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Lakeview College of Nursing

N431: Adult Health II

Professor Linda Scribner

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Demographics (3 points)

Date of Admission 02/05/2024	Client Initials KLW	Age 84 10/10/1939	Gender male
Race/Ethnicity White Caucasian	Occupation Mechanic	Marital Status Married	Allergies Phenergan (promethazine), Sulfonamide antibiotic,
Code Status Full code/attempt CPR	Height 162.6 cm (5' 4'')	Weight 92.1 kg (203 lb.)	

Medical History (5 Points)

Past Medical History: The patient has coronary artery disease (CAD), HTN, DM2, chronic respiratory failure, colon polyps, sleep apnea syndrome, hyperlipidemia, aortic stenosis, carotid stenosis, floaters.

Past Surgical History: Left knee surgery (cartilage tear, 1988), thyroid gland surgery (1970), coronary artery bypass (2000), toe amputation (2019).

Family History: Mother and father lived to old age; one parent had Alzheimer disease. The patient had four brothers and five sisters. Only one brother is still alive. One sister died as a child from brain tumor, one brother died from ALS. He does not remember in details the family history.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): patient was a smoker for 20 years, 5 packs a day, when he was young. He stopped smoking during 70'. Patient denies use of alcohol or drugs.

Assistive Devices: walker

Living Situation: The patient lives with his wife in their house. They are still independent and can help each other. Family helps them too.

Education Level: GED

Admission Assessment

Chief Complaint (2 points): Shortness of breath, extreme fatigue.

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

The patient has had coronary artery disease (CAD) for the last 25 years. In the last few weeks, the problems have become more evident. The patient was getting tired, short of breath, and dizzy. The duration of these symptoms was during walking or associated with other physical activity. At first, the rest would help with symptoms, but with time, the rest was not helping anymore. The patient did not have any other treatment besides his regular medications. Problems were getting more severe. In the end, his family brought him to the Emergency Department, where he was diagnosed with atrial fibrillations and high troponin levels.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Atrial fibrillation.

Secondary Diagnosis (if applicable): n/a

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

Coronary Artery Disease

Coronary arteries are small arteries that supply blood rich in oxygen and nutrients to the heart muscle. If these blood vessels get narrowed with atherosclerotic plaques, the heart muscle cannot get enough oxygen for its metabolic demand and starts to get damaged. This lack of oxygen leads to symptoms like precordial chest pain, usually described as squeezing or choking. A person becomes short of breath. These symptoms of precordial pain are called angina pectoris,

and it is reversible. If a plaque in coronary blood vessels ruptures the intima layer, a thrombus can form and   close the artery almost entirely, and that can cause myocardial infarction (MI). Myocardial infarction produces more significant damage to the myocardium than angina pectoris. If muscle cells are without oxygen for longer, many will die and become necrotic (Capriotti, 2020). The size of the damage depends on how big the occluded blood vessel is. The larger the occluded vessel, the more significant the damage to the heart. The symptoms of myocardial ischemia are chest pain that radiates to the left shoulder, jaw, or back, as well as extreme anxiety, SOB, pallor, weak pulses, and diaphoresis (Capriotti, 2020). Diagnosis of MI is based on EKG with ST elevation and lab results for cardiac enzymes like CPK-MB and cardiac troponin 1 (cardiac protein specific for necrosis) (Hinkle et al., 2022). The the patient this student studied was admitted because of shortness of breath, extreme tiredness, and cough. The patient had CAD in the past twenty-five years. He had a bypass surgery in 2000. There are new plaques in the patient's coronary arteries, even in the grafts he received in 2000. He had atrial fibrillations and very high Troponin I (cTnI) protein on admission. This shows that the heart was not functioning correctly. Not enough oxygen was getting to the heart muscle, and the sign of damage was the high Troponin I that leaked out of dead muscle cells. This client first had a catheterization of the coronary blood vessels to find out where the problems were. There were plaques in several places, even on the grafts done before. The next was cardioversion, which stabilized the patient's heart function using electricity. Heart rhythm became regular sinus rhythm. After that, the patient received two stents. The patient stated that he feels much better. He is still under observation.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical*

   Pe*rspectives.* F. A. Davis.

