N441 Care Plan

Lakeview College of Nursing

Verceles, Charlane Mae D.

Demographics (3 points)

Date of Admission 9/10/19	**Patient Initials** HC	**Age** 75	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Veteran	**Marital Status** Married	**Allergies** Sulfa antibiotics, Symbicort
Code Status Full Code	**Height** 5'10'	**Weight** 111.9kg	

Medical History (5 Points)

Past Medical History: Sleep apnea, shingles, neuropathy, hyperlipidemia, hypertension, cardioversion, history of cardiac Cath, type 2 diabetes mellitus, COPD, atrial fibrillation

Past Surgical History: Vasectomy, tonsillectomy, heart catheterization, and ankle fracture surgery

Family History: Patient's family history indicates that his mother died from Cancer of the stomach, his father suffered from hypertension, and two sisters died from cancer (one of them is the lungs and the other is unknown)

Social History (tobacco/alcohol/drugs): denies smoking and drinking and use of recreational drug

Assistive Devices: none

Living Situation: Patient is living in Danville, Illinois with wife

Education Level: High School

Admission Assessment

Chief Complaint (2 points): Chest pain

History of present Illness (10 points): HC, a 75 y/old was transferred from Danville to OSF-HMMC with pericarditic pain and evidence of pericardial effusion with atrial fibrillation that occurred a day before. On his way home he started complaining of chest discomfort

described as sharp radiating to the back and base of the neck and jaw worse with deep inspiration and worse when he laid down he spent the night in his recliner and presented to the emergency room in Danville with pain when he was found to have mild elevation troponin CT scan was performed indicated moderate pericardial effusion. Patient has had cardiac ablation, he patient was transferred to OSF Champaign where a stat echocardiogram indicated presence of moderate circumferential pericardial effusion with early signs of tamponade with mitral inflow variation of 35%, patient was also taken to the Cath lab for intervention and then transferred to CCU.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pericardial Tamponade

Secondary Diagnosis (if applicable): Atrial Fibrillation

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

Cardiac tamponade is a serious medical condition in which blood or fluids fill the space between the sac that encases the heart and the heart muscle. This places extreme pressure on the heart. The pressure prevents the heart's ventricles from expanding fully and keeps your heart from functioning properly.

Pericardial tamponade is caused by penetration to the pericardium, which is the thin, double-walled sac that surrounds your heart. The cavity around the heart can fill with enough blood or other bodily fluids to compress it. As the fluid presses on the heart, less and less blood can enter. Less oxygen-rich blood is pumped to the rest of your body as a result. Signs and symptoms include pain in the chest which was the main complaint of my patient, low blood pressure, fainting, lightheadedness, fast heart rate or palpitations and fast breathing or shortness of breath. Patient HC complained of chest discomfort and described it as sharp radiating to the

back and base of the neck and jaw worse with deep inspiration which were similar to the sign and symptom tamponade with an underlying abnormal rhythm.

This disease is usually diagnosed by echocardiogram, which is an ultrasound of your heart. It can detect whether the pericardium is distended and if the ventricles have collapsed due to low blood volume. other diagnostic procedures include chest CT, MRI and EEG. For my patient, he was diagnosed via a chest CT scan and an elevated troponin level. This can be treated by giving oxygen, and administering inotropic agent such as dobutamine. If there's too much fluid accumulation, the fluid should be drained immediately. My patient was on continuous oxygen and beta blocker to decrease the heart's workload.

Pathophysiology References (2) (APA):

Sullivan, Debra. (2017). Cardiac Tamponade. Retrieved September 12, 2019 from https://www.healthline.com/health/cardiac-tamponade

Mayo Clinic. (2019). Cardiac Tamponade. Retrieved from https://www.mayoclinic.com/health/cardiac-tamponade

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	3.4-5.8	**4.05**	**3.74**	**Red blood cell counts are decreased in situations involving chronic disease due to lack of needed elements for erythrocyte production since pt is in a disease state (Corbett and Banks,2013)**

