N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 2/17/2020	Patient Initials H.T.	Age 73	Gender Female
Race/Ethnicity Hispanic	Occupation Mother	Marital Status Widowed	Allergies None
Code Status Full code	Height 5'2 "	Weight 91.2kg (202 lb)	

Medical History (5 Points)

Past Medical History: Patient has a past medical history of Hypertension and hyperlipidemia.

Past Surgical History: Patient has no past surgical history.

Family History: Daughter has history of hypertension. Husband died of cardiovascular disease.

Social History (tobacco/alcohol/drugs): None

Assistive Devices: Patient can walk on own but with assistance.

Living Situation: Patient lives at home with her daughter.

Education Level: Patient did not want to answer.

Admission Assessment

Chief Complaint (2 points): Palpations and shortness of breath

History of present Illness (10 points): A 73-year-old female presents to the ED complaining of palpations and shortness of breath. She states that the pain being earlier that day and consisted of fast palpations. She stated, " It felt as though my heart was beating out of my chest". Daughter of patient explained that her mother has a history of AFib and that no relieving factors such as walking was doing any good. Patient was admitted to the hospital for farther observation and monitoring of heartbeat. Patient is taking warifan as a home medication and but daughter has notified that her mother did not take it that morning.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Arrhythmias

Secondary Diagnosis (if applicable): Diabetes

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

Arrhythmias are a common cause of heart failure. They are described as producing a problem with the rate or rhythm in your heartbeat (Davis, 2019). One common arrhythmia that this patient has is Arterial Fibrillation or A-fib or AF. A-fib is where there is an irregular heartbeat that can lead to blood clots, stroke, heart failure or other complications. During AFib the upper chambers of the heart, the atria, beat irregular instead of effectively to move blood into the ventricles (AHA, 2016). In order to identify a AF one has to hook the patient on a 12 lead EKG. This EKG will allow the healthcare team to visually see where the AF and treat it according. As for the patient of this care plan, she had a history of AF, which means that this patient possibly came into the hospital because she was noncompliant with her medications. Typically with older adults forgetting to take medications are not uncommon. This patient possible forgot to take their medication because of their dementia. They were admitted to the hospital for observation in cause of complications with their AF rhyme.

The patient also has a history of Diabetes. Diabetes is quite typical in individuals who are over weight. As for this patient, she has many risk factors that suggest that she is overweight. Such as age, ethics she Hispanic, Latin speaking communities often have more overweight individuals because they lack the ability to find resources that will allow them to afford healthy food choices (Sellgren, 2018). Low- income families like Hispanic speaking Americans lack the means to gather health food choices because of their income. Healthy food options are expensive

(Organics, 2018). However, over weight does contribute to high cholesterol and adds in the build

up of plaque and compression of blood vessels.

Pathophysiology References (2) (APA):

American Heart Association (AHA). (2016). What is Atrial Fibrillation (AFib or AF)? Retrieved

from https://www.heart.org/en/health-topics/atrial-fibrillation/what-is-atrial-fibrillation-

afib-or-af

Davis, P. (2019). Heart Disease: Causes of a Heart Attack. Retrieved from

https://www.medicinenet.com/heart_disease_pictures_slideshow_visual_guide/

article.htm

Organics (2019). Why is The Price of Healthy Food So Damn High? Retrieved from

https://www.organics.org/why-is-the-price-of-healthy-food-so-high/

Sellgren, K. (2018). BBC News. Families 'can't afford to follow healthy diet guidance'. Retrieved

from https://www.bbc.com/news/education-45420295

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.8-5.1			
Hgb	12.0-16.0			
Hct	35-45%			
Platelets	50-150 x10^9			
WBC	4.5-11.0			
Neutrophils	57-67%			
Lymphocytes	20-40%			
Monocytes	2-8%			

Eosinophils	<3%			
Bands	3-5%			

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-	135-145	137	138	
K+	3.5-5.0	4.1	4.6	
Cl-	97-107	107	103	
CO2	20-29	22.5	24.5	
Glucose	<100	<mark>200</mark>	<mark>250</mark>	Glucose is high because the patient is a diabetic & they are under stress and the blood is not producing as much insulin as it should be (Holman, 2019).
BUN	7-20	19	16	
Creatinine	0.6-1.5	1.22	1.33	
Albumin	3.5-5.0	3.6	3.9	
Calcium	8.6-10.2	9.2	9.0	
Mag	1.5-2.5	2.1	1.7	
Phosphate	2.5-4.5	n/a	n/a	
Bilirubin	0.3-1.9	0.5	0.7	
Alk Phos	33-131	83	65	
AST	<35	33	31	

