N281

STUDENT NAME Kendra Koenig	DATE CARED FOR PATIENT 2/13/12
Age: 81 Gender: M Length of Stay:6.0 days	Post-Op Day: NA
Code Status: (Circle or Highlight the status) Full Code Full Care/Do Not Resuscitate Comfort Care	Allergies: List medication/herbs/food and the reaction they cause: NKDA
Reason for admission to the hospital: CP and Palpitations	Give a brief description of the pathophysiology of the client's disease/disorder in your own words: With **atrial dysrthymias,** the focus of impulse generation shifts away from the sinus node to the atrial tissue, which acts as an ectopic pacemaker for one or more beats. With **SVT 'supraventricular tachycardia'**, there is rapid stimulation of atrial tissue and the heart beats anywhere from 100-280 bpm in adults. In Pt's with **atrial fibrillation 'A-Fib'**, multiple rapid impulses from many atrial foci depolarize the atria in a totally disorganized manner at a rate of 350-600 times per minute. "The result is a chaotic rhythm with no clear P waves, no atrial contractions, loss of atrial kick, and an irregular ventricular response. A-Fib increases the Pt's risk of thrombus formation. As the atria quiver in fibrillation, blood pools in the atria making the Pt at risk for CVA and/ or MI. **Tachybrady syndrome** is characterized by periods of fast arrhythmias (such as SVT's), especially A-Fib or atrial flutter, alternating with periods of very slow heart rates (bradycardia).
Admitting diagnoses: Atrial tachycardia (HR 230 bpm) without CP; Pt was given 6mg of Adenosine and converted back to a NSR with a HR of 64 bpm in the ED Surgery/procedures done and when: 2/13/12 Pt will go to the cath lab for a PTCA 'Percutaneous Transluminal Coronary Angioplasty' with possible stent placement. The Pt had the PTCA done on the 13th and it was found that his: EF was 35%, he had a 90% blockage of the LAD, 100% blockage of the mid LAD, and 90% blockage of the OML. Dr. Spiegel decided to have the Pt consult with a surgeon instead of stent placement. The surgeon cam to talk to the Pt while I was on lunch. The Pt told me the surgeon didn't know if he was going to perform the operation because of the risks of the CABG. The surgeon would revisit the Pt later after he consulted with a few other MD's. The Pt said no matter what, he wants the procedure done; he isn't ready to die (he was very adamant about this).	
Clinical signs and symptoms **expected** for this client with this diagnosis: (from your textbook) Palpations, CP, weakness, dizziness, decreased exercise tolerance, fatigue, SOB, nervousness, anxiety, hypotension, syncope (clinical manifestations depend on the duration of SVT)	Clinical signs and symptoms your client demonstrated: Sudden onset of CP at 6AM on 2/6/12; Pt also c/o palpitations and L arm pain; Pt reported pain as "sharp and achy"; HR 230 bpm; on 2/13/12 Pt was in and out of A-Fib the entire day with frequent episodes of Tachybrady syndrome; the Pt also c/o weakness and fatigue

Pertinent Health History:

- EF 34% 2008 stress test
- DVT
- PE
- Rapid A-fib/ flutter
- IVC filter placement
- HTN
- Type II DM (Dx at 50 y/o)
- Inguinal hernia repair
- Arthritis
- Appendectomy
- CP
- Cardiomyopathy
- Tachybrady syndrome

After obtaining shift report what is the one most important nursing intervention for you to carry out this shift?

I didn't obtain shift report this AM but I made sure to introduce myself to my RN and told her I would be accompanying my Pt to the cath lab (I had grabbed a set of VS on him at about 655 and looked him over quickly and made sure to check his labs before I went). The most important thing for me to do was to frequently assess my Pt after his PTCA procedure (focused cardiovascular and neurovascular assessments) as well as looking at his dressing and checking his VS.