Hinkle, J. L., Cheever, K. H. & Overbaugh, K. (2022). *Bruner's & Suddartth's Textbook of*

   Medical Surgical Nursing. Walter Kluwer.

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Laboratory Data (15 points)

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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	**4.10-5.70 mil/mcL**	4.21 mil/mcL	4.38 mil/mcL	Normal value
Hgb	**12.0-18.0 g/dL**	12.6 g/dL	12.4 g/dL	Normal value
Hct	**37.0-51.0 %**	40.0 %	40.3 %	Normal value
Platelets	**140-400mcL**	237 mcL	268 mcL	Normal value
WBC	**4.00-11.00 x10 mcL**	8.94 mcL	9.63 mcL	Normal value
Neutrophils	**50-80%**	79.7	==81.0==	Increased in infection
Lymphocytes	**20-40%**	==7.9==	==11.1==	Decreased probably due to malnutrition and lack of vitamins.
Monocytes	**2-8%**	==10.5==	==7.2==	Increased in cardiovascular diseases
Eosinophils	**5%**	1.3	0.3	Normal value
Bands	**0-6%**	n/a	n/a	n/a

Chemistry <mark>Highlight All Abnormal Labs</mark>—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-	**136-145mmol/L**	137	138	Normal value
K+	**3.5-5.1mmol/L**	4.4	4,2	Normal value
Cl-	**98-107mmol/L**	100	<mark>96</mark>	Electrolyte disbalance due to infusions.
CO2	**22.0-29.0 mmol/L**	25.0	23.0	Normal value
Glucose	**70-100 mg/dL**	<mark>201</mark>	<mark>269</mark>	Patient has DM
BUN	**8-26 mg/dL**	26	<mark>43</mark>	Renal problems due to heart problems
Creatinine	**0.70-1.30 mg/dL**	1.09	<mark>1.32</mark>	Renal problems due to heart disease
Albumin	**3.4-4.8 g/dL**	<mark>3.2</mark>	<mark>3.2</mark>	Malnutrition
Calcium	**8.9-10.6 mg/dL**	<mark>8.7</mark>	9.1	Malnutrition
Mag	**1.6-2.6mg/dL**	2.4	2.1	Normal values
Phosphate	**3-4.5 mg/dL**	n/a	n/a	n/a
Bilirubin	**0.2-1.2**	0.4	0.7 mg/dL	Normal values
Alk Phos	**40-150 U/L**	61	59	Normal values
AST	**5-34 U/L**	20	<mark>40</mark>	Liver damage due to statin therapy or other medications
ALT	**0-55U/L**	20	47	Normal value
Amylase	**30-220U/L**	n/a	n/a	n/a
Lipase	**0-160U/L**	n/a	n/a	n/a
Lactic Acid	**3-7 mg/dL**	n/a	n/a	n/a

Troponin	0.00-0.03ng/mL	159-2070 ng/mL	n/a	n/a
CK-MB	0-4.0 ng/mL	n/a	n/a	n/a
Total CK	22-269 IU/L	n/a	n/a	n/a

Other Tests <mark>Highlight All Abnormal Labs</mark>—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	**1-2**	1.3	n/a	Normal value
PT	**11.7-13.8**	16.2 sec	n/a	The patient was on Eliquis
PTT	**22.4-35.9 sec**	n/a	<mark>140.4 sec</mark>	Patient received anticoagulants before catheterization
D-Dimer	**<0.5 mg/L**	n/a	n/a	n/a
BNP	**22-77 ng/L**	n/a	n/a	n/a
HDL	**65 mg/L**	n/a	n/a	n/a
LDL	**<100mg/L**	n/a	n/a	n/a
Cholesterol	**<200mg/L**	n/a	n/a	n/a
Triglycerides	**<150 mg/L**	n/a	n/a	n/a
Hgb A1c	**<5.7-6.4**	n/a	n/a	n/a
TSH	**0.4-4.0milliU/L**	n/a	n/a	n/a