Hgb	13-16.5	**12.5**	**11.2**	**Hemoglobin is decreased in situations where RBC is low such as mentioned above**
Hct	38-50%	**35.9**	**32.8**	**Hematocrit values are decreased in the presence of chronic disease and decreased number of true RBCs**
Platelets	140-440 K	**213**	**164**	
WBC	4-12 K	**10.4**	**6.4**	
Neutrophils	40-68.0	**75.5**	**64.9**	**Comorbidities of tamponade is infection; neutrophils are body's first line of defense vs infections**
Lymphocytes	19-49	**11.2**	**16.9**	**Lymphocyte levels decrease during an increase in neutrophil**
Monocytes	3.0-13.0	**16**	**16.7**	**Monocytes is increased due to chronic inflammation of the pericardium**
Eosinophils	0.0-8	**00**	**0.00**	
Bands	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-	135-145	**129**	**131**	**Decreased in sodium can be caused by the use of a diuretic Lasix**
K+	3.5-5.1	**4.5**	**4.1**	

Cl-	98-107	**96**	**97**	
CO2	22-29	**29**	**28**	
Glucose	70-99	**229**	**153**	**Patient's glucose is elevated due to diabetes mellitus**
BUN	6-20	**27**	**12**	**Increased BUN can indicate dehydration due to diuretic use.**
Creatinine	0.5-0.9	**0.94**	**0.91**	
Albumin	3.5-5.2	**4.0**	**NA**	
Calcium	8.6-10.4	**9.5**	**NA**	
Mag	1.6-2.4	**NA**	**NA**	
Phosphate	N/A	**NA**	**NA**	
Bilirubin	0.0-1.2	**2.0**	**NA**	
Alk Phos	35-105	**45**	**NA**	
AST	0-32	**36**	**NA**	
ALT	0-33	**36**	**NA**	
Amylase	N/A	**NA**	**NA**	
Lipase	N/A	**NA**	**NA**	
Lactic Acid	0.5-2.4	**NA**	**NA**	
Troponin	<0.4	**0.378**	**0.410**	**Increased troponin indicates injury to cardiac muscle**
CK-MB	N/A	**NA**	**NA**	
Total CK	N/A	**NA**	**NA**	

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 (9/11/19)	Reason for Abnormal
INR	0.86-1.14	**1.1**	**1.1**	
PT	11.9-15	**12.9**	**12.8**	
PTT	N/A	**32**	**55**	
D-Dimer	N/A	**NA**	**NA**	
BNP	N/A	**NA**	**NA**	
HDL	>50	**NA**	**77**	
LDL	<130	**NA**	**41**	
Cholesterol	<200	**NA**	**NA**	
Triglycerides	<200	**NA**	**106**	
Hgb A1c	5.7-6.4%	**NA**	**NA**	
TSH	0.4-4.0	**NA**	**NA**	

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**		
pH	5.0-8.0	**N/A**		
Specific Gravity	1.005-1.034	**N/A**		
Glucose	Negative	**N/A**		
Protein	Negative	**N/A**		
Ketones	Negative	**N/A**		
WBC	<5	**N/A**		

RBC	0-3	**N/A**		
Leukoesterase	Negative	**N/A**		

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

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
pH	7.35-7.45	**N/A**		
PaO2	98-100	**N/A**		
PaCO2	35-45	**N/A**		
HCO3	22-26	**N/A**		
SaO2	95-100	**N/A**		

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

Test	Normal Range	**Value on Admission**	**Today's Value**	**Explanation of Findings**
Urine Culture	Negative	**N/A**		
Blood Culture	Negative	**N/A**		
Sputum Culture	N/A	**N/A**		
Stool Culture	N/A	**N/A**		

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

9/10/19 Chest CT scan with Contrast

Findings:

No pulmonary embolism. Small to moderate, slightly hyperdense pericardial effusion.

Diagnostic Test Correlation (5 points):

A thoracic CT scan to look for fluid accumulation in your chest or changes to your heart. Through this scan, size of the heart and air accumulation can also be seen. This diagnostic tool can also be helpful in determining presence of infection, abscesses and lesions.