Physical: information obtained and documented that reflects what has occurred with the client prior to your arrival. This information is found in the H&P in the chart or computer and the nursing assessment documentation in the computer and is documented on the left side of this form.	**Student Assessment: this is information you observe during clinical and is documented on the right side of the form**
Cognitive/Perceptual: Sensory impairment and correction (circle all that apply): hard of hearing/hearing aid, impaired vision/glasses, dentures, decreased sensation in extremities Dysphagia: documented or suspected	**Cognitive/Perceptual**: General Appearance (posture, position, hygiene) The Pt was upright in bed ready for the procedure. He didn't seem anxious; he just wanted to get it done (so he can feel better). He looked great after his early morning bed bath (and shave) before the procedure.

PERRL: yes/ no Size of Pupils: Not charted

Level of Consciousness: Alert

Orientation: X4

Extremity Movement: Both UE and LE have equal movement

Speech Quality & Comprehension: Appropriate and clear

Affect: calm/ cooperative/ flat/ agitated/ combative

Restraints: yes/ no Type:_____

Sitter: yes/ no

Sensory impairment and correction (circle all that apply): (EXTREMLY) hard of hearing/hearing aid, impaired vision/glasses, dentures, decreased sensation in extremities

Dysphagia: documented or suspected

PERRL: yes/ no Size of Pupils: 3mm

Level of Consciousness: Alert

Orientation: X4

Extremity Movement: Both UE and LE have equal movement

Speech Quality & Comprehension: Clear and appropriate; easy to comprehend

Affect: calm/ cooperative/ flat/ agitated/ combative

Restraints: yes/ no Type:_____

Sitter: yes/ no

Oxygenation/Perfusion:

Lung Sounds & Location: All lobes have clear breath sounds

Heart Sounds: Not charted

Heart Rate (regular vs irregular): Regular

Previous Vital Signs: 36.8 degrees, 136/70, Apical HR 60 bpm, 18 RR, 98% room air, 0 pain

Pulses	Radial	Dorsalis Pedis	Posterior Tibial
Right	2+	2+	
Left	2+	2+	

Pulse Quality Scale

0 -Absent
1+ - Palpable but weak
2+ - Normal
3+ - Increased
4+ - Bounding

Capillary Refill: <2 seconds

Skin Color: Normal for ethnicity

Skin temperature: Warm

Risk for Venous Thromboembolic Event (VTE): Yes No
(Why) Pt has a Hx of DVT/ PE, Pt has reduced mobility, Pt is older (81 y/o)

SCD: yes no Heparin or LMWH (circle if applicable)

Edema (Amount and Location): None

Edema Scale

1+ Mild pitting, slight indentation, no perceptible swelling of the leg
2+ Moderate pitting, indentation subsides rapidly
3+ Deep pitting, indentation remains for a short time, leg looks swollen
4+ Very deep pitting, indentation lasts a long time, leg is very swollen

Oxygenation/Perfusion:

Lung Sounds & Location: Lung sounds were clear bilaterally with diminished capacity at the bases

Accessory muscle use: NA

Clubbing: NA Cough: Occasional dry cough Sputum: Clear with slight blood tinge

Heart Sounds: S1 and S2 (sounded distant)

Heart Rate (regular vs irregular): Regularly Irregular

Telemetry Rhythm: alternating between NSR and A-Fib (with tachybrady syndrome)

JVD: yes/ no

	BP	HR	RR	Temp	O2 Sat/ O2 amt
0700	94/64	106	18	36.3	98% room air
1130	143/69	54	36.6		96% room air

Pulses	Radial	Dorsalis Pedis	Posterior Tibial
Right (weaker pulses on R side)	2+	1+	1+
Left	2+	1+	1+

Oxygen type and amount: Room air

Telemetry Rhythm: Sinus bradycardia

Renal Dialysis Access: yes no Location:_____

Bruit/thrill present? _____

Pulse Quality Scale

0 -Absent
1+ - Palpable but weak
2+ - Normal
3+ - Increased
4+ - Bounding

Capillary Refill: <2 seconds

Skin Color: White-"normal for ethnicity"

Skin temperature: Warm

Risk for Venous Thromboembolic Event (VTE): Yes No
(Why) Pt has a Hx of DVT/ PE, Pt has reduced mobility, Pt is older (81 y/o), Pt had a PTCA today