Urinalysis <mark>Highlight All Abnormal Labs</mark>—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	n/a
pH	**4.5 – 8.0**	n/a	n/a	n/a

Specific Gravity	1.050 – 1.025	n/a	n/a	n/a
Glucose	negative	n/a	n/a	n/a
Protein	0 mg/dL	n/a	n/a	n/a
Ketones	negative	n/a	n/a	n/a
WBC	negative	n/a	n/a	n/a
RBC	negative	n/a	n/a	n/a
Leukoesterase	negative	n/a	n/a	n/a

Arterial Blood Gas <mark>Highlight All Abnormal Labs</mark>—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	<mark>7,288</mark>	N/A	Respiratory acidosis was caused by problems in blood oxygenation.
PaO2	80.0 -100.0	n/a	N/A	n/a
PaCO2	35.0- 45.0	<mark>51.7</mark>	N/A	Respiratory acidosis
HCO3	22.0-26.0	24.2	N/A	Normal value
SaO2	95-100 %	N/A	N/A	N/A

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	negative	n/a	n/a	N/A

Blood Culture	negative	N/A	N/A	N/A
Sputum Culture	negative	N/A	N/A	N/A
Stool Culture	negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J. & Pagana, T. N. (2022). *Mosby's Manual of Diagnostic and*

   Laboratory Tests. Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): EKG and coronary artery catheterization

Diagnostic Test Correlation (5 points): EKG showed the atrial fibrillation and A-V block.

Catheterization was done to find where to instill new stents.

Diagnostic Test Reference (1) (APA):

Hinkle, J. L., Cheever, K. H. & Overbaugh, K. (2022). *Bruner's & Suddartth's Textbook of*

   Medical Surgical Nursing. Walter Kluwer.

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

Home Medications (5 required)

(Brand)/ Generic	Metformin hydrochloride /(Glucophage)	Tamsulosin (Plavix)	Metoprolol succinate ER (Toprol XL)	Insulin glargine (Basaglar Kwik Pen) 3mL 100U/mL	Albuterol sulfate 2.5mg/3mL(0.083%) nebulizer

Dose	5mg tab	0.4 mg extended-release caps	25 mg ER tab	50 U sc. injection	Inhale 3mL 2.5mg total
Frequency	2x daily	HS	2x daily	2 x daily	Q 6 hrs. PRN
Route	PO	PO	PO	SC	inhaler
Classification	Therapeutic: antidiabetics Pharmacologic: biguanides	Therapeutic: BPH drugs Pharmacologic: alfa blocker	Therapeutic: antihypertensives Pharmacologic: selective beta-adrenergic blocker	Therapeutic: antidiabetic Pharmacologic: insulins	Therapeutic: bronchodilators Pharmacologic: adrenergic
Mechanism of Action	Decreases glucose production in liver and GI absorption.	Relaxes smooth muscles of bladder neck and prostate and improves urine flow.	Selective beta blocker. Decreases CO and peripheral resistance. Depresses renin secretion.	Help intake of glucose into the muscle cells and hepatocytes and lovers the level of glucose in the blood.	Relaxes smooth muscle in bronchia, and blood vessels.
Reason Client Taking	Diabetes mellites type 2	Benign prostatic hypertrophy/micturition agent	Hypertension arrhythmia	The patient has diabetes mellitus (DM).	Patient has cough, non-productive.
Contraindications (2)	Liver disease. Renal problems with lactic acidosis.	Don't use in head injury or increased ICP Do not use in paralytic ileus	Sinus bradycardia. Liver disease.	Diabetic ketoacidosis. Fasting patients.	Cardiovascular disorders. Hyperthyroidism.
Side Effects/Adverse Reactions (2)	HTN, hypoglycemia, myalgia, N/V.	Dizziness, syncope Increased cough, orthostatic hypotension	Hypotension, stroke, rush, pruritus.	Hypoglycemia Hypokalemia	Tachycardia, tremor, nervousness, insomnia.
Nursing Considerations (2)	Monitor for low vit B12. Monitor for lactic acidosis.	Monitor for low BP. Monitor for HR.	Always check apical pulse before administer. This drug can	Hypoglycemia can be treated with oral glucose.	Monitor for toxicity in patients who use pills and inhaler.