Diagnostic Test Reference (APA):

Henry, N.J.E., & McMichael, M. (2016). ***Content Mastery Series Review Module: RN Adult Medical Surgical Nursing*** **(10.0 ed.). ATI Nursing Education**

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

Home Medications (5 required)

Brand/Generic	**Furosemide**	**Amiodarone**	**Metoprolol succinate**	**Xarelto (Rivaroxaban)**	**Metformin**
Dose	**40mg**	**200mg**	**50 mg**	**20mg**	**1000mg**

Frequency	**Twice daily**	**Daily**	**Twice daily**	**daily**	**two times daily**
Route	**By mouth**	**by mouth**	**By mouth**	**by mouth**	**by mouth**
Classification	**Loop Diuretic**	**Antiarrhythmics type III**	**Beta-blocker**	**Anticoagulant**	**Oral Antidiabetic**
Mechanism of Action	**Inhibits reabsorption of sodium and Chloride ions at proximal and distal tubules in loop of henle**	**Prolongs action potential and refractory period. Inhibits adrenergic stimulation. • Slows the sinus rate, increases PR and QT intervals, and decreases peripheral vascular resistance (vasodilation).**	**Blocks response to beta-adrenergic stimulation**	**Acts as selective factor X inhibitor that blocks the active site of factor Xa, inactivating the cascade of coagulation.**	**• Decreases intestinal glucose absorption. • Increases sensitivity to insulin.**
Reason Client Taking	**Blood pressure regulation**	**For Arrhythmia control (Afib))**	**Blood pressure regulation**	**Reduction in risk of stroke/systemic embolism**	**To control blood sugar level**
Contraindications (2)	**Hypersensitivity Hypokalemia**	**• Patients with cardiogenic shock; • Severe sinus node**	**Hypersensitivity Myocardial infarction**	**Hypersensitivity; • Active major bleeding; • Severe**	**• Hypersensitivity; • Metabo**

		dysfunction; **• 2nd- and 3rd-degree AV block;** **•Bradycardia (has caused syncope unless a pacemaker is in place);** **•Hypersensitivity to amiodarone or iodine;**		**renal impairment**	**lic acidosis (including diabetic ketoacidosis)**
Side Effects/Adverse Reactions (2)	**Hypokalemia** **Hyperuricemia**	**QT INTERVAL PROLONGATION, *bradycardia*, *hypotension*.**	**Bradycardia** **Headache**	**blister, pruritus. BLEEDING.**	***abdominal bloating*, *diarrhea*, *nausea*, *vomiting*, unpleasant metallic taste.**
Nursing Considerations (2)	**Monitor potassium and uric acid levels** **Do not administer more than 20mg/min**	**Monitor AST, ALT, and alkaline phosphatase at regular intervals** **• May cause asymptomatic in ANA titer concentrations.**	**Monitor proper intake, cannot be abruptly stopped** **Always monitor blood pressure regularly**	**• Monitor renal function periodically during therapy. When switching from warfarin to rivaroxaban, discontinue warfarin and start rivaroxaban as soon as INR <3.0 to avoid periods of**	**• Assess renal function before initiating. Monitor patients at risk for renal impairment (eg. elderly) more frequently. Discontinue metformin if renal impairme**

				inadequate anticoagulation	**nt occurs.**
Key Nursing Assessment(s) Prior to Administration	**Report any unusual nausea symptoms** **Swallow whole. Do not cut in half**	**• Monitor serum potassium, calcium, and magnesium prior to starting and periodically during therapy.**	**Report any unusual nausea symptoms** **Swallow whole. Do not cut in half**	**Assess for signs of bleeding and hemorrhage**	**• Patients who have been well controlled on metformin who develop illness or laboratory abnormalities should be assessed for ketoacidosis or lactic acidosis.**
Client Teaching needs (2)	**Caution patient to change positions slowly to minimize orthostatic hypotension .Advise patient to contact health care professional immediately if rash, muscle weakness, cramps, nausea, dizziness, numbness, or tingling**	**Teach patients to monitor pulse daily and report abnormalities. Inform patients that bluish discoloration of the face, neck, and arms is a possible side effect of this drug after prolonged use.**	**Instruct patient to take medication as directed, at the same time each day** **• Do not take if apical pulse is less than 60**	**Advise patient to report any symptoms of unusual bleeding or bruising Instruct patient not to drink alcohol or take other Rx, OTC, or herbal products, especially those containing aspirin, NSAIDs or St. John's wort**	**Review signs of hypoglycemia and hyperglycemia with patient** **• Explain to patient that metformin helps control hyperglycemia but does not cure diabetes.**

	of extremities occurs.				

