N321 Care Plan #

Lakeview College of Nursing

Name

Demographics (3 points)

Date of Admission 11/18/19	Patient Initials AR	Age 83	Gender Female
Race/Ethnicity White	Occupation Retired	Marital Status Divorced	Allergies Dilantin (Phenytoin sodium extended) Gadolinium-containing contrast media
Code Status DNAR	Height 152.4cm	Weight 61.8kg	

Medical History (5 Points)

Past Medical History: benign essential hypertension, coronary artery disease, chronic anticoagulation, chronic fatigue, emphysema, history of DVT in adulthood, history of non-ST elevation myocardial infarction, idiopathic neuropathy, LV dysfunction, osteopenia, paroxysmal atrial fibrillation, personal history of breast cancer, personal history of irradiation, pure hypocholesterolemia, rheumatoid arthritis, seizures.

Past Surgical History: breast lumpectomy, left heart catheterization

Family History: father had cancer and mother had hypertension

Social History (tobacco/alcohol/drugs): denies any tobacco/alcohol/drug use

Assistive Devices: cane

Living Situation: lives at home by herself

Education Level: high school

Admission Assessment

Chief Complaint (2 points): tachycardia and a 20lb weight gain with leg swelling (left)

History of present Illness (10 points): The patient is a 83 year old Caucasian female with a history of paroxysmal atrial fibrillation, hypertension, DVT, and coronary artery disease,

who initially came to her doctor's office yesterday for 4 days of left leg swelling. She admitted to feeling tired. She denied any chest pain or palpitations. Family member with her mentioned that the patient had even fallen due to how weak she was. In the doctor's office, the patient was found to be in rapid atrial fibrillation with a hear rate of 129 on EKG. The patient is compliant with her Metoprolol and Xarelto. Due to her symptoms, she was brought to the E.R. for further evaluation and admitted to the med-surg floor for further observation.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): paroxysmal atrial fibrillation

Secondary Diagnosis (if applicable): LV dysfunction with subsequent CHF

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

Pathophysiology References (2) (APA):

Patient's diagnosis of atrial fibrillation is due to her EKG results. "Atrial fibrillation is the most commonly encountered arrhythmia in the clinical setting, with the highest prevalence within the elderly population" (Capriotti). This holds true with my patient who is 83 years old. It is defined as the absence of coordinated, rhythmic atrial contractions. There are multiple, irregular fibrillatory P waves on the EKG that represent multiple, rapid reentrant impulses moving around in the atrial chamber (Capriotti). The result is a fast and irregular heart rhythm, which was seen on my patient's EKG. The heart rate in atrial fibrillation may range from 100 to 175 beats a minute (Mayo Clinic). The patient presented to the ED with tachycardia, but her HR went down as evidenced by her HR of 99 earlier in the day on 11/19 and down to 90 by the afternoon.

The sinus node produces the signal that normally starts each heartbeat. Normally, the signal travels through the two upper heart chambers, and then through a connecting pathway between the upper and lower chambers called the atrioventricular (AV) node (Capriotti). The movement of the signal causes your heart to squeeze (contract), sending blood to your heart and body (Mayo Clinic). In atrial fibrillation, the signals in the upper

chambers of your heart are chaotic. As a result, they quiver and the AV node is bombarded with impulses trying to get through to the ventricles (Mayo Clinic).

"Possible causes of atrial fibrillation include: high blood pressure, heart attack, coronary artery disease, abnormal heart valves, heart defects you're born with, an overactive thyroid gland or other metabolic imbalance, exposure to stimulants, such as medications, caffeine, tobacco or alcohol, sick sinus syndrome, lung diseases, previous heart surgery, viral infections, stress due to surgery, pneumonia or other illnesses or sleep apnea" (Mayo Clinic).

I don't know what else to really say as to why she was diagnosed with it other than the EKG said so??