ALT	<35	**31**	**29**	
Amylase	23-85	**n/a**	**n/a**	
Lipase	0-160	**n/a**	**n/a**	
Lactic Acid	----------	**n/a**	**n/a**	
Troponin	**0.0-0.05**	<mark>**6.03**</mark>	<mark>**3.06**</mark>	Troponin level is high means that damage was done to the heart (Hinkle & Cheever, 2018).
CK-MB	**n/a**	**n/a**	**n/a**	
Total CK	**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	**1.1**	**1.1**	
PT	12.1-14.9 sec	**13.8 sec**	**14.2 sec**	
PTT	22.5-35.9sec	**30**	**32**	
D-Dimer	0-0.5	**n/a**	**n/a**	
BNP	0-100	<mark>**105**</mark>	**34**	BNP is high it means that the heart cannot pump blood effectively (Holman, 2019). This is because the patient has AF.
HDL	>50	<mark>**37**</mark>	<mark>**48**</mark>	HDL is lowered due to Metabolic syndrome, high cholesterol, hyperlipidemia, hypergylceridmeia, and dyslipidemia (Hinkle & Cheever, 2018).
LDL	<130	**<90**	**<70**	
Cholesterol	<200	**130**	**114**	
Triglycerides	<150	<mark>**336**</mark>	<mark>**225**</mark>	Triglycerides are increased due to obesity, poor diabetes, and history

				of lipids (Hinkle & Cheever, 2018).
Hgb A1c	5.6-7.5	<mark>10</mark>	<mark>7.5</mark>	Hgb A1c is increased due to signs of diabetes, heart disease, kidney disease, and nerve damage (Hinkle & Cheever, 2018). This is can be a caused in the patient because of her diabetes.
TSH	**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	Yellow/ Clear	Yellow/ Clear	
pH	4.5-8.0	4.0	5.0	
Specific Gravity	1.01-1.02	<mark>1.055</mark>	1.020	Specific gravity is increase can be caused by dehydration; diarrhea, excessive sweating, and decreased blood flow to kidneys (Holman, H.C, et al, 2019). Patient had trauma to kidney, which could of elevated the level.
Glucose	Negative	Negative	Negative	
Protein	0-20	----------	----------	
Ketones	Negative	Negative	Negative	
WBC	Negative	Negative	Negative	
RBC	Negative	Negative	Negative	
Leukoesterase	Negative	Negative	Negative	

**These labs were not taken on the patient

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	n/a	n/a	n/a	*These labs were not included in the patients care
PaO2	n/a	n/a	n/a	
PaCO2	n/a	n/a	n/a	
HCO3	n/a	n/a	n/a	
SaO2	n/a	n/a	n/a	

*These labs were not included in the patients care

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	n/a	n/a	n/a	*These labs were not included in the patients care
Blood Culture	n/a	n/a	n/a	
Sputum Culture	n/a	n/a	n/a	
Stool Culture	n/a	n/a	n/a	

*These labs were not included in the patients care

Lab Correlations Reference (APA):

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing*

(14th ed.). Philadelphia, PA: Wolters Kluwer

Holman, H.C., et al. (2019). *RN Adult Medical-Surgical Nursing* (11th ed.). Assessment

Technologies Institute, LLC.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

The patient is on a telemontior, which is used to keep the healthcare team up-to-date on the status

of the patient's condition (Cleland, 2017). The telemontior showed a normal sinus rhythm. There

was also a CT X-ray done on the patient to see if there were any abnormal findings of heart

complications. The CT was negative. A CT scan is where providers take the use of computers

and x-ray to combine in order to create detailed image of what is going on in one's body (Hinkle

& Cheever, 2018).

Diagnostic Test Correlation (5 points):

The CT of chest and lungs, plus the telemetry combined allowed the provider to come up with

the best choice of action into order to treat the patient. Without multiple resources conducted on

a patient the providers would not have a sense of knowing what is actually going on in the body.