Hospital Medications (5 required)

Brand/Generic	**Glucagon injector**	**Heparin**	**Isosorbide mononitrate**	**Metoprolol succinate**	**Venlafaxine**
Dose	**1mg**	**5000 U**	**60mg**	**50 mg**	**37.5mg**
Frequency	**as needed for low blood sugar**	**As needed**	**Daily**	**Twice daily**	**daily**
Route	**IM**	**Subcutaneous**	**By mouth**	**By mouth**	**by mouth**
Classification	**Hormone**	**Anticoagulant**	**Antiangina**	**Beta-blocker**	**SSRI antidepressant**
Mechanism of Action	**• Stimulates hepatic production of glucose from glycogen stores (glycogenolysis).**	**Accelerates antithrombin III and deactivates thrombin which inhibits fibrinogen's conversion to fibrin**	**• Decrease left ventricular end-diastolic pressure and left ventricular end-diastolic volume (preload). Net effect is reduced myocardial oxygen consumption.**	**Blocks response to beta-adrenergic stimulation**	**Inhibits serotonin and norepinephrine reuptake in the CNS.**

Reason Client Taking	**• Acute management of severe hypoglycemia when administration of glucose is not feasible.**	**DVT prophylaxis, helps prevent heart attack and stroke**	**Antiarrhythmic due to atrial fibrillation**	**Blood pressure regulation**	**Used as antidepressant**
Contraindications (2)	**•Hypersensitivity; • Pheochromocytoma;**	**Thrombocytopenia Hemophilia**	**•Hypersensitivity; • Concurrent use of PDE-5 inhibitor (sildenafil, tadalafil, vardenafil) or riociguat.**	**Hypersensitivity Myocardial infarction**	**Hypersensitivity Concurrent use of MAOi**
Side Effects/Adverse Reactions (2)	***nausea, vomiting*. Misc: HYPERSENSITIVITY REACTIONS INCLUDING ANAPHYLAXIS.**	**Bleeding, bruising Thrombocytopenia**	**hypotension, tachycardia, paradoxic bradycardia, syncope.**	**Bradycardia Headache**	**THROMBOTIC THROMBOCYTOPENIC PURPURA/HEMOLYTIC UREMIC SYNDROME**
Nursing Considerations (2)	**Monitor serum glucose levels throughout episode, during treatment, and for 3-4 hr after**	**Check Platelet counts regularly Assess stool for any signs of bleeding**	**• Assess location, duration, intensity, and precipitating factors of anginal pain. • Monitor**	**Monitor proper intake, cannot be abruptly stopped Always monitor blood**	**Monitor CBC with differential and platelet count periodically during therapy. Assess for**

	patient regains consciousness. **Use of bedside fingerstick blood glucose determination methods is recommended for rapid results.**		**BP and pulse routinely during period of dose adjustment.**	**pressure regularly**	**serotonin syndrome (mental changes: agitation, hallucinations, coma)**
Key Nursing Assessment(s) Prior to Administration	**• Assess for signs of hypoglycemia** **• Assess neurologic status throughout therapy.**	**Have platelet checked once a month** **Report any signs of excessive bleeding**	**Assess baseline heart rhythm**	**Report any unusual nausea symptoms** **Swallow whole. Do not cut in half**	**• Assess mental status and mood changes** *** Assess suicidal tendencies**
Client Teaching needs (2)	**-Teach patient and family signs and symptoms of hypoglycemia.** **-Instruct patient to take oral glucose as soon as symptoms of hypoglycemia occur**	**• Advise patient to report any symptoms of unusual bleeding or bruising to health care professional immediately.** **• Instruct patient not to take medications containing aspirin or NSAIDs while on**	**• Caution patient to make position changes slowly to minimize orthostatic hypotension.** **• Caution patient to avoid driving or other activities requiring alertness until**	**Instruct patient to take medication as directed, at the same time each day** **• Teach patient and family how to check pulse daily and BP biweekly and to report significant changes to**	**Advise patient, family, and caregivers to look for suicidality** **Advise patient to take same time daily**

		heparin therapy.	**response to medication is known.**	**health care professional .**	

Medications Reference (APA):