SCD: yes no Heparin or LMWH (circle if applicable)90mg Lovenox resumed at 1300

Edema (Amount and Location): Bilateral ankle edema without pitting

Edema Scale

1+ Mild pitting, slight indentation, no perceptible swelling of the leg
2+ Moderate pitting, indentation subsides rapidly
3+ Deep pitting, indentation remains for a short time, leg looks swollen
4+ Very deep pitting, indentation lasts a long time, leg is very swollen

Oxygen type and amount: NA

Renal Dialysis Access: yes no Location:_____

Bruit/thrill present? _____

Nutrition/Hydration

Bowel Sounds: Present all 4 quadrants

Abdomen tender or non tender

Abdomen distended: yes no-"soft&flat"

Previous 24 hours intake and output: I= 353mL; O=300mL

Diet: NPO @ midnight 2/13/12 (Pt noted to have a good appetite)

Tube Feeding: NA Type_____ Rate/hour_____

Height/weight:173 cm, 89.3 kg

Vascular Access: (circle which one applies) Peripheral or Central

Central Vascular Access Type:_____

PIV gauge: 20g R hand IV Site: (use phlebitis scale) 0 Phlebitis, 0 infiltration

IV solution: Saline Lock @ rate :_____

Dates : (when PIV site and tubing to be changed)
Inserted 2/9/12 (needs to be changed 2/13/12)

Nutrition/Hydration

Bowel Sounds: Present all 4 quadrants-Normoactive

Abdomen tender or non tender- Pt had one small area that was "achy" in the RLQ upon palpation

Abdomen distended: yes no

Current Intake and Output: (your shift) The Pt was NPO since midnight 2/13/12 and was able to first eat at 0830)

- I: 495.1 mL (410 milk and 85.1 0.9% NS)
- 0: 0mL (As I was leaving the Pt called the CNA for the urinal; I wasn't able to get the amount of output; I offered him assistance but he denied it because he said he wasn't able to urinate in the position he had to be kept in after the PTCA; he said he needed to stand up so he would wait until he could do so)

  Pt had no upper teeth and didn't wear dentures. He stated that he had his remaining upper teeth pulled so he could eat better. He said he can eat without difficulties and if issues arise, he will get dentures

Diet: NPO until 0830; after 0830, cardiac diet

% of food intake per meal: B: 100% L: 75%

Tube Feeding: NA Type_____ Rate/hour_____

Tube Placement Check_____ Residual_____ mL

Vascular Access: (circle which one applies) Peripheral or Central

Central Vascular Access Type:_____

PIV gauge: 20g R hand IV Site: (use phlebitis scale): 0 Phlebitis and 0 infiltration Dressing: Tegaderm with stat lock

