N321 Adult Health 1 Care Plan # 2

Lakeview College of Nursing

Name: Chiquita Baker, BSN Student

Instructor: Kristal Henry

Demographics (3 points)

Date of Admission	**Client Initials**	**Age**	**Gender**
3/5/2023	R.M.	85	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Self Employed	Married	No Known allergies
Code Status	**Height**	**Weight**	
Full Code	5'11	194 lbs	

Medical History (5 Points)

Past Medical History: He has a past medical history of acute kidney failure, atherosclerotic heart disease of the native coronary artery without angina pectoris, bilateral leg edema, BPH (benign prostatic hyperplasia), CKD (chronic kidney disease), complex tear of lateral meniscus of the left knee as current injury, coronary artery disease, diabetes mellitus, diabetic polyneuropathy (HCC), DJD (degenerative joint disease), Dupuytren's contracture of both hands, dyspepsia, GERD (gastroesophageal reflux disease), hyperlipemia, hypertension, long term use of insulin (current), MI (myocardial infarction) (HCC), nocturia, NSTEMI (non-st elevated myocardial infarction) (HCC), OA (osteoarthritis), pain in the left knee, polyneuropathy, PVD (peripheral vascular disease), SOB (shortness of breath), trigger finger, left middle finger, and trigger finger, left ring finger

Past Surgical History: He has a past surgical history that includes stent placement retro carotid.

Family History: His family history includes kidney disease in his son.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): He reports that he has never smoked. He has never used smokeless tobacco. He reports that he does not drink or use drugs.

Assistive Devices: He does not use any assistive devices.

Living Situation: He Lives at home with his wife and has a son who does not live in the home.

Education Level: He graduated high school, and did not go to college.

Admission Assessment

Chief Complaint (2 points): Chest pain

History of Present Illness – OLD CARTS (10 points): 85-year-old male with a history of CAD, DM, COPD, patient with mid-sternal chest pain and dyspnea that started on 3/5/2023. The pain has stopped as of 3/6/2023. He said the pain in his chest felt achy and it was difficult for him to breathe. Getting up and moving around made the chest pain and SOB worse. The client states that resting made him feel better and he also stated that he took 2 Alka -seltzer and that didn't stop the chest pain and that's when his son brought him to the hospital.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): A Fibrillation (A-Fib)

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): This patient was diagnosed with A-fib, which stands for atrial fibrillation and is a type of arrhythmia. It is caused by extremely fast abnormal beats in the upper chambers (atria) of the heart. In a healthy heart the upper chambers contract and push blood from the atria to the ventricles (the two lower chambers). Then the ventricles contract and push blood to the lungs and the rest of the body. When a person has A fib the electrical signals in the atria are faulty and cause the upper chambers to contract chaotically and irregularly with the lower chambers of the heart. If this happens there is a possibility for blood to pool in the atrium, which can lead to blood clots that could travel to the brain and cause a stroke.

A healthy heart beats 60 to 100 beats per minute, but with A fib the electrical impulses are firing from multiple sites in both atria instead of from the sinus node, this can make the heartbeat more than 400 times per minute. It overwhelms the upper and lower chambers not allowing them time to fill with blood and pump correctly. The rapid contractions of the atria make the ventricles beat too quickly and they don't receive enough blood and cannot meet the body's need for oxygenated blood which may lead to heart failure.

Some risk factors for A-fib are age older than 50, alcohol use, hypertension, and obesity. In some patients, atrial fibrillation has no symptoms and in others it can cause angina, dizziness, syncope, fatigue, palpitations, weakness, and shortness of breath. It usually doesn't cause death but could lead to more serious cases like blood clots, heart failure, and stroke which may be fatal. If a provider suspects a patient is in A-fib they will perform a physical examination, and they may also order an electrocardiogram (EKG). This is done by placing electrodes on the chest, arms, and legs and measuring electrical currents in the body. It provides information about how well the heart is pumping, the rate and rhythm of the heart, how the electrical signals in the heart travel, and which parts of the heart are contracting.