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Yes** **Orientation: Oriented** **Distress: No** **Overall appearance:**	**Patient is alert and oriented with no signs of distress.** **Patient is on hospital gown with a heart monitor**
INTEGUMENTARY (2 points): **Skin color: pink** **Character: dry** **Temperature: warm** **Turgor:** **Rashes: none** **Bruises: none** **Wounds: no wounds present.** **Braden Score: 22** **Drains present: Y☐ N ☐** **Type:**	**Patients skin is pink, warm, dry with a Braden score of 22**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head is midline with no deviations. Hair is black and gray. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. Hair present on chin and above upper lip. PERRLA. Nose shows no deviated septum, turbinate equal bilaterally. Oral**

	mucosa is moist Patient's teeth present in yellow to white in color. **No dentures noted.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 2+** **Capillary refill: <3** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema: ankles and feet bilaterally**	**Patient is monitored via telemetry and presents with atrial fibrillation and no murmurs and gallops were heard upon auscultation.** **Pulses were graded 2+ bilaterally.** **Cardiac rhythm was irregular**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** **ET Tube: N/A** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	**No accessory muscle use when breathing. Trachea midline. No deviations. Patient is denies current shortness of breath. Oxygen levels are noted to be 97 and 99 with 2L of 02**
GASTROINTESTINAL (2 points): **Diet at home: Regular diet** **Current Diet: Cardiac diet** **Height: 5 10'** **Weight:111.9 kg** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:**	**Patient says he can eat whatever he wants at home, went to the bathroom once during the clinical day** **-Absence incisions in abdomen,** **- Normoactive bowel sounds**

Feeding tubes/PEG tube Y ☐ N ☐ **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	**Patient is able to switch positions with assistance. No difficulty or pain in urinating** **Genitals not evaluated**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score: 10** **Activity/Mobility Status: Assist** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Results show that he is at a fall risk. He is able to go to the commode with one person assist and a gait belt and is about to be discharged**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC: none**	**Patient is awake, oriented to people, time, place and events.** **The speech is also intact and there was no variation in his level of consciousness** **Mental status is within defined limits,**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient is very sociable, and kind. Religion was not discussed upon interview. Patient has graduated high school and served as a veteran**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
4:03	79	94/54	20	97.54	97 @2L N/C
8:05	86	107/69	20	97	99@2L N/C

Vital Sign Trends/Correlation:

Vitals signs are stable with no significant changes. Patient is projected to go home within the day.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
4:03	**Numerical pain scale**	**NA**	**Patient denies pain or discomfort**	**NA**	**NA**
8:05	**Numerical pain scale**	**NA**	**Patient denies pain or discomfort**	**NA**	**NA**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:18 g **Location of IV: metacarpal R vein** **Date on IV:9/10/19** **Patency of IV: flushed with-out difficulty; flushed per policy** **Signs of erythema, drainage, etc.:** **IV dressing assessment: dressing: dry and intact**	Single lumen peripheral IV line for medication administration and saline flush

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:18g	Single lumen peripheral IV line for

Location of IV: metacarpal L vein **Date on IV: 9/10/19** **Patency of IV: flushed with-out difficulty; flushed per policy** **Signs of erythema, drainage, etc.:** **IV dressing assessment: dressing: dry and intact**	medication administration and saline flush
Other Lines (PICC, Port, central line, etc.)	NA
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1000	**765**

Nursing Care

Summary of Care (2 points)

Overview of care: During the clinical time with the patient, we seemed very cooperative and has recovered well-enough. He was a candidate for discharge that day from a recent pericardial tamponade. First was meeting the patient with the nurse, patient was asked if there was something he would need and declined. We came back into his room to check on him if there was something he needs. Later that day, he also did a head-to-toe physical assessment on him, had small talks about his life and how he was a veteran on his younger years.

Procedures/testing done: The patient has undergone cardiac ablation in OSF Danville, was taken to Cath lab in OSF Urbana. Diagnostic procedures done for this patient is a CT scan and also Troponin level measurement.

Complaints/Issues: The patient's main complaint is chest pain

Vital signs (stable/unstable: Vital signs were stable during the clinical day

Tolerating diet, activity, etc.: Cardiac diet, with minimal ADL assistance

Physician notifications: Physician gave the patient a go signal to be discharged

Future plans for patient: Continue monitoring patient's heart by scheduling a follow-up appointment with the provider. Continue taking home medications and following the cardiac diet at home.

Discharge Planning (2 points)

Discharge location: OSF-HMMC Urbana

Home health needs (if applicable): Home medications such as furosemide, amiodarone, Xarelto and metformin

Equipment needs (if applicable): Patient might need a gait belt during early phases of recovery and a cane for mobility assistance when alone.

Follow up plan: Patient's telemetry has been seen to have an Atrial Fibrillation every now and then. Regular check-up and medication refills are needed for patient maintenance.