Capriotti, Theresa, (2016). ***Pathophysiology: Introductory Concepts and Clinical Perspectives*** **Philadelphia, Pa: F.A. Davis Company.**

Mayo Clinic, (2019). ***Atrial Fibrillation.*** **Retrieved on 27 November 2019 from**

https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.50-5.20x10^6/uL	4.24	3.71	
Hgb	11.0-16.0g/dL	13.0	11.8	
Hct	34-47%	41.9	36.8	
Platelets	140-400x10^3/uL	307	261	

WBC	**4.00-11.0x10^5/uL**	**10.41**	**8.19**	
Neutrophils	**1.60-7.70x10^6/uL**	**7.80**	**5.39**	**Could be high due to possible infection or because patient is taking Plaquenil which suppresses the immune system (Jones & Bartlett)**
Lymphocytes		**15.3**	**18.7**	
Monocytes		**8.2**	**11.4**	
Eosinophils		**0.8**	**2.7**	
Bands		**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-	**136-145mmol/L**	**138**	**140**	
K+	**3.5-5.1mmol/L**	**4.4**	**3.8**	
Cl-	**98-107mmol/L**	**101**	**101**	
CO2	**22.0-33mmol/L**	**26.7**	**31.3**	**This isn't abnormal but I figured it would be elevated due to being tachy and CHF**
Glucose	**60-99mg/dL**	**115**	**97**	**High due to taking TIAZAC or furosemide(Jones & Bartlett)**
BUN	**7-18mg/dL**	**15**	**20**	**Can be high due to past hypertension, CHF, age of patient, and furosemide (Capriotti, Jones & Bartlett)**
Creatinine	**0.60-1.30mg/dL**	**1.05**	**1.07**	
Albumin	**3.4-5.0g/dL**	**3.5**	**N/A**	
Calcium	**8.5-10.1mg/dL**	**9.3**	**9.2**	

Mag	**1.8-2.4mg/ dL**	**2.0**		
Phosphate		**N/A**	**N/A**	
Bilirubin	**0.2-1.0mg/ dL**	**0.9**	**N/A**	
Alk Phos		**N/A**	**N/A**	
AST	**15-37 U/L**	**27**	**N/A**	
ALT	**12-78 U/L**	**28**	**N/A**	
Amylase		**N/A**	**N/A**	
Lipase		**N/A**	**N/A**	
Lactic Acid		**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	**0.9-1.1**	**1.2**	**1.2**	**Aspirin and acetaminophen can both cause a higher INR (Jones & Bartlett)**
PT		**N/A**	**N/A**	
PTT		**N/A**	**N/A**	
D-Dimer		**N/A**	**N/A**	
BNP		**N/A**	**N/A**	
HDL		**N/A**	**N/A**	
LDL		**N/A**	**N/A**	
Cholesterol		**N/A**	**N/A**	

Triglycerides		**N/A**	**N/A**	
Hgb A1c		**N/A**	**N/A**	
TSH		**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		**N/A**	**N/A**	
pH		**N/A**	**N/A**	
Specific Gravity		**N/A**	**N/A**	
Glucose		**N/A**	**N/A**	
Protein		**N/A**	**N/A**	
Ketones		**N/A**	**N/A**	
WBC		**N/A**	**N/A**	
RBC		**N/A**	**N/A**	
Leukoesterase		**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		**N/A**	**N/A**	
Blood Culture		**N/A**	**N/A**	

Sputum Culture		**N/A**	**N/A**	
Stool Culture		**N/A**	**N/A**	

Lab Correlations Reference (APA):

Capriotti, Theresa, (2016). ***Pathophysiology: Introductory Concepts and Clinical Perspectives*** **Philadelphia, Pa: F.A. Davis Company.**

Jones & Bartlett Learning. (2019). ***Nurse's Drug Handbook.*** **Jones & Bartlett Learning, LLC an Ascend Company.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points): chest X-ray and EKG

Diagnostic Test Correlation (5 points): Patient had a chest X-ray that showed stable mild to moderate cardiomegaly, persistent small amount of left-sided pleural fluid with atelectasis in the left lung base, interval opacification of the right lower chest secondary to pleural fluid, and probable atelectasis.