	IV solution: 0.9% NS @ 20mL/ hr (TKVO-this was started in the cath lab) ***IV needed to be changed today and I communicated with Sue and my primary RN; we all decided it'd be best to wait and see the surgeon's plan of care for the Pt before we started a new line (if he was going to have the CABG, he would have needed an 18g IV) *** **Phlebitis Scale (Circle appropriate criteria)** Grade — Clinical Criteria 0 — no symptoms 1 — erythema at access site with or without pain 2 — pain at access site with erythema and or edema 3 — pain at access site with erythema and or edema, streak formation, palpable venous cord 4 — pain at access site with erythema and or edema, streak formation, palpable venous cord > 1" length, purulent drainage
Elimination Urine: Voiding –yellow& clear urine Foley Other:_____ BM pattern (prior to hospital) : Regular-daily Date of Last BM: 2/12/12 @ 1000 Possible Causes of Diarrhea or Constipation in this client: NA Ostomies: describe type, location, stoma, character of output NA	**Elimination** Urine: Voiding Foley Other:_____ BM pattern (prior to hospital): "Quite regular" according to the Pt; everyday or every other day Date of Last BM: 5/13/12 0530 Possible Causes of Diarrhea or Constipation in this client: NA Ostomies: describe type, location, stoma, character of output NA
Mobility/Activity and Rest: Activity ordered: OOB ad lib ROM/Muscle Strength: Strong 5 Full ROM, full strength 4 Full ROM, less than normal strength 3 Can raise extremity but not against resistance 2 Can move extremity but not lift it 1 Slight movement 0 No movement **Extremity** / **Grade**: RUE 5; LUE 5; RLE 5; LLE 5 Amputations : None Assistive devices used: None PT/OT Ordered: Yes No Sleep Pattern: (prior to hospital) _____ What does client do to aid in sleep at home	**Mobility/Activity and Rest:** Activity ordered: OOB ad Lib; due to the **PTCA**, the Pt was on complete **bed rest** until 1420; at 1020 we were able to elevate the HOB to almost 30 degrees ROM/Muscle Strength: Strong 5 Full ROM, full strength 4 Full ROM, less than normal strength 3 Can raise extremity but not against resistance 2 Can move extremity but not lift it 1 Slight movement 0 No movement **Extremity** / **Grade**: RUE 5; LUE 5; RLE 5; LLE 5 Amputations: None Assistive devices used: None (there was a walker in his room so I questioned him about it; he said one of the RN's brought it in just in case; he said he never uses a walker and that he walked perfectly fine in the halls yesterday; he also stated that he would NOT be using a walker) PT/OT Ordered: Yes No Sleep Pattern: (prior to hospital) Excellent according to my Pt; He goes to bed around 9pm and wakes up around 9am on a daily basis. He reports no issues with insomnia, or frequent night time awakenings. What does client do to aid in sleep at home: He has his cat, Cali, sleep with him ☺
Comfort (N/V/D/C/fatigue/lack of appetite)/Pain: Pain Level: 0 "No actual or suspected pain" Location:_____ Location:_____	**Comfort (N/V/D/C/fatigue/lack of appetite)/Pain:** Pain Level: 0"No actual or suspected pain"- Pt reported no pain throughout the day (I questioned him on multiple occasions) Location:_____ Location:

Quality:_____ Alleviating factors:_____ Aggravating factors:_____ **Other Comfort Issues:** Interventions Ordered/Performed:	Quality:_____ Alleviating factors:_____ Aggravating factors:_____ **Other Comfort Issues:** Uncomfortable bed (Pt's shoulder started to "ache" but he denied medication). At 1400, I gave my Pt a nice **head-toe** 'rub-massage' with lotion because his skin was dry and he had been lying quit uncomfortably due to the PTCA. When I asked him in the morning, "What's the one thing I can do for you today to make your day better and make a difference?" He said he couldn't think of anything so I suggested a back rub-massage. His face **light up** with excitement and he said he couldn't wait. Treatment (includes meds, non-pharmacological treatments and pain level) -Back rub (Pt stated he felt so much better after the massage) -Foot rub
Regulation: evidence of immune compromise, any endocrine/hormonal disorder: **Type II DM** Bedside glucose readings (previous 24 hours): 2/12/12) **0851- H 164; 1209-H 223**	**Regulation:** evidence of immune compromise, any endocrine/hormonal disorder: **Type II DM (Pt was Dx at 50 y/o; his father was also a diabetic)** Bedside glucose readings when caring for client: • 0820: 156- 2 units of insulin • 1150: 256-5 units of insulin given by primary RN
Integumentary: note location, size and description Braden Scale:18 (Pt: has slightly limited mobility, slightly limited sensory perception, is occasionally moist, walks occasionally, has no apparent problem with friction and shear, adequate nutrition, and slightly limited mobility) Wound surgical: NA Wound: Skin tear L upper arm Abrasions/bruises/rash: NA Pressure Ulcers: (length, width and depth, describe wound bed and stage) NA	**Integumentary: note location, size and description** Braden Scale: 19 (slightly limited sensory perception, rarely moist, walks occasionally, slightly limited mobility, adequate nutrition, potential problem with friction and shear) Wound surgical: Transparent gauze dressing to R femoral artery after PTCA (no drainage noted) Wound: Skin tear on L bicep area (he had a bruise from his anticoagulant therapy that ripped open) Abrasions/bruises/rash: Multiple bruises bilaterally on Pt's forearms; Pt also had multiple 0.5cm circle bruises to the RLQ area due to Lovenox injections Pressure Ulcers: (length, width and depth, describe wound bed and stage) NA Treatment:

Diagnostic Results (include labs, radiology, endoscopy, cardiac procedures)
Please list the most recent lab value unless the client is admitted with a critical lab value and list all PT/INR, PTT, Platelets on all clients receiving heparin, or LMWH

Laboratory	List values and indicates Normal/High or Low	Why is the lab abnormal for your client?	Nursing Concerns
Na+	N 138		
K+	N 4.5		
Cl-	N 100		
Co2	N 28		
BUN	N 25 (according to Mosby's this value is high)	Recent MI, dehydration	If BUN continues to increase; monitor I&O's; assess urine

Cr	H 1.62	Diabetic nephropathy? Dehydration	Continue to monitor Cr and I&O's
Ca+	N 8.8		
Glucose	H 139	Pt has a Type II DM	Administer insulin as ordered based upon FSBS; delayed wound healing/ longer recovery after PTCA with elevated BS
WBC	N 6.4		
RBC HgB Hct	L 4.41 N 14.0 L 40.9	Dietary deficiency, renal disease?	Encourage intake of a well balanced diet (high in iron and folic acid); monitor H&H, assess for S/Sx's of anemia: weakness, pallor, SOB, etc.
PT PT/ INR	H 15.3 N 1.2	Pt is receiving Lovenox injections and 81mg of aspirin daily	Assess for S/Sx's of bleeding: pertichae, ecchymosis, pallor, tachycardia, hypotension
BNP	H 601 (2/6/12)	Recent MI	Cardiac rhythm analysis Q4h as ordered; assess for CP; monitor for S/Sx of CHF: edema, SOB, fatigue, crackles, increased weight, etc.
CPK	N 33		
Troponin (critical value)	H 0.22	Recent MI	Assess for CP and S/Sx of MI: L arm numbness, substernal CP, diaphoresis, sense of impending doom, etc.
Platelets	N 202		
Cholesterol	N 127		
HDL	N 41		
LDL	L 68.8	Hypoproteinemia (dietary deficiency)	Continue to monitor LDL value; increase protein through dietary changes.
Triglycerides	N 86		
MB Fraction	N 4.2		
ALT	N 15		
ALK Phos	N 72		
AST	N 15		
Bili total	N 0.9		
Total protein Albumin	L 5.6 L 3.0	Pt may be suffering from imbalanced dietary intake. Pt is 81 y/o (albumin levels decrease with age)	Monitor closely for drug-drug interactions since decreased levels of albumin. Monitor for delayed wound healing. Try to increase protein intake through diet.

Radiology/ Endoscopy/Cardiac Test	Results
X Ray barium swallow	Low grade gastroesophageal reflux noted and moderate esophageal dysmotility
2/6/12 12 Lead ECG	Sinus rhythm with sinus arrhythmia; incomplete R bundle branch block

2/7/ 12 12 Lead ECG	**Atrial flutter; Tachycardia; ******Acute MI*******
2/7/12 Chest X Ray	**Small L pleural effusion; "excluding explansile sclerotic 7th rib lesion vs. parenchymal scarring"**
2/10/12 12 Lead ECG	**Sinus bradycardia"; L anterior fascicular block; abnormal ECG**
Sexuality: (complete only if reason client admitted to hospital) STD's_____ Menstrual cycle:_____ Genitalia:_____ Pregnancy:_____	
Safety/Security Needs: Morse Fall Risk Assessment: 45 (Pt has a secondary Dx, IV access, and a weak gait) Interventions to prevent injury: Adequate lighting, educate Pt about medication SE, bed alarm on, close to nurses station, fall risk armband, stoplight magnet on door frame	**Safety/Security Needs:** Morse Fall Risk Assessment: 35 (Pt has a secondary Dx and IV access) Interventions to prevent injury: (must list) Adequate lighting, educate Pt about medication SE, bed alarm on, close to nurses station, fall risk armband, stoplight magnet on door frame and at HOB, frequent rounding, bed in low position, side rails up X2, call light with the Pt in bed, items on bedside table within close reach to the Pt (i.e. tissues, H20, phone), room free of clutter

Love and Belonging Needs:

Occupation (current or prior to retirement): Pt was a Veteran (he was drafted into the Army for 2 years). He retired 4 years ago, at the age of 77, from his business that he owned ("Ed's construction clean up").