			mask tachycardia.		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Get GFR, do not give if <30mL/min. Discontinue if acute congestive HF.	Assess for sulfa allergy. Do not give if positive.	Assess HR and BP before administer.	Check blood glucose before administering insulin. Check A1c.	Check potassium level, because albuterol can decrease level of potassium. Check vitals.
Client Teaching Needs (2)	Do not take with alcohol Stop medication if slow or irregular HR, hyperventilation, sleepiness	Do not crush, chew or open capsule. Report priapism immediately.	Take with meal or immediately after. Report every side effect.	Do not share insulin pen with other people because of infection. Check insulin label before use. Rotate injection site. Caution while driving.	If more than one inhalation ordered, wait two minutes between inhalations. If using corticosteroid inhaler too, use it after albuterol. Teach the patient how to use spacer and how to clean it weekly.

Hospital Medications (5 required)

Brand/ Generic	apixaban (Eliquis)	Amiodarone hydrochloride (Nexterone)	Aspirin (Bayer aspirin)	Atorvastatin (Lipitor)	Clopidogrel (Plavix)
Dose	5 mg tab	200 mg tab	81 mg tab	80 mg	75 mg
Frequency	2x daily	daily	daily	HS	daily

Route	PO	PO	PO	PO	PO
Classification	Therapeutic: anticoagulant Pharmacologic: factor Xa inhibitor	Therapeutic: antiarrhythmics Pharmacologic: benzofuran derivatives	Therapeutic: NSAIDs Pharmacologic: Salicylates	Therapeutic: antilipemic Pharmacologic: HMG-CoA reductase inhibitor.	Therapeutic: antiplatelet drugs Pharmacologic: platelet aggregation inhibitors
Mechanism of Action	Selective inhibition of factor Xa and decrease thrombus production.	Blocks potassium chloride causing larger duration of action potential.	Analgesia. Decrease fever acting on hypothalamus. Prevents clotting by acting on platelets.	Inhibits enzyme HMG-CoA reductase and decrease production of cholesterol by the liver.	Inhibits ADP binding to platelets preventing them from aggregation.
Reason Client Taking	Prevents embolism in patients with atrial fibrillation.	Patient takes it to prevent life threatening arrhythmia.	Patient takes it to prevent clotting.	Patient has coronary artery disease and hypercholesterolemia.	Patient has CAD and had MI in the past.
Contraindications (2)	In patients who will have spinal surgery can cause hematoma w paralysis. Contraindicated in severe renal disease (bleeding).	Avoid in patients with atrial fibrillation. Contraindicated in cardiogenic shock.	Thrombocytopenia, liver impairment. Peptic ulcer.	Heavy alcohol use, damaged liver, renal failure.	Contraindicated in the time of surgical procedure. Contraindicated in those with bleeds.
Side Effects/Adverse Reactions (2)	Major bleeding, anemia, bruising.	Heart block, asystole, severe pulmonary toxicity, blue-gray skin.	GI bleeding, angioedema, Reye syndrome.	Rhabdomyolysis arthralgia, extremity pain.	Intracranial bleeding, hematuria.
Nursing Considerations (2)	Monitor for bleeding. If switching from warfarin to apixaban, stop warfarin and wait for	Medication can cause hypo or hyperthyroidism. It can cause liver damage.	Monitor salicylate level. Stop medication 7 days before surgery.	Patient should try low cholesterol diet before starting on this medication.	Monitor for thrombocytopenia. Monitor for renal Teach patient to report