This is what the provider ordered for this patient and the results came back and showed he was indeed in A-fib. The provider then ordered enoxaparin which is used to prevent blood clots and clopidogrel which is a blood thinner that prevents stroke and heart attack. Luckily whatever was going on with this patient corrected on its own, he was monitored for another day then he was discharged from the hospital. The provider may also order some labs such as potassium and thyroid. These labs can help find the cause of A fib and tells how well your liver and kidneys are working. Which helps the doctor decide what medications are best for the patient. An echocardiograph is another test providers use to diagnose a fib. This is basically an

ultrasound that looks at the heart valves, chamber size, and heart pumping function. It also helps to identify blood-clots. The main goal of a fib treatment is to bring the heart back to normal sinus rhythm by controlling the heart rate and reducing the risk of stroke and blood clots. To do this providers may prescribe medications like digoxin, or metoprolol which prevent the ventricles from beating too fast. They may also give blood thinners like warfarin to reduce the risk of blood clots if medications don't help then the patient may have to have a surgical procedure done. Thankfully that wasn't the case for this patient.

Pathophysiology References (2) (APA):

Clinic, C. (2023). *Atrial fibrillation (AFIB): Causes, symptoms and treatment*. Cleveland Clinic. Retrieved March 10, 2023, from https://my.clevelandclinic.org/health/diseases/16765-atrial-fibrillation-afib

Clinic, M. (2021, October 19). *Atrial fibrillation*. Mayo Clinic. Retrieved March 10, 2023, from https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624#:~:text=Atrial%20fibrillation%20(A%2Dfib),and%20other%20heart%2Drelated%20complications.

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	4.40 – 5.80 mcl	4.92	4.80	
Hgb	13.0 – 16.5 g/dL	14.1	13.8	
Hct	38.0 – 50.0 %	42.7	41.7	
Platelets	140 – 440 mcl	172	148	
WBC	4.00 – 12.00 mcl	8.00	6.80	

Neutrophils	1.40 – 5.30 mcl	61.7	50.7	
Lymphocytes	19.0 – 49.0 %	25.7	35.3	
Monocytes	3.0 – 13.0 %	7.6	8.3	
Eosinophils	0.0 – 8.0 %	3.7	4.4	
Bands	0 – 5	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	139	140	
K+	3.5 – 5.1 mmol/L	4.0	3.6	
Cl-	98 – 107 mmol/L	106	106	
CO2	22 – 30 mmol/L	23		
Glucose	70 – 99 mg/dL	216	62	The client has diabetes mellitus. (Pagana, 2019)
BUN	8 -26 mg/dL	22	17	
Creatinine	0.70 – 1.30 mg/dL	1.48	1.23	The client is dehydrated. (Pagana, 2019)
Albumin	3.5 – 5.0 g/dL	3.3	3.1	The client has inflammation. (Pagana, 2019)
Calcium	8.7 – 10.5 mg/dL	8.6	8.6	The client has renal failure. (Pagana, 2019)
Mag	1.6 – 2.6 mg/dL	1.8	1.8	
Phosphate	3.0 – 4.5 mg/dL	N/A	N/A	
Bilirubin	0.2 – 1.2 mg/dL	0.5	0.8	
Alk Phos	40 – 150 u/L	115	107	
AST	5 – 34 u/L	24	22	

ALT	0 – 55 u/L	25	24	
Amylase	60 -120 uL	N/A	N/A	
Lipase	8 – 78 u/L	N/A	N/A	
Lactic Acid	0.7 – 2.0	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	1.0	1.1	
PT	10.1 – 13.1 sec	11.9	N/A	
PTT	25 – 36 sec	32	N/A	
D-Dimer	0 – 622 ng/mL	552	N/A	
BNP	0 – 100 pg/mL	98	N/A	
HDL	➢ 60	N/A	N/A	
LDL	< 130	N/A	N/A	
Cholesterol	< 200	N/A	N/A	
Triglycerides	40 – 180 mmol/L	N/A	N/A	
Hgb A1c	4.0 – 6.0 %	8.4	N/A	The client has diabetes mellitus. (Pagana, 2019)
TSH	0.300 – 5.000 mlu/L	N/A	1.538	

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	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 mg/dL	N/A	N/A	
Ketones	Negative mg/dL	N/A	N/A	
WBC	Negative 0 - 5/hpf	N/A	N/A	
RBC	Negative 0 – 2/ hpf	N/A	N/A	
Leukoesterase	Negative	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 < 10,000 Positive > 100,000	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Normal upper respiratory tract	N/A	N/A	
Stool Culture	Normal intestinal flora	N/A	N/A	

Lab Correlations Reference (1) (APA):