Education needs: The patient should be educated about watching out for signs of angina, (such as chest pain that can extend to left extremity, shortness of breath, and feeling of impending doom). Patient is also taking a beta blocker and amiodarone (which can slow heart rate), patient should be instructed to measure apical pulse prior to administration, if below 55/60,

then patient should withhold the medication. Patient should also be taught about the proper dose and intake of medications.

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

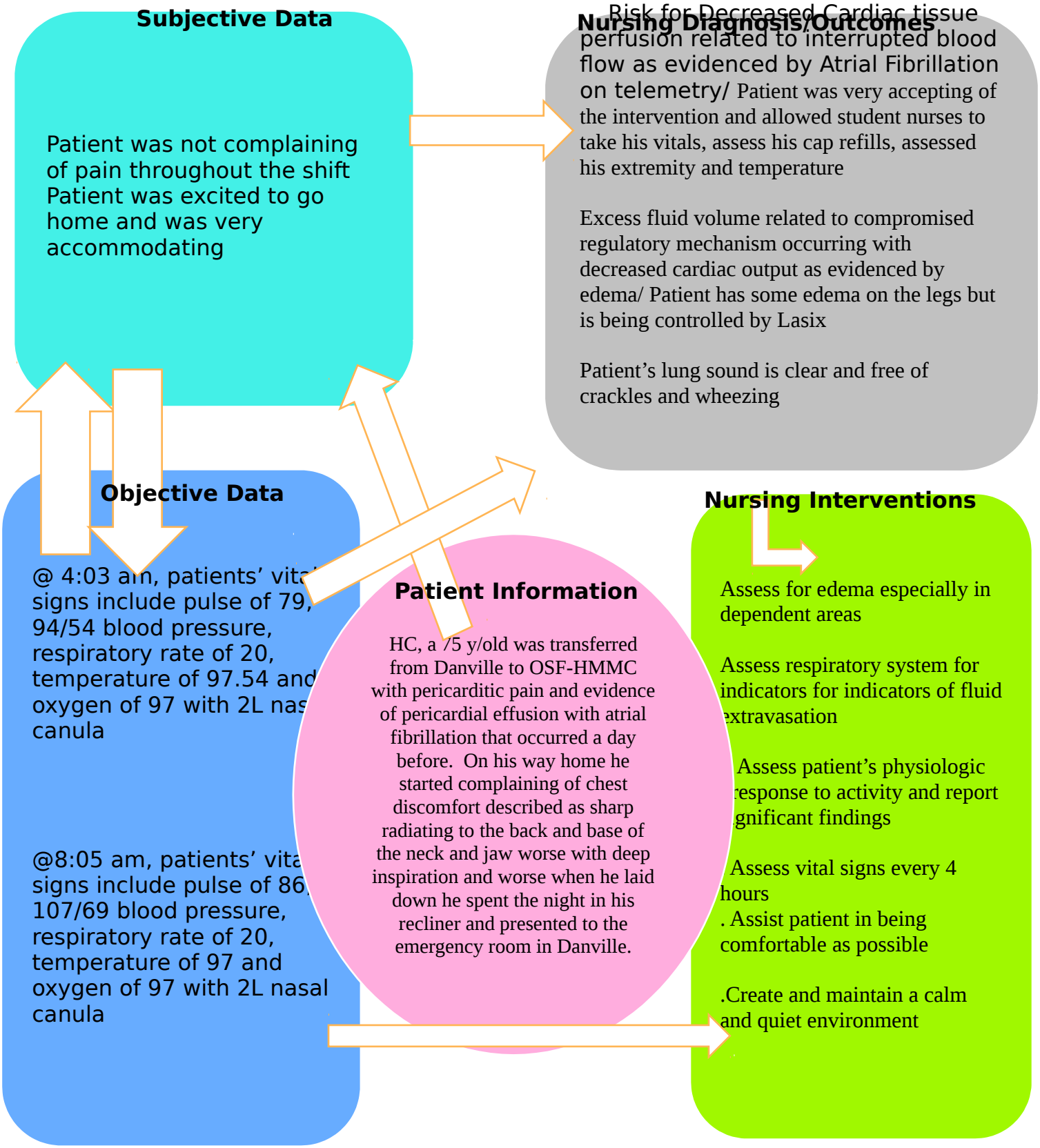
Nursing Diagnosis ● Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** ● Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** ● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Risk for Decreased Cardiac tissue perfusion related to interrupted blood flow as evidenced by Atrial Fibrillation on telemetry	Patient's telemetry shows that he has an atrial fibrillation going on as he breaths, patients' main complaint was also chest pain which was a pericardial tamponade impending proper circulation of blood	1. Assess blood pressure and heart rate every 2-4 hours or sooner as needed. 2. Assess extremity for pulse pressure, capillary refill, extremity for edema and temperature	No family member was present during the clinical day Patient was very accepting of the intervention and allowed student nurses to take his vitals, assess his cap refills, assessed his extremity and temperature. Vitals were stable
2. Risk for Infection related to pericardial swelling as evidenced by	Cardiac tamponade's comorbidity is infection. Neutrophils are body's first	1. Assess vitals routinely as directed 2. Observe proper handwashing techniques	Patient's lab values were within normal limits during the day of clinical which is also his discharge day. Patient's vitals were stable