Support System: Son and granddaughter; Pt reports that he has 2 sons and he is really close to his son that lives down the street from him in Oceanside (he doesn't really get along well with his other son); his granddaughter is a RN and she visits him frequently (Pt lives alone)

Spirituality: Protestant (religion, etc)

Culture: Traditionalist American (Pt was born in America but both of his Pt's are German)

Language: English

Interpreter needed: yes no

Body Image/Self Esteem Needs:

Potential changes in client's body that may result in negative feelings: Pt has no upper teeth but this doesn't seem to concern him. He also has multiple bruises on his body r/t anticoagulant therapy (which causes his skin to be fragile and tear easily) which concerns/ annoys him.

Client's Perception of Health and Illness: Pt reported that no matter what, he wanted Sx to fix his cardiovascular issues. He feels like he has many years left in him and he's not ready to die. He understood his blockages and knows that medications won't be effective! He wants the surgery so he's back to his old self (not so tired and weak). He wants to feel better so he can move to Montana where he can do all the fishing he wants!

Client/Family Education (all the education the client needs to manage their health): DVT/ PE prophylaxis education, medication reconciliation and education (why Pt is on various medications and side effects), ROM, IS, education on DM (insulin, FSBS, foot care, etc.) **Answer this question: If the physician came in at this moment to discharge the client, what is <u>the one priority</u> teaching instructions for this client? DVT/ PE prophylaxis education; S/Sx's of DVT/ PE; and when to notify the HCP**	**Barriers to learning:** (circle all that apply) language, vision, hearing, fatigue, cognition, pain, lack of time, lack of knowledge, lack of motivation, too much stimulus, cold/hot Clients preferred method of learning: (reading, seeing, doing, hearing)
Discharge Planning: (does client need SNF, HH, Rehab, OT/PT, medical equipment?) I don't know when the Pt will be discharged. He is consulting with a surgeon in regards to a CABG. If the Pt gets the CABG, he will probably need to go to a SNF for a few weeks for rehabilitation and nursing care because he lives alone.	**Health Promotion:** What does the client do to maintain their health prior to hospitalization? The Pt likes to fish and go for walks. He hasn't been able to walk lately because he gets very SOB and weak with exertion. He has been compliant with his medications.