Diagnostic Test Reference (APA):

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing*

      (14th ed.). Philadelphia, PA: Wolters Kluwer

Cleland, J., (2017). Cardiology Telemetry. Cardiology Advisor. Retrieved from

      https://www.thecardiologyadvisor.com/home/decision-support-in-medicine/cardiology/

      telemonitoring/

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

Home Medications (5 required)

Brand/Generic	Xarelto	Warfian	n/a	n/a	n/a

	(Rivaroxaban)	(Coumadin)			
Dose	2.5 mg	2mg	n/a	n/a	n/a
Frequency	Daily	Daily	n/a	n/a	n/a
Route	PO	PO	n/a	n/a	n/a
Classification	anticoagulants	Anticoagulant	n/a	n/a	n/a
Mechanism of Action	reduce the risk of stroke and blood clots in people who have a medical condition called atrial fibrillation	Prevents clots	n/a	n/a	n/a
Reason Client Taking	History of Afib	Blood clots	n/a	n/a	n/a
Contraindications (2)	Hepatic impairment, breast feeding	High risk for bleeding, liver or kidney disease	n/a	n/a	n/a
Side Effects/Adverse Reactions (2)	Increase blood clots if stop taking it, Increased bleeding	Cramps, dermal nercosis	n/a	n/a	n/a
Nursing Considerations (2)	Soft tooth brush, no electric razors	No electric razors, fall risk alert	n/a	n/a	n/a
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver panel, AST, ALT, Bilirubin,	PT, INR	n/a	n/a	n/a
Client Teaching needs (2)	Watch for bloody or black stool, Sob or dizziness	High risk for falls, education of Vitamin K foods	n/a	n/a	n/a

Hospital Medications (5 required)

Brand/Generic	HumuLIN R	Warfian	Sodium chloride	Zestril (Lisinopril)	Metformin (Glucophage)
Dose	0.1units	3 mg	0.9% SN	20mg	1,000mg
Frequency	Daily	Daily	Continuous	Daily	BID w/ meals
Route	SubQ	PO	IV	Oral	Oral
Classification	hormone	Anticoagulant	Mineral and electrolytes	Antihypertensives	Anti-diabetics
Mechanism of Action	Lowers blood glucose	Prevents clots	Rebalance fluid in the body	Inhibitors block the conversion of angiotensin I to the vasoconstrictor angiotensin II	Decreases hepatic glucose production
Reason Client Taking	Diabetic, or body in stress	Blood clots	Loss of electrolytes	the management of hypertension. Management of heart failure.	Management of type 2 DM
Contraindications (2)	Hypoglycemia, allergy	High risk for bleeding, liver or kidney disease	Hypertonic, hypernatremia	Hypersensitivity; History of angioedema with previous use of ACE inhibitors	Dehydration, renal & hepatic impairment
Side Effects/Adverse Reactions (2)	Lipodystrophy, swelling	Cramps, dermal nercosis	PE, Hypervolemia	Diarrhea & chest pain	Abdominal bloating, & Nausea/ vomiting
Nursing Considerations (2)	Assess tingling in hands and	No electric razors, fall risk alert	I/Os, Daily weights	Assess signs of angioedema dyspnea, facial	Assess for ketoacidosis & signs/

				swelling	symptoms of hypoglycemia
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Blood glucose, A1c	PT, INR	Monitor Na, & K+	Renal function, BUN and Creatinine, CBC	Blood sugars, A1c
Client Teaching needs (2)	Education on diet (foods), and sites of injections	High risk for falls, education of Vitamin K foods	Education of purpose of infusion, risk for dehydration	Avoid sub salt, take same time each day, do not double up on medications	When to take it, education on what it does

Medications Reference (APA):

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing*

    (14th ed.). Philadelphia, PA: Wolters Kluwer

Jones & Bartlett Learning (2019). Nurse's Drug Handbook (18th ed.). Jones & Bartlett Learning,

    LLC an Ascend learning company Boston, MA.

Vallerand, A. H., Sanoski, C.A., & Deglin J. H., (2015). Davis's Drug Guide for Nurses (14th

    ed.). F.A. Davis Company Philadelphia, PA.