elevated neutrophils	responder against infection. Elevated neutrophils indicate that body is trying to fight infection		and proper handwashing techniques were observed
3. Excess fluid volume related to compromised regulatory mechanism occurring with decreased cardiac output as evidenced by edema	Decreased output occurs if heart is not pumping efficiently, this alters proper circulation of blood and some backflow which can lead to edema	1.Assess for edema especially in dependent areas 2. Assess respiratory system for indicators for indicators of fluid extravasation	Patient has some edema on the legs but is being controlled by Lasix Patient's lung sound is clear and free of crackles and wheezing
4. Activity intolerance related to decreased cardiac muscle contractility as evidenced by abnormal troponin levels upon admission	Increased troponin is indicative of a cardiac muscle damage affecting the heart's ability to contract	1. Assess patient's physiologic response to activity and report significant findings 2. Assess vital signs every 4 hours	Patient tolerates activity well during the clinical day. Patient requires minimum assistance when going to the bathroom. Patient's vital signs were stable during the clinical day.
5. Fear related to a potentially life-threatening situation as evidenced by cardiac on scan	Patient has had chest pain and anxiety. Cardiac tamponade is a potentially life-threatening event if no interventions were given right away.	1. Assist patient in being comfortable as possible 2.Create and maintain a calm and quiet environment	Patient did not show signs of anxiety and fear during clinical day. Patient was very friendly and openly talks about himself Patient was left in private after doing the assessments and vitals were stable

Other References (APA):

Swearingen, P. L. (2016). *All-In-One Nursing Care Planning Resource* (4 ed.). St. Louis, Missouri: ELSEVIER.

Concept Map (20 Point


Subjective Data
Patient was not complaining of pain throughout the shift Patient was excited to go home and was very accommodating
Nursing Diagnosis/Outcomes
Risk for Decreased Cardiac tissue perfusion related to interrupted blood flow as evidenced by Atrial Fibrillation on telemetry/ Patient was very accepting of the intervention and allowed student nurses to take his vitals, assess his cap refills, assessed his extremity and temperature
Excess fluid volume related to compromised regulatory mechanism occurring with decreased cardiac output as evidenced by edema/ Patient has some edema on the legs but is being controlled by Lasix
Patient's lung sound is clear and free of crackles and wheezing
Objective Data
@ 4:03 am, patients' vital signs include pulse of 79, 94/54 blood pressure, respiratory rate of 20, temperature of 97.54 and oxygen of 97 with 2L nasal canula
@8:05 am, patients' vital signs include pulse of 86, 107/69 blood pressure, respiratory rate of 20, temperature of 97 and oxygen of 97 with 2L nasal canula
Patient Information
HC, a 75 y/old was transferred from Danville to OSF-HMMC with pericarditic pain and evidence of pericardial effusion with atrial fibrillation that occurred a day before. On his way home he started complaining of chest discomfort described as sharp radiating to the back and base of the neck and jaw worse with deep inspiration and worse when he laid down he spent the night in his recliner and presented to the emergency room in Danville.
Nursing Interventions
Assess for edema especially in dependent areas
Assess respiratory system for indicators for indicators of fluid extravasation
Assess patient's physiologic response to activity and report significant findings
Assess vital signs every 4 hours
. Assist patient in being comfortable as possible
.Create and maintain a calm and quiet environment