	INR to be < 2.0.			The medication can cause liver damage.	
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check for INR, PT, aPTT.	Check thyroid hormones. Check electrolytes.	Assess the patient for GI bleeds. Check BUN, potassium before administering aspirin, because aspirin will increase these values.	Assess patient for causes of hypercholesterolemia. Get baseline lipid profile. Get liver panel tests.	Assess patient for bleeding. Check bleeding time.
Client Teaching Needs (2)	Teach patient not to stop taking medication w/o consulting the doctor because of clotting. Tell patient to inform all health providers about taking this drug.	Teach patient to wear sunscreen. Check vision and report any changes.	Teach patient not to chew or crush the enteric coated aspirin. Teach patient not to take alcohol if taking aspirin.	Teach patient about good diet, exercise and weight control. Tell patient to avoid alcohol.	Teach patient to report unusual bleeding and bruising. Teach patient to avoid injury.

Medications Reference (1) (APA):

Jones & Bartlet Learning. (2020). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett

Learning.

Assessment

Physical Exam (18 points) – <mark>HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS</mark>

GENERAL: **Alertness:** alert **Orientation:** oriented x4 **Distress:** no distress **Overall appearance:** well groomed, clean	
INTEGUMENTARY: **Skin color:** pink **Character:** dry **Temperature:** worm **Turgor:** fast recoil **Rashes:** no rashes noted on the skin **Bruises:** <mark>bruises present on the both arms, due to iv injections, blood samples draw</mark>. **Wounds:** no new wounds noted. <mark>There are old postsurgical scars on the chest, neck and legs.</mark> **Braden Score:** 18 **Drains present: Y**☐ **N** ☒ **Type:** n/a	
HEENT: **Head/Neck:** are symmetrical, trachea in midline without deviation, thyroid not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. No lymphadenopathy in the head or neck is noted. **Ears:** Auricles have no visible or palpable deformities, lumps or lesions bilaterally. Ear canal clear, no discharge noted bilaterally. Hearing aids not in ear canals. <mark>Patient can</mark> <mark>hear increased tone of voice.</mark> **Eyes:** Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink. Bilateral lids moist w/o discharge or lesions noted. PERRLA bilaterally, EOMs intact bilaterally. <mark>Patient wears glasses</mark>. **Nose:** Septum is in midline, turbinates moist and pink, no polyps, no exudate noted. No discharge from nasal canals bilaterally. Bilateral frontal and maxillary sinuses nontender on palpation. **Teeth:** <mark>The patient wears dentures</mark> (upper and lower).	.
CARDIOVASCULAR: **Heart sounds:** Clear S1 and S2, but <mark>diminished.</mark> <mark>**No noted murmurs, gallops, rubs.**</mark> **Cardiac rhythm:** normal rhythm and rate. PMI palpable at 5th intercostal space at MCL. **Peripheral Pulses:** pulses palpable throughout bilaterally, 2+, <mark>1+ on lower extremities</mark> **Capillary refill:** less than 3 seconds	.

Neck Vein Distention: Y ☐ N ☒ **Edema Y ☒ N ☐** **Location of Edema:** <mark>lower extremities</mark>	
RESPIRATORY: **Accessory muscle use:** Y☐ N ☒ **Breath Sounds:** Location, character Normal rate and pattern of breathing. Lung sounds clear anteriorly and posteriorly. No wheezes, crackles or rhonchi noted.	.