Diagnostic Test Reference (APA):

Capriotti, Theresa, (2016). ***Pathophysiology: Introductory Concepts and Clinical Perspectives*** **Philadelphia, Pa: F.A. Davis Company.**

Mayo Clinic, (2019). ***Atrial Fibrillation.*** **Retrieved on 27 November 2019 from**

https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624

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

Hospital Medications (5 required)

Brand/Generic	**acetaminophen**	**aspirin**	**calcium carbonate (TUMS)**	**dilTIAZem HCl TIAZAC**	**furosemide**
Dose	**650mg**	**81mg**	**400mg**	**120mg**	**40mg**
Frequency	**every 4 hours PRN**	**daily**	**daily**	**daily**	**BID**
Route	**PO**	**PO (chewable)**	**PO (chewable)**	**PO**	**IV push**
Classification	**analgesic/ antipyretics, non-salicylate**	**platelet aggregation inhibitor**	**antacid**	**calcium channel blocker**	**Loop diuretic**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation. Acts directly on temperature-regulating center in the hypothalamus by inhibiting synthesis of prostaglandin.**	**Inhibits platelet aggregation by interfering with production of thromboxane A2, a substance that stimulates platelet aggregation.**	**Plays a role in normal cardiac and renal function respiration, coagulation, and cell membrane and capillary permeability**	**Inhibits the calcium influx into cardiac and vascular smooth muscle during depolarization**	**Inhibits sodium and water reabsorption in the loop of Henle and increase urine formation**

Reason Client Taking	**To treat mild/moderate pain**	**To reduce severity of or prevent acute MI**	**To prevent hypocalcemia**	**To treat atrial fibrillation**	**To reduce edema and manage hypertension**
Contraindications (2)	**Severe hepatic or liver impairment Hypersensitivity**	**Asthma, bleeding problems, PUD**	**Hypercalcemia Renal calculi, hypophosphatemia**	**Acute MI AV block Sick sinus syndrome**	**Anuria Hypersensitivity to furosemide or sulfonamides**
Side Effects/Adverse Reactions (2)	**Headache, insomnia, constipation, diarrhea, atelectasis, dyspnea**	**Confusion, CNS depression, tinnitus, GI bleeding**	**Hypotension, irregular heartbeat, hypercalcemia**	**Atrial flutter EKG abnormalities hyperglycemia**	**Dizziness, drowsiness, arrhythmias, hyperglycemia,**
Nursing Considerations (2)	**Take liver function tests before administration Check dosage for administration**	**Monitor for tinnitus Be sure to not crush time-released tablets**	**Store at room temperature, don't freeze Monitor serum calcium level**	**Assess patient for signs and symptoms of heart failure Watch for digitalis toxicity**	**Obtain patient's weight periodically Monitor fluid loss Administer IV slowly over 1-2 minutes to prevent ototoxicity (which I did ☺)**

Home Medications (5 required)

Brand/ Generic	**PLAQUENIL hydroxychloroquine**	**lisinopril**	**TOPROL XL Metoprolol succinate**	**NITROSTAT nitroglycerin**	**XARELTO rivaroxaban**
Dose	**200mg**	**20mg**	**100mg**	**0.4mg**	**15mg**
Frequency	**at bedtime daily**	**daily**	**daily**	**every 5 minutes PRN**	**daily with evening meal**
Route	**PO**	**PO**	**PO**	**sublingual**	**PO**
Classification	**antimalarial drug**	**antihypertensive Ace inhibitor**	**beta-adrenergic blocking agent**	**vasodilator**	**Direct factor XA inhibitor**
Mechanism of Action	**May mildly suppress the immune system, inhibiting production of rheumatoid factor and acute phase reactants**	**May reduce BP by inhibiting conversion of angiotensin 1 to angiotensin 2**	**Inhibits stimulation of beta receptor sites, located mainly in the heart**	**May interact with nitrate receptors in vascular smooth-muscle cell membrane reducing nitroglycerin to nitric oxide, increasing intracellular formulation of cGMP**	**Selectively blocks the active site of factor Xa, which plays a central role in the cascade of blood coagulation**
Reason Client Taking	**To treat acute or chronic rheumatoid arthritis**	**To treat hypertension**	**To manage hypertension and angina**	**To prevent or treat angina attacks**	**To reduce risk of stroke in patients with a-fib, to treat DVT**
Contraindications (2)	**Hypersensitivity Possible drug interaction with antacids→reduced absorption**	**Diabetes Renal impairment Idiopathic angioedema**	**Acute heart failure, AV block, pulse less than 45 beats/min**	**Acute MI, glaucoma, circulatory failure, hypotension**	**Active bleeding Hypersensitivity Possible drug interactions (aspirin,**

