17	35.9 C	98%
1100	59	113/59	18	35.0 C	97%

Vital Sign Trends: The patients vital signs were stable for the whole shift. The blood pressure was higher in the morning, but the patient has a history of hypertension.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	0-10	N/A	0	N/A	Continue to monitor.
1100	0-10	N/A	0	N/A	Continue to monitor.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G **Location of IV: Left peripheral forearm** **Date on IV: 2/10/2023** **Patency of IV: Patent** **Signs of erythema, drainage, etc.: None** **IV dressing assessment: Clean, dry, intact**	Saline lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
250 mL – orange juice	**40 mL – external catheter** **1 BM – incontinent**

Nursing Care

Summary of Care (2 points):

Overview of care: Patient was calm, but dismissive to staff about the orders from the doctor; patient felt like the doctor's orders were unnecessary even when attempts to educate were made.

Procedures/testing done: None

Complaints/Issues: Discharge; diet complaints

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: Regular diet with caffeine-free beverages. Up with 1 assist.

Physician notifications: Patient was refusing all orders

Future plans for client: Discharge to assisted living

Discharge Planning (2 points)

Discharge location: Assisted living

Home health needs (if applicable): N/A

Equipment needs (if applicable): Motion detection for fall prevention

Follow up plan: Follow up with PCP and neurology in March

Education needs: Severe education on syncope management, and precipitating factors to monitor and how to manage elevated troponin levels. Education of symptoms and of myocardial infarctions and angina.

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 impaired tissue perfusion related to decreased blood flow to the myocardium and potential for thrombosis as evidenced by abnormal cardiac rhythm.	**NSTEMI can cause significant damage to the heart muscle and requires urgent intervention to retore blood flow and prevent further damage.**	**1. Administer anticoagulation medications** **2. Implement measures to prevent thrombosis like applying SCDs**	**1. To improve cardiac rhythm and increase blood flow to the myocardium**	**The patient was calm when receiving anticoagulation medications but refused SCDs. The patient will need to be educated on the importance and reasoning behind SCDs.**

2. Risk for injury related to loss of consciousness and fall as evidenced by patient's history of syncope and reports of dizziness and lightheadedness.	**The patient is at risk for falls and other injuries due to the sudden occurrence of syncope.**	**1. Declutter the patients room often, keep the bed lowered, and bed alarm activated** **2.Educate the patient on the symptoms of syncope and how to manage it**	**1. To decrease the risk for falls and injury and keep the patient aware about how to react to an incoming syncope episode**	**The patient received the education and preventative measures well and described implementing these measures at her assisted living. The goal is still appropriate.**
3. Anxiety related to the fear of death or permanent disability as evidenced by verbalization of not wanting to die to staff and absence of coping methods.	**Anxiety can affect the patient's overall well-being and may require supportive measures to help alleviate fears and provide reassurance.**	**1.Work on defining proper coping methods** **2.Encourage the patient to discuss her feelings and concerns openly**	**1. The patient feels comfortable to express her fears and attains positive coping methods to handle her emotions.**	**The patient was hesitant to talk about her coping methods but opened up about their support systems and how they've helped her in her years. The patient reminisced on her past life and occupation as a teacher and smiled. Efforts can still be made towards assisting the patient with depression and anxiety.**
4. Deficient knowledge related to lack of information about the causes,	**The patient's understanding of the condition may affect their ability**	**1.Educate the patient on treatment of NSTEMI** **2. Educate the patient on lifestyle**	**1. The patient will be more receptive to treatment.**	**The patient was still dismissive of teaching efforts and was adamant on not**

symptoms, and management of syncope and NSTEMI as evidenced by patient's refusal of treatment and questioning the necessity.	**to manage and prevent future episodes of syncope.**	**changes that can help improve the patient's function of life**		**receiving certain treatment options. Efforts should still be made to teach her as much as possible.**

Other References (APA):

Concept Map (20 Points):

Subjective Data

- "I don't want to die"
- Dizziness
- Refusal of treatment
- Denies chest pain

Objective Data

- No head trauma
- Stable vitals
- Abnormal RBC, Hgb, Hct, BUN, BNP, troponin level, urinalysis, albumin, calcium
- Abnormal EKG and cardiac rhythm

Client Information

- 94 years old
- Female
- Past medical hx: **Diabetes, dementia, GERD, hypothyroidism, rectal bleeding, hyperlipidemia, hypertension, chronic anticoagulation, chronically elevated troponin, right hip fracture, anemia, CAD, recurrent syncope**
- Assisted living

Nursing Diagnosis/Outcomes

1 Diagnosis: **Risk for impaired tissue perfusion related to decreased blood flow to the myocardium and potential for thrombosis as evidenced by abnormal cardiac rhythm.**
1 Outcome: **To improve cardiac rhythm and increase blood flow to the myocardium**
2 Diagnosis: **Risk for injury related to loss of consciousness and fall as evidenced by patient's history of syncope and reports of dizziness and lightheadedness.**
2 Outcome: **To decrease the risk for falls and injury and keep the patient aware about how to react to an incoming syncope episode**
3 Diagnosis: **Anxiety related to the fear of death or permanent disability as evidenced by verbalization of not wanting to die to staff and absence of coping methods.**
3 Outcome: **The patient feels comfortable to express her fears and attains positive coping methods to handle her emotions.**
4 Diagnosis: **Deficient knowledge related to lack of information about the causes, symptoms, and management of syncope and NSTEMI as evidenced by patient's refusal of treatment and questioning the necessity.**
4 Outcome: **The patient will be more receptive to treatment.**

Nursing Interventions

1. Intervention: **Administer anticoagulation medications. Implement measures to prevent thrombosis like applying SCDs.**
2. Intervention: **Declutter the patient's room often, keep the bed lowered, and bed alarm activated. Educate the patient on the symptoms of syncope and how to manage it.**
3. Intervention: **Work on defining proper coping methods. Encourage the patient to discuss her feelings and concerns openly.**
4. Intervention: **Educate the patient on treatment of NSTEMI. Educate the patient on lifestyle changes that can help improve the patient's function of life.**