GASTROINTESTINAL:
 Diet at home: regular and cardiac diet. <mark>The patient does not follow the cardiac diet all the time.</mark>
 Current Diet: cardiac diet.
 Height: 162.6 cm
 Weight: 92.1 kg
 Auscultation Bowel sounds: normal, normoactive in all quadrants
 Last BM: 2/26/24
 Palpation: Pain, Mass etc.: Abdomen non-tender on palpation. No organomegaly or masses found on palpation in all 4 quadrants. CVA checked, tenderness not present.
 Inspection:
    Distention: not distended
    Incisions: not noted
    Scars: not noted
    Drains: no drains present
    Wounds: no wounds noted
 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: 400mL during the shift
 Pain with urination: Y ☐ N ☒
 Dialysis: Y ☐ N ☒
 Inspection of genitals:
 Catheter: Y ☐ N ☒
   Type: n/a
   Size: n/a	

MUSCULOSKELETAL:	.

Neurovascular status: good **ROM:** extremities were checked while patient was in bed **Supportive devices:** <mark>walker</mark> **Strength:** <mark>Diminished in upper extremities because the patient was postoperative and both lower arms had iv.</mark> **ADL Assistance:** **Y** ☒ N ☐ **Fall Risk:** **Y** ☒ N☐ **Fall Score:** <mark>high fall risk >13</mark> **Activity/Mobility Status:** **Independent (up ad lib)** ☐ Yes. **Needs assistance with equipment** ☐ No **Needs support to stand and walk** ☐ <mark>Yes, needs walker</mark>.	
NEUROLOGICAL: **MAEW:** Y ☒ N☐ **PERLA:** Y ☒ N☐ **Strength Equal:** Y ☒ N ☐ if no - Legs ☐ **Arms** ☐ **Both** ☐ **Orientation:** oriented x4 **Mental Status:** good **Speech:** normal **Sensory:** good **LOC:** alert and awake	.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** family help **Developmental level:** Erickson's ego/integrity **Religion & what it means to pt.:** Patient is religious, Christian, religion gives him strength and hope. **Personal/Family Data (Think about home environment, family structure, and available family support):** Patient lives in his house with his wife. They help each other. The patient has a son, a daughter and a daughter in law who help him.	.

Vital Signs, 2 sets

(5 points) – <mark>**HIGHLIGHT ALL ABNORMAL VITAL SIGNS**</mark>

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1415	62	121/69	16	97.3 F	96%

1630	68	<mark>147/79</mark>	16	97.5	97%

Vital Sign Trends: Vital signs were stable during this shift.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	0 pain (on scale 1-10)	n/a	n/a	n/a	n/a
1700	0 pain (on scale 1-10)	n/a	n/a	n/a	n/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20G, 20G **Location of IV:** 1. peripheral iv ante cubital left, 2. peripheral iv right arm **Date on IV:** 2/26/24 and 2/17/24 **Patency of IV:** both patent **Signs of erythema, drainage, etc.:** no signs of redness, drainage, swelling **IV dressing assessment:** dry, clean and intact in both	0.9% NS 120mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
NPO until 1630, IV 300mL, 240 mL with supper.	500 mL during the shift 1200-1730

Nursing Care

Summary of Care (2 points)

  Overview of care: The patient had complete assessment. Vitals were checked two times. Patient was administered medication before supper.

  Procedures/testing done: The patient had catheterization of coronary blood vessels during which the stent was inserted.

  Complaints/Issues: Patient had no complaints/issues.

  Vital signs (stable/unstable): Vital signs were stable during the shift.

  Tolerating diet, activity, etc.: The patient is tolerating the diet well. He was NPO for the procedure. After the procedure, he was hungry and ate well. He ate 100% of his supper. The patient is not tolerating activity. He was tired and could only sit in the chair.

  Physician notifications: No physician notification was done.

  Future plans for client: The patient will be discharged when he gets well. At this time, it is not known when that will occur. He will go home from here.

Discharge Planning (2 points)

  Discharge location: The patient will go home to live with his wife.

  Home health needs (if applicable): n/a

  Equipment needs (if applicable): The patient is using a walker now and he will use it when discharged home.

  Follow up plan: Patient will take his medications as proscribed. The patient will call his provider if any changes occur like shortness of breath,

  Education needs: The patient needs education on how to control his diabetes because his A1c results are between 7% and 9%. The patient also needs education on nutrition to follow the cardiac diet.