					acetaminophen)
Side Effects/ Adverse Reactions (2)	**Cardiomyopathy, anorexia, diarrhea, anemia**	**Confusion, depression, blurred vision, anemia**	**Anxiety, confusion, dizziness, drowsiness**	**Hallucinations, headache, blurred vision, peripheral edema**	**Cerebral hemorrhage, anxiety, hepatitis, excessive bleeding**
Nursing Considerations (2)	**Obtain periodic blood cell counts Monitor patient's vision**	**Use cautiously in patients with fluid volume deficit Monitor patient for hepatic dysfunction**	**Use cautiously in CHF patients Assess EKG regularly during DO visit Take as prescribed**	**Use cautiously in elderly patients Plan a nitro free period (10 hours) Do not chew**	**Monitor patient for any hypersensitivity reaction Take exactly as prescribed Monitor renal function**

Medications Reference (APA):

Capriotti, Theresa, (2016). ***Pathophysiology: Introductory Concepts and Clinical Perspectives*** **Philadelphia, Pa: F.A. Davis Company.**

Jones & Bartlett Learning. (2019). ***Nurse's Drug Handbook.*** **Jones & Bartlett Learning,**

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Assessment

Physical Exam (18 points)

GENERAL (1 point): PERRLA **Alertness: x4** **Orientation: x4** **Distress: minimal observed** **Overall appearance: worsening fatigue, tachy**	**PERRLA. The patient denies any fever or chills, but has worsening fatigue. Patient has tachycardia but is pleasant with minimal observed discomfort.**
INTEGUMENTARY (2 points): **Skin color: pink** **Character: dry** **Temperature: warm** **Turgor: present** **Rashes: none** **Bruises: none** **Wounds: none** **Braden Score: 22** **Drains present: Y☐ N ☐** **Type:**	**Patient has pitting edema 1+ in left leg, but it is non-tender to touch. No rash or bruising. No Homan sign. Peripheral pulses bilaterally 2+. IV right antecubital (20G). Weight change of 20lb in last week with left leg swelling. No drains present. Braden score of 22.**
HEENT (1 point): **Head/Neck: normal** **Ears: pink** **Eyes: white** **Nose: pink** **Teeth: dentures**	**No headaches or dizziness. Extraocular muscles are intact. Mucous membranes are moist. Atraumatic, MAE, good CNS.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: 2+ bilaterally** **Capillary refill: 2** **Neck Vein Distention: Y ☐ N ☐ Edema Y ☐ N ☐** **Location of Edema: left lower leg**	**Patient did have tachycardia, but denied any chest pain/palpitations. Positive S1 and S2 with irregular rhythm.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**Patient had shortness of breath (respiration 22) that was clear to auscultation bilaterally. No wheezing, rhonchi, wheezes. Patient has**

	history of CHF.
GASTROINTESTINAL (2 points): **Diet at home: previously non-restricted** **Current Diet: cardiac until discontinued** **Height: 152.4cm** **Weight: 61.8kg** **Auscultation Bowel sounds: normoactive** **Last BM: this morning** **Palpation: Pain, Mass etc.: None** **Inspection:** **Distention: None** **Incisions: None** **Scars: None** **Drains: None** **Wounds: None** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	**No nausea or vomiting. Non-tender, positive bowel sounds.**
GENITOURINARY (2 Points): **Color: pale yellow** **Character: clear** **Quantity of urine: N/A** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals: N/A** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**Patient up to bathroom on own. Was not on strict I's and O's (which I don't understand why especially with history of CHF, HF and with her CC of 20lb weight gain…) No urinary complaints.**
MUSCULOSKELETAL (2 points): **Neurovascular status: good** **ROM: yes** **Supportive devices: cane** **Strength: equal** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score: 17** **Activity/Mobility Status:** **Independent (up ad lib) ☐ with help** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	**Patient has fallen within the last 2 years and fell 4 days ago due to fatigue. Patient has had worsening fatigue and wants AP there more for support/preventative rather than out of true necessity. Patient does not have any cognitive limitations. No high fall risk due to current medications. Patient used a cane to ambulate and is very fast-moving.**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐**	**Patient is awake, alert, and moving all extremities. No focal deficit. EOM present.**