Nursing Diagnoses: Prioritize client problems in order of priority with 1 being the highest priority (must have a minimum of 3 **complete** nursing diagnoses, 1 of which must be psychosocial):	**Interventions (5 interventions) for each nursing diagnoses in order of priority**
I. Decreased cardiac output **R/T: altered electrical conduction** **AEB: the Pt fluctuating between NSR and A-Fib (with tachybrady syndrome) and during the PTCA, it was found that the Pt's EF was 35%, he had a 90% blockage of the LAD, 100% blockage of the mid LAD, and 90% blockage of the OML.**	**I.** **1. Monitor for symptoms of heart failure (HF) and decreased cardiac output; listen to heart sounds, lung sounds; note symptoms, including dyspnea, orthopnea, Cheyne-Stokes respirations, fatigue, weakness, third and fourth heart sounds, and crackles in lungs.** **2. After 1420 (post- PTCA procedure orders), place client in semi-Fowler's or high Fowler's position with legs down or in a position of comfort** **3. Provide a restful environment by minimizing controllable stressors and unnecessary disturbances. The Pt likes the TV off with his door open. Schedule rest periods after meals and activities.** **4. Check blood pressure, pulse, and condition before administering cardiac medications such as angiotensin-converting enzyme (ACE) inhibitors, digoxin, calcium channel blockers, and beta-blockers such as carvedilol. We withheld the Pt's 0900 diltiazem (Cardizem) as well as Metoprolol (Toprol-XL) due to bradycardia. The primary RN withheld the Pts 1200 dose of digoxin due to bradycardia. The Pt was alternating between NSR and A-Fib (with tachybrady syndrome) the entire day.** **5. Observe for chest pain or discomfort; note location, radiation, severity, quality, duration, associated manifestations such as nausea, indigestion, and diaphoresis; also note precipitating and relieving factors. The Pt denied any CP throughout the day.** **6. Refer the Pt to a HF program for education, evaluation, and guided support to increase activity and rebuild life.**
II. (risk for) Ineffective peripheral tissue perfusion **R/T: circulatory stasis** **AEB: the Pt's Hx of A-Fib, the Pt had a previous DVT/ PE in 2008 with subsequent IVC filter placement, and the Pt had 1+ bilateral DP and PT pulses**	**II.** **1. Check the brachial, radial, dorsalis pedis, posterior tibial, and popliteal pulses bilaterally. If unable to find them, use a Doppler stethoscope and notify the physician immediately if new onset of pulses is not present. Note skin color and feel the temperature of the skin. Check capillary refill. Note the presence of edema in the extremities and rate severity on a four-point scale.** **2. Do not elevate the legs above the level of the heart.** **3. Keep the client warm and have the client wear socks and shoes or sheepskin-lined slippers when mobile. The Pt was**

	constantly wearing his hospital slippers. Make sure to put them on right away after you assess his lower extremities (pulses, cap refill, sensation, edema, presence of pressure ulcers, etc.). **4. After 1420, get the Pt OOB and have him ambulate. First start in his room, then progress to the nurse's station, and finally ambulate in the halls (each time the distance will progressively increase). Have the Pt complete leg/ foot exercises while in bed (after 1420 due to post-PTCA restrictions).** **5. Observe for signs of deep vein thrombosis, including pain, tenderness, swelling in the calf and thigh, and redness in the involved extremity. Take serial leg measurements of the thigh and calf circumferences. If S/Sx of DVT are present, contact physician to order a Doppler U/S and d-dimer test.** **6. Recognize that the elderly have an increased risk of developing pulmonary embolism; if it is present, the symptoms are nonspecific and often mimic those of heart failure or pneumonia.**
III. Fear **R/T: threat of death** **AEB: the Pt saying that: he was going to have the CABG no matter what, he wasn't ready to die , he still had many more years in him (he wants to live to be at least 90); and he called his son multiple times throughout the day to discuss the PTCA and the CABG.**	**III.** **1. Assess source of fear with the client. Encourage the client to explore underlying feelings that may be contributing to the fear.** **2. Stay with clients when they express fear; provide verbal and nonverbal (touch and hug with permission and if culturally acceptable) reassurances of safety if safety is within control. I stroked the Pt's arm and hand when he was talking to me about the CABG and death; I felt as if he became a bit calmer and more at ease.** **3. Explore coping skills previously used by the client to deal with fear; reinforce these skills and explore other outlets. Assess (/inquire) how the Pt coped with his DVT that turned into a PE and almost killed him several years back.** **4. Provide backrubs and massage for clients to decrease anxiety. The Pt reported, "feeling so much better" after I gave him a head-toe massage! He particularly enjoyed the back rub as well as the hand & foot massage.** **5. Identify how the client expresses fear. The Pt called his son about 4 times to discuss the PTCA and CABG. Validate the client's feelings regarding fear.**

Medications: Name/Amount/Route (generic names only)	Classification	Mechanism of Action	Why is Your Client on this Med?
amiodarone 200mg, tab, PO, BID	Antiarrhythmics	Management of suparventricular tachyarrhythmias, prolongs action potential and refractory period. Inhibits adrenergic stimulation. Slows sinus rate, ↑ PR and QT intervals, vasodilates.	***BLACK BOX WARNING*** 2/6/12 Pt BIB medics for atrial tachycardia,; 2/7/12