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 peripheral tissue perfusion related to decreased blood supply to the lower extremities as evidenced by diminished pulses and cold feet.	The patient has diminished pulses in lower extremities, very cold feet.	1.AEncourage walking 2. Encourage leg exercise when sitting	1. goal is to increase circulation through the lower legs.	The daughter was positive about the exercise in bed. The patient was willing to do exercise to become more independent.
2. Deficient knowledge of DM control, related to lack of information as evidenced by high blood sugar.	Blood sugar very high, A1c 7%-9%	1. Encourage the family to help with sugar control. 2. Learn what are the patient's main obstacles to do this.	1. Patient will control his sugar better in the future	Family was interested to help the patient with this. Patient showed some interest in this.
3. Increased	Patient takes	1. Nurse	1. Patient	Family agrees with

risk for bleeding related to surgical interventions as evidenced by pt's medications that can cause bleeding and very high PT time,	aspirin and clopidogrel.	should check all medications pt takes and see if redundant medications can be taken out. 2. Check vitals often For bleeding monitor BP and HR.	will have less meds which can cause bleeding,	this. Patient agrees too. Teach the patient to avoid injury.
4. Decreased activity tolerance related to decreased cardiac output as evidenced by short distance patient can walk.	Patient can walk only 20 feet.	1.Assess patient's ability to improve. 2. Assess patient's interest to make changes in his life like exercise.	1. Patient will be able to walk more than 20 feet.	Patient liked the idea and is willing to try. Family will support the patient because that could improve the quality of his life,

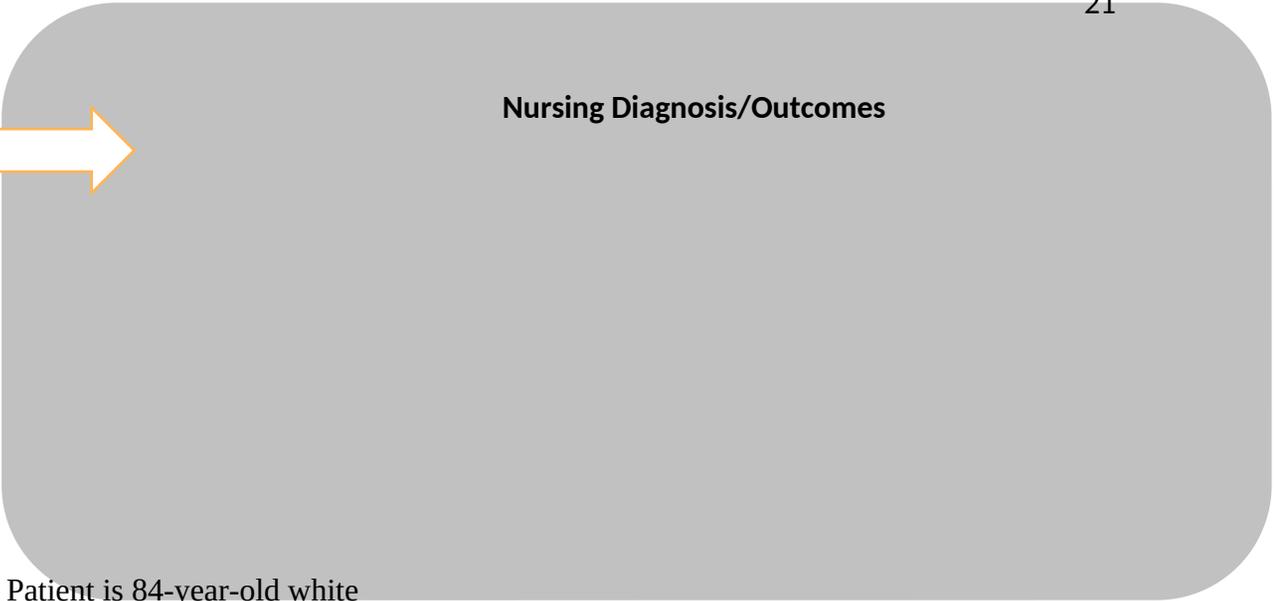**Other References (APA):**

Ackley, B. J., Ladwig, G. B., Makic, M. B. F., Martinez-Kratz, M., & Zanotti M., (2022).