PERLA: Y ☐ N☐ **Strength Equal: Y ☐ N ☐ if no - Legs ☐** **Arms ☐ Both ☐** **Orientation:** **Mental Status: good** **Speech: good** **Sensory: good** **LOC: no**	
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): religious** **Developmental level: normal** **Religion & what it means to pt.: religious** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient lives at home on her own. She stated she is religious and frequents church 3-4 times a week. Patient stated she graduated high school and worked for an insurance company for 35 years before retiring. Patient likes to read and watch TV to relax.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
11:13	99	136/73	20	98.2F	96% on room air
13:33	90	127/58	18	98.4F	97% on room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:13	Denies any pain/discomfort				
13:33	Denies any pain/discomfort				

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20G **Location of IV: peripheral right antecubital** **Date on IV: 11/18/19** **Patency of IV: WDL** **Signs of erythema, drainage, etc.:** **IV dressing assessment: dry, WDL**	**Patient IV WDL. No erythema, phlebitis, drainage. No fluids were running, only used for furosemide push.**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Was not on strict I's and O's but noted 380mL intake with dinner.	Was not on strict I's and O's but noted 425mL output.

Nursing Care

Summary of Care (2 points)

Overview of care: Patient admitted from DO to ED to med-surg for HR of 129 on EKG. Patient will be kept for observation for edema of left leg and HR of 129.

Procedures/testing done: EKG, X-ray, CBC, CMP, cardiac panel, liver panel, IV.

Complaints/Issues: No pain, but worsening fatigue, weight gain of 20lb, left leg swelling, apparent SOB. Denied any palpitations.

Vital signs (stable/unstable): Unstable

Tolerating diet, activity, etc.: Patient now on a cardiac diet

Physician notifications: Observation until stable and follow up and primary physician office

Future plans for patient: Remain on cardiac diet

Discharge planning (2 points)

Discharge location: back to home

Home health needs (if applicable): none

Equipment needs (if applicable): continue using cane

Follow up plan: Follow up with primary physician, continue medication compliance

Education needs: 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	**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. Fatigue related to past medical history of chronic fatigue and atrial fibrillation as evidenced by patient reporting she has no energy	**Patient stated in the DO, ED, and med-surg floor that she has worsening fatigue**	**1. Encourage the patient to discuss what she thinks makes her fatigue the worst.** **2. Help the patient to prioritize tasks.**	**Patient understood the need to prioritize tasks to get done what she wanted to get done for the day. Patient was going to keep a diary of what seems to make her the most tired.**
2. Risk for decreased cardiac output related to altered electrical conduction as evidenced by EKG results	**Patient's EKG shows atrial fibrillation and patient has tachycardia**	**1. Monitor vitals regularly and encourage patient to let someone know when she feels as if she is experiencing palpitations** **2. Encourage continued medication compliance**	**Patient understands it is okay to bother people with palpitations even if she otherwise feels "okay." Patient understands the need to take her medication exactly as prescribed**
3. Risk for falls as evidenced by worsening fatigue related	**Patient's worsening fatigue puts her at risk for**	**1. Encourage use of the call light** **2. Encourage**	**Patient understood to use call light to notify AP/nurse when she needs to get up as a**

to patient falling within the past few days	**falling. She is currently not on any medications that might increase her risk for falls.**	**removing blankets before getting up/moving around.**	**back-up measure. Patient was always very cold and had multiple blankets. Just like throw rugs, getting stuck in a blanket can be a fall risk. Patient understood the need to remove all blankets before getting up.**

Other References (APA):

Capriotti, Theresa, (2016). ***Pathophysiology: Introductory Concepts and Clinical Perspectives*** **Philadelphia, Pa: F.A. Davis Company.**