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Assessment

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Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient appears alert, orientated, and awake. Patient knows the year, where he is at, day, time and condition in which he was admitted. Patient shows no immediate distress, and appearance is calm and not every engaged in conversation. Patient was irritable to get out of hospital.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:**	Patient's skin appears pink and dry; temperature is warm to the touch, skin turgor is elastic and 1 inch was seen to come off the bone when pulled at, no rashes where noted. Braden score 19. No

Rashes: **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	wounds visible. No Bruises. No drains.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	HEENT: PERRLA, White sclerae, conjunctivae were pink. Nose: clear, and pink mucosa membranes. Throat: mucous membranes are moist and pink. Neck: no pain when moveable, nodules palpated, nontender. Patient has own teeth, appears yellow stain. .
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Heart: normal sinus, clear S1 & S2 sounds, no murmurs. All Peripheral pulses are strong and 2+. Cardiac rhythm is A fib. Patient has a history of A fib rhythm. Patient is on a telemonitor. Capillary refill is less than 3 seconds. No neck vein distention. No edema. No CVA tenderness. No rash. No ecchymosis. No deformities appearance. .
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	No accessory muscles are used, clear equal bilateral breathe sounds.

GASTROINTESTINAL (2 points):
Diet at home:
Current Diet
Height:
Weight:
Auscultation Bowel sounds:
Last BM:
Palpation: Pain, Mass etc.:
Inspection:
    Distention:
    Incisions:
    Scars:
    Drains:
    Wounds:
Ostomy: Y ☐   N ☐
Nasogastric: Y ☐   N ☐
    Size:
Feeding tubes/PEG tube Y ☐   N ☐
	Patient is a diabetic. At home and in the hospital patient is on a diabetic and cardiac diet. Wt 91.9kg (202lbs), Ht 5'2", Patient's bowels are active and normal, Her last bowel movement was at 1026 it was large. There was no pain after palpations; there were no signs of distention, incisions, scars, drains or wounds. No ostomy. No NG tube. No feeding tube..

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:
	Genitourinary were not assessed, however a typically color would be pink, dry, and moist. Quantity of urine is large and clear yellow. No pain upon urination. No catheters.

MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient is alert and oriented times 2- 3. Patient has early dementia. ROM is assessed and good, Patient is moveable with help of assistance and family support. Strength is strong and equal in both hands as well as toes. ADL assistance moderate with walking, Fall score 21; high risk Patient is a fall risk due to her dementia. Patient is independent and needs support to stand.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	PERLA intact. Grip strength is equal in both legs and arms. Patient is oriented to self (x2-3), not a good reliable source of history. Mental status is demised. Patient recalls why she was admitted. Speech is clear. Patient is confused (has dementia). Sensory factors indicted and functional. No LOC, patient is alert and orientated, consciously aware of their surroundings.
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):**	Coping methods are watching TV, talking to family members; Developmental level was not mentioned by patient. Religion and what it means to the patient, patient did not respond and looked away. Patient's daughter was there and is her support. Patient lives at home with her daughter.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	99	130/63	20	96.8 F	99 room air
1532	84	137/63	16	98.6 F	98 room air

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1300	1-10; 10 being the worst	Chest	4/10	Dull pain	None, no pain meds were given because she did not want them
1532	1-10; 10 being the worst	Chest	3/10	Dull, sore	None, no pain meds were given because she did not want them

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	Patient IV is 22 gauge on the right wrist. Date was placed 2/17/2020. Dressing is intact, clean, and dry. No signs of drainage or erythema. Skin is cool and warm to the touch, dry and skin turgor less than 1 inch.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

550mL	335mL

Nursing Care

Summary of Care (2 points)

Overview of care: SBAR was given at 1230, from another nursing student. Patient was stable, with minor issue of walking away for the unit before officially getting discharged. Patient was company by her daughter for the whole day. Assessment and vitals were done on patient around 1300 and then again at 1532. Patient was waiting for discharged orders for the provider. Patient attempted to leave and then pulled out her IV across the hallway. Nursing staff and I stopped the bleeding at patched the patient up. Patient got discharged at 1700 to her daughter who took her home.

Procedures/testing done: None

Complaints/Issues: Patient was getting irritable waiting for discharged papers that they started to make a run out of the unit while pulling out her IV in her hand.

Vital signs (stable/unstable): Vital signs were stable.

Tolerating diet, activity, etc.: Patient is tolerating diabetic and cardiac diet, taking medication as prescribed, activity level is intermediate. Patient is tolerating activity with help of assistive devices and staff/ family support. Fluid intake and output are stable.

Physician notifications: Physician notes that patient is alert, aware, and orientated to self. Physician has done assessment and checked vitals. They plan for discharged today. Physician notes that the **p**atient will continue medication and diet compliancy.

Future plans for patient: Patient will continue with medication, diet and telemetry checks every two weeks with primary healthcare provider.