   Nursing diagnosis handbook. An evidence-based guide to planning care (12th ed.).

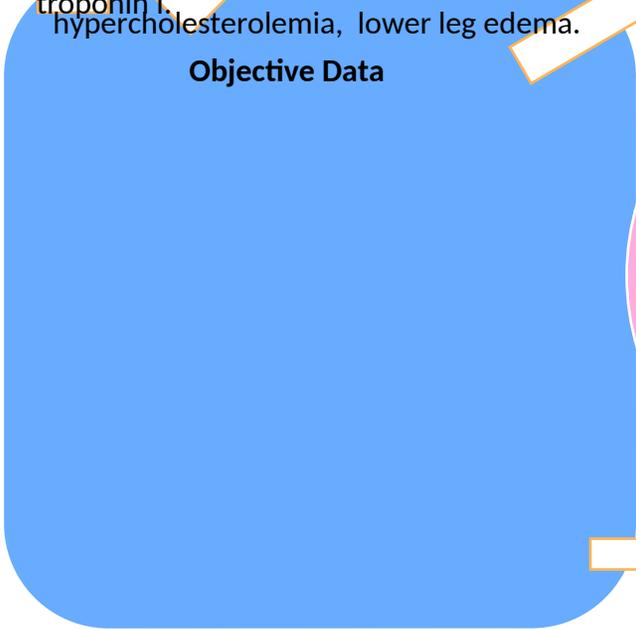   Elsevier.

Concept Map (20 Points):
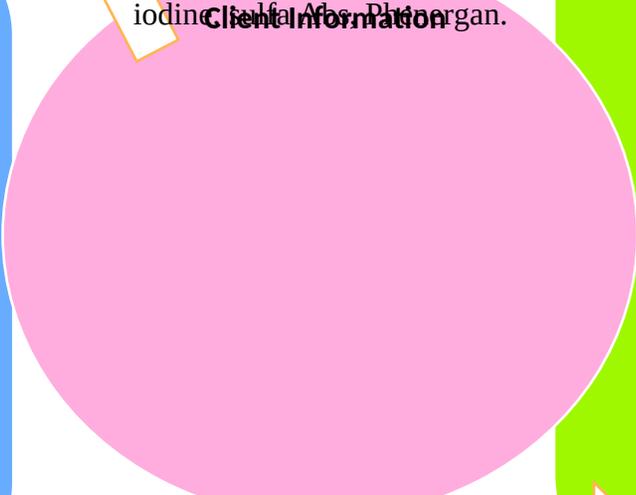
Subjective Data

Patient brought to ER with complaint of SOB, increasing fatigue, cough. These symptoms were developing over last several weeks. His admitting diagnosis was atrial fibrillation with increased troponin I

Nursing Diagnosis/Outcomes

Acute pain related to surgical incision and evidenced by inability to use right lower arm
Patient will have less pain in one week.
Patient will get medication to decrease the pain
Patient will minimize use of his right arm.

Objective Data

. Labs, vitals checked. Appearance: patient looks his age, overweight. The patient has CAD, coronary artery by pass in 2000..two stents, DM, HTN, hypercholesterolemia, lower leg edema.

Client Information

Patient is 84-year-old white male. He was admitted on 2/5/24. He lives with his wife and has two daughter.
Full code. Weight 92.11kg
Height 162.6cm. Allergies: iodine, shellfish, Plmorgan.

Nursing Interventions

Nurse will check the level of pain
Nurse will promote health and wellness like good rest, hydration and good nutrition. Good nutrition will include proteins and vitamins like vit C, A, D. These will speed up the healing. Nurse will check the patient takes his medications regularly.