Pagana, Kathleen. (2019). Mosby's Diagnostic and Laboratory Test Reference, (14th ed.). Elsevier

Diagnostic Imaging

All Other Diagnostic Tests (5 points): N/A

Diagnostic Test Correlation (5 points): N/A

Diagnostic Test Reference (1) (APA):

Sparks & Taylor, (2020). Nursing Diagnosis Reference Manual (11th ed.). Linda Lee Phelps

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

Home Medications (5 required)

Brand/ Generic	tramadol (Ultram)	isosorbide mononitrate (Imdur)	nitroglycerin (Nitrostat)	albuterol (Proventil HFA)	aspirin (acetylsalicylic)
Dose	50 mg	30 mg	0.4 mg	2 puffs	81 mg
Frequency	Every 6 hours	Every morning	Every 5 minutes	Every 4 hours	Every other day
Route	Oral	Oral	Sublingual	Inhalation	Oral
Classification	Opioid agonist, Opioid analgesic	Nitrate, Antianginal	Nitrate, Antianginal, vasodilator	Adrenergic, bronchodilator	Salicylate, NSAID
Mechanism of Action	Binds with mu receptors and inhibits the reuptake of norepinephrine and serotonin, which may	Isosorbide may interact with nitrate receptors in vascular smooth-muscle cell membrane. By interacting with receptors'	May interact with nitrate receptors in vascular smooth-muscle cell membrane to reduce	Albuterol attaches to beta 2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate	Blocks the activity cyclooxygenase, the enzyme needed for prostaglandin synthesis.

	account for tramadol's analgesic effect.	sulfhydryl groups, drug is reduced to nitric oxide.	preload and afterload, decreasing myocardial workload and oxygen demand.	cyclase to convert adenosine triphosphate(ATP) to cyclic adenosine monophosphate (cAMP).	
Reason Client Taking	To manage moderately severe chronic pain.	To prevent angina.	To treat acute angina, to manage hypertension.	To prevent or treat bronchospasm.	To relieve mild pain or fever
Contraindications (2)	Significant respiratory depression, acute or severe bronchial asthma in the absence of resuscitative equipment	Patients with low blood pressure, concurrent use of phosphodiesterase inhibitor.	Acute MI, angle-closure glaucoma, cerebral hemorrhage.	Patients with high blood pressure, and patients with an overactive thyroid gland.	Active bleeding or coagulation disorders; breastfeeding
Side Effects/Adverse Reactions (2)	Seizures, suicidal ideation	Arrhythmias, hemolytic anemia	Hypotension, syncope	Angina, Anxiety, dizziness	CNS depression, GI bleeding
Nursing Considerations (2)	Be aware that tramadol shouldn't be given to patients with a history of anaphylactoid reactions to codeine or other opioids, Avoid giving tramadol to	Use cautiously in patients with hypovolemia, or mild hypertension, monitor blood pressure often during isosorbide therapy, especially in elderly patients; the drug may cause severe	Check vitals before every dosage adjustment and often during therapy, plan a nitroglycerin-free period of about 10 hours each day as	Use cautiously in patients with cardiac disorders, Monitor serum potassium level because albuterol may cause transient hypokalemia	Be aware that elderly patients and dehydrated febrile children are at higher risk for toxicity, Monitor salicylate level in patients receiving long term therapy.

	patients with acute abdominal conditions because it may mask evidence and disrupt assessment of the abdomen.	hypotension.	prescribed, to maintain therapeutic effects and avoid tolerance.		

Hospital Medications (5 required)

Brand/ Generic	acetaminophen (Tylenol)	atorvastatin (Lipitor)	calcium carbonate (Tums)	enoxaparin (Lovenox)	clopidogrel (Plavix)
Dose	650 mg	40 mg	1000 mg	90 mg	75 mg
Frequency	Every 4 hours PRN	Nightly	Every 8 hours	Every 12 hours	75 mg
Route	Oral	Oral	Oral	Subcutaneous	Oral
Classification	Non salicylate, Antipyretic	HMG-CoA reductase inhibitor, antihyperlipidemic	Calcium salts, antacid	Low-molecular-weight heparin, anticoagulant	P2Y12 platelet inhibitor, Platelet aggregation inhibitor
Mechanism of Action	Inhibits the enzyme cyclooxygenase, blocking	Reduces plasma cholesterol and lipoprotein	Increases levels of intracellular and	Potentiates the action of antithrombin III, a	Binds to adenosine diphosphate receptors

	prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors in liver cells to enhance LDL uptake and breakdown.	extracellular calcium, which is needed to maintain homeostasis, especially in the nervous system.	coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with an inactivates clotting factors.	on the surface of activated platelets, this action blocks ADP.
Reason Client Taking	Mild or severe pain	To control lipid levels	Heartburn/ indigestion	To prevent blood clots	To reduce the risk of CVA and MI
Contraindications (2)	Severe hepatic impairment, severe active liver disease	Active hepatic disease, breastfeeding, pregnancy	Cardiac resuscitation with risk of existing digitalis toxicity or presence of ventricular fibrillation, concurrent use of calcium supplements.	Active major bleeding, history of immune-mediated heparin-induced thrombocytopenia within the past 100 days, or in the presence of circulating antibodies	Active pathological bleeding, hemorrhage, and peptic ulcers
Side Effects/Adverse Reactions (2)	Hepatotoxicity, anaphylaxis	Hypoglycemia, hepatic failure	Hypotension, hypercalcemia	Heart failure, atrial fibrillation	Fatal intracranial bleeding, hallucinations, depression
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment or active hepatic disease,	Be aware that atorvastatin may be used with colestipol or cholestyramine for additive antihyperlipide	Check the intravenous site regularly for infiltration because calcium	Use cautiously in those with bleeding diathesis, be aware that the drug isn't recommended for patients	Be aware that clopidogrel prolongs bleeding time, and monitor patients

	Monitor renal function in patient on long term therapy.	mic effects, monitor diabetic patient's blood glucose levels because atorvastatin therapy can affect blood glucose.	causes necrosis, monitor serum calcium levels in all patients and evaluate therapeutic response by assessing for Chvostek's and Trousseau' s sign, which shouldn't appear.	with prosthetic heart valves	who take aspirin closely because risk of bleeding is increased.

Medications Reference (1) (APA):

Jones & Bartlett Learning, (2023). Nurse's Drug Handbook (22nd ed.). Jones & Bartlett

Assessment

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

GENERAL: **Alertness:** Alert and responsive **Orientation:** person, place, situation, time **Distress:** no acute distress **Overall appearance:** appropriate	
INTEGUMENTARY: **Skin color:** pale	

Character: intact and dry **Temperature:** warm **Turgor:** normal mobility **Rashes:** no rashes **Bruises:** no bruises **Wounds:** no wounds **Braden Score:** 21 **Drains present: Y☒ N ☐** **Type:** N/A	
HEENT: **Head/Neck:** Normocephalic and atraumatic **Ears:** hearing aids present, no abnormal findings present **Eyes:** PERRLA present, EOM intact **Nose:** No polyps, lumps, bumps, or bleeding **Teeth:** No dentures	.
CARDIOVASCULAR: **Heart sounds:** normal heart sounds S1, S2, present **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** normal rate and rhythm **Peripheral Pulses:** 3+ **Capillary refill:** less than 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character:** respirations regular, unlabored, breath sounds clear throughout bilaterally.	.
GASTROINTESTINAL: **Diet at home:** regular **Current Diet:** clear diet **Height:** 5’11 **Weight:** 194 lbs **Auscultation Bowel sounds:** active **Last BM:** 3/5/2023 **Palpation: Pain, Mass etc.:** N/A **Inspection:** **Distention:** no distention	.

Incisions: no incision **Scars:** no scars **Drains:** no drains **Wounds:** no wounds **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** N/A **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** N/A	
GENITOURINARY: **Color:** Yellow **Character:** clear **Quantity of urine:** X 1 occurrence **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** patient states there are no abnormal findings this nursing student did not assess genitals. **Catheter: Y ☐ N ☒** **Type:** N/A **Size:** N/A	
MUSCULOSKELETAL: **Neurovascular status:** Nail beds intact, extremities warm and dry **ROM:** active **Supportive devices:** N/A **Strength:** 5/5 bilateral upper/ lower extremities **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** 65 **Activity/Mobility Status: active mobility** **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☐ N/A **Needs support to stand and walk** ☐ N/A	.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** person, place, situation, and time **Mental Status:** Normal cognition **Speech:** clear	.