Mayo Clinic, (2019). ***Atrial Fibrillation.*** **Retrieved on 27 November 2019 from**

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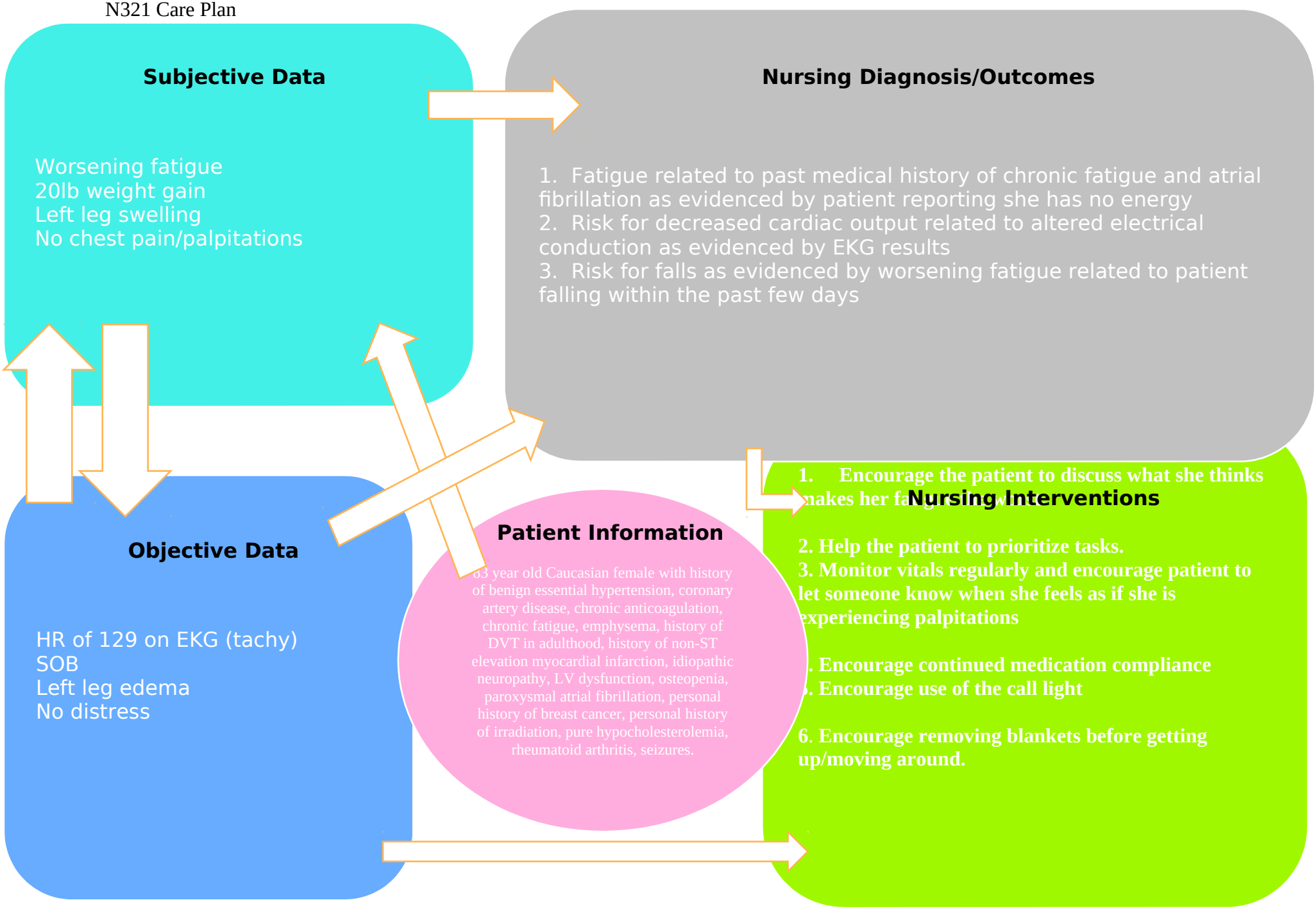
Concept Map (20 Points):

N321 Care Plan



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