Discharge Planning (2 points)

Discharge location: Patient will be discharged home with daughter.

Home health needs (if applicable): Patient will need assistive deceives such as handle-bars, and a cane.

Equipment needs (if applicable): Patient will need assistance with moving around house with the assist of a cane or handle bars.

Follow up plan: Patient will follow up within two week to confirm medication complaint, diet complaint, and telemetry is still in normal sinus rhyme.

Education needs: Patient will need education on diabetic and cardiac diet, using assistive devices and watching hypertension.

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. Patient is decreased cardiac output as related irregular heartbeat as evidence by A-Fib.	This diagnosis was chosen because the patient claims to have a history of an irregular heartbeat.	1.Patient will be put on warfarin 3 mg daily PO to increase the prevention of clotting. 2.Patient will receive education medications	The family member of the patient responded to goals set for the patient and has minor complaints stating "I will take care of the medications and explain it to my mom".

1. 2. Patient has Anxiety related to feeling restlessness as evidence by trying to run away from the unit twice.	This diagnosis was chosen because the patient claims to have	**1.** Patient will be put on the lowest setting bed in order to prevent falling while at hospital. **2.**Patient will walk twice daily up and down the hall with assistance from a nurse, CNA, or assistive devices such as a walker for 1 week.	Patient responded to goals set for them and has minor complaints stating, "she feels less irritable and more calm."
2. Patient is a fall risk related to decreased Cardiac output as evidence by irregular heartbeat	This diagnosis was chosen because the patient claims to have	1.Patient will be placed on a fall risk protocol. 2. Patient's bed will be at the lowest height in case of a fall and mats will be put down.	Family member states that she is happy her mom is being taken care of so well and no falls have occurred.
3. Patient is bleeding risk as related medications they are on like blood thinners as evidence by pulling out IV when walking out of unit.	This diagnosis was chosen because the patient claims to have	1. Patient will allow nurse to remove IV catheter and apply gauze. 2. Patient will hold direct pressure on the open site to stop bleeding.	Daughter and patient both state that applying gauze pads and applying pressure on the site was best course of action.

Other References (APA):

Capriotti, Theresa, (2016). *Pathophysiology: Introductory Concepts and Clinical*

Perspectives Philadelphia, Pa: F.A. Davis Company.

Hinkle, J. L., Cheever, K.H. (2018). *Brunner & Suddarth's textbook of medical- surgical nursing*

(14th ed.). Philadelphia, PA: Wolters Kluwer

NANDA. (2017). NANDA- Approved Nursing Diagnoses 2015-2017. Retrieved from

     https://www.deanza.edu/faculty/hrycykcatherine/NANDA_2015-

     2017_list__November_2014.pdf

Concept Map (20 Points):

Subjective Data

Patient had palpations and sob related to AF irregular heartbeat. Vitals were taken at 1300 pulse 99, BP 130/63, RR20, Temp 96.8 F, O2 room air 99. Then again at 1582, pulse 84, BP 107/63, RR 16, Temp 98.6 F, O2 room air 98. Pain scale was taken at both 1582 and 1300. Both pain scales were 0, and now it is good in chest region, no intervention was take no place. Assessment abnormal findings were rhythm was AFib. No other abnormal findings. BNP was high at 105. I/o's: intake of 550cc output of 350cc.

Objective Data

Nursing Diagnosis/Outcomes

Patient will allow nurse to remove IV catheter and apply gauze. Patient will hold direct pressure on the open site to stop bleeding. Patient will be placed on a fall risk protocol. Patients 's bed will be at the lowest height in case of a fall and mats will be put down. Patient will be put on the lowest setting in order to prevent falling while at hospital.

1. Patient is decreased cardiac output as related A-Fib.
2. Patient has Anxiety related to feeling restlessness as evidence by getting out of bed.
3. Patient is a fall risk related to decreased Cardiac output as evidence by irregular heartbeat that is alert.
4. Patient is bleeding risk as related medication. Nursing Interventions: 1. Patient will be put on warfarin 3 mg daily PO to increase the prevention of clotting. 2.Patient will receive education medications

Patient Information

The patient is 73-year-old female, Hispanic, admitted 2/17/2020. Hx of Afib, and dementia. Diabetic, Full code, c/o sob, and palpation's around the chest and that is alert and oriented to self (x1). Daughter has HTN, and father died of CAD. Weight 202lbs, ht 5'2".