Sensory: normal sensory **LOC:** alert – awake and answers questions appropriately	
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** talking with wife, watching tv **Developmental level:** the client can read and write, he graduated high school. **Religion & what it means to pt.:** the client does not practice religion **Personal/Family Data (Think about home environment, family structure, and available family support):** the client lives at home with his wife and has one son not in the home.	.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:20	73	157/85	20	98.4	96%
11:00	73	156/75	20	98.5	97%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:20	0 – 10	N/A	0	N/A	N/A
11:00	0 – 10	N/A	0	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock

Size of IV: 18 G **Location of IV:** left forearm **Date on IV:** 03/05/2023 **Patency of IV:** IV patent **Signs of erythema, drainage, etc.:** No **IV dressing assessment:** Clean, dry, and intact, saline heplock	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
720 mL	X 1 occurrence

Nursing Care

Summary of Care (2 points)

Overview of care: I came in to see the patient at 7:00 am. I took his vitals and administered his medication, as well as gave him some fresh water. I then did a head-to-toe assessment and helped him get cleaned up. I changed his bed linen and helped him to the restroom X 1 occurrence.

Procedures/testing done: No testing or procedures were done.

Complaints/Issues: Chest pain and shortness of breath.

Vital signs (stable/unstable): Stable.

Tolerating diet, activity, etc.: The patient is tolerating the current diet.

Physician notifications: N/A

Future plans for client: I have plans for this client to continue taking his medications as prescribed and return to the hospital if the chest pain returns and doesn't subside after taking his nitroglycerin, 3 doses 5 minutes apart.

Discharge Planning (2 points)

Discharge location: The patient is going home with his wife.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow-up plan: The patient should follow up with his provider if his chest pain or shortness of breath returns.

Education needs: Reeducate the patient on the importance of taking his insulin when it is scheduled.

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

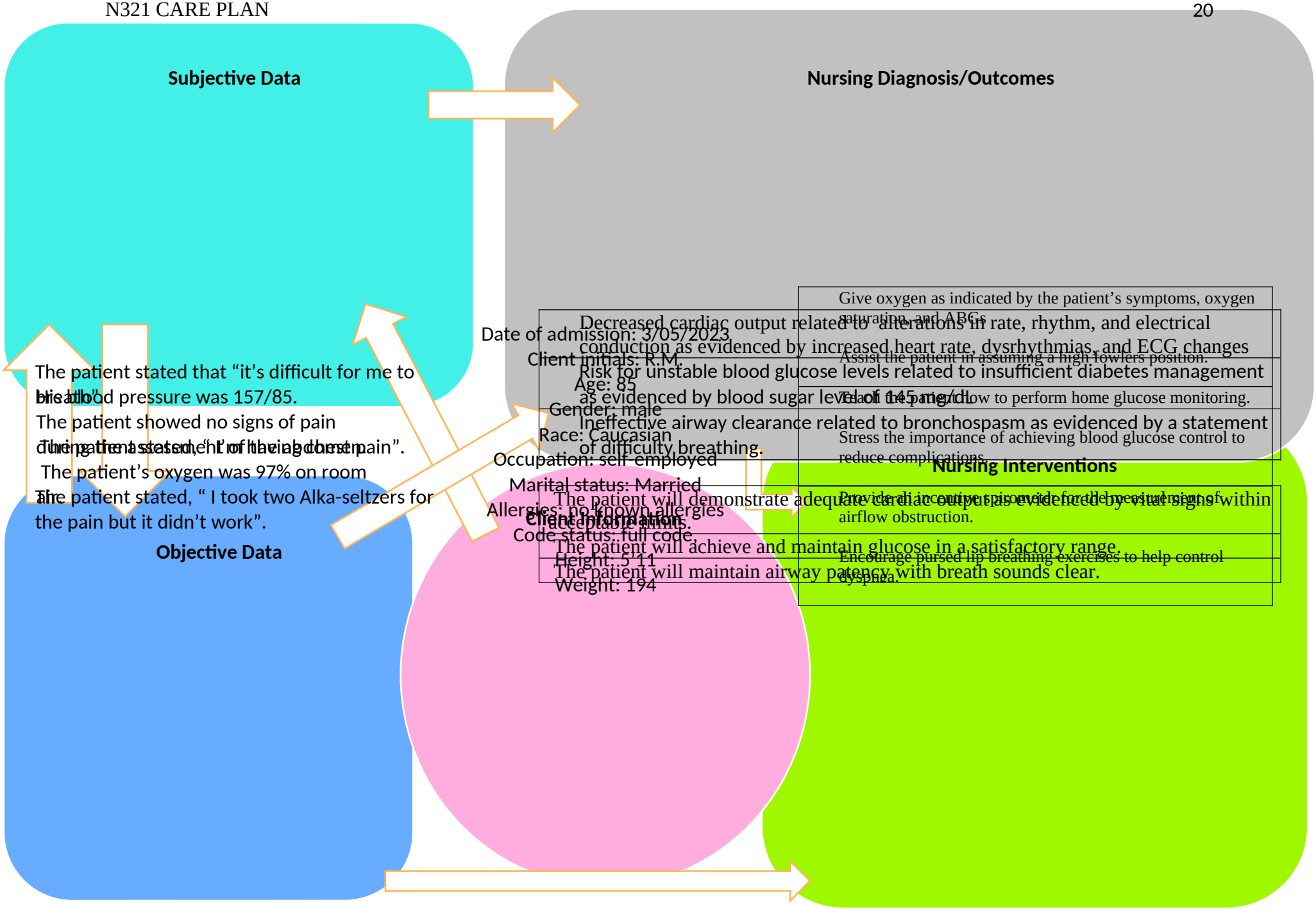
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Decreased cardiac output related to alterations in rate, rhythm, and electrical conduction as evidenced by increased heart rate, dysrhythmias, and ECG changes	The client came to the hospital complaining of chest pain and shortness of breath.	1. Give oxygen as indicated by the patient's symptoms, oxygen saturation, and ABGs 2. Assist the patient in assuming a high fowlers position.	1. The patient will demonstrate adequate cardiac output as evidenced by vital signs within acceptable limits.	The patient's cardiac output remains adequate.
2. Risk for unstable blood glucose	The client has a long history of	1. Teach the patient how to perform home	1. The patient will achieve and	The patient maintained a fasting blood

levels related to insufficient diabetes management as evidenced by blood sugar level of 145 mg/dL	diabetes mellitus.	glucose monitoring. 2. Stress the importance of achieving blood glucose control to reduce complications.	maintain glucose in a satisfactory range.	glucose level of less than 140 mg/dL.
3. Ineffective airway clearance related to bronchospasm as evidenced by a statement of difficulty breathing.	The client stated he had some shortness of breath, and he has COPD.	1. Provide an incentive spirometer for the measurement of airflow obstruction. 2. Encourage pursed lip breathing exercises to help control dyspnea.	1. The patient will maintain airway patency with breath sounds clear.	Auscultation of the patient's lung fields reveals no adventitious breath sounds.

Other References (APA):

Sparks & Taylors, (2020). Nursing Diagnosis Reference Manual (11th ed.). Linda Lee Phelps

Concept Map (20 Points):


Subjective Data
The patient stated that “it’s difficult for me to breath”
The patient stated, “I have a chest pain”.
The patient stated, “ I took two Alka-seltzers for the pain but it didn’t work”.
Objective Data
Blood pressure was 157/85.
The patient showed no signs of pain during the assessment.
The patient’s oxygen was 97% on room air.
Nursing Diagnosis/Outcomes
Decreased cardiac output related to alterations in rate, rhythm, and electrical conduction as evidenced by increased heart rate, dysrhythmias, and ECG changes
Risk for unstable blood glucose levels related to insufficient diabetes management as evidenced by blood sugar level of 145 mg/dL
Ineffective airway clearance related to bronchospasm as evidenced by a statement of difficulty breathing.
Client Information
Date of admission: 3/05/2023
Client initials: R.M.
Age: 85
Gender: male
Race: Caucasian
Occupation: self-employed
Marital status: Married
Allergies: no known allergies
Code status: full code
Height: 5’11
Weight: 194
The patient will demonstrate adequate cardiac output as evidenced by vital signs within acceptable limits.
The patient will achieve and maintain glucose in a satisfactory range.
The patient will maintain airway patency with breath sounds clear.
Nursing Interventions
Give oxygen as indicated by the patient’s symptoms, oxygen saturation, and ABGs.
Assist the patient in assuming a high fowlers position.
Teach the patient how to perform home glucose monitoring.
Stress the importance of achieving blood glucose control to reduce complications.
Provide an environment conducive for the measurement of airflow obstruction.
Encourage pursed lip breathing exercises to help control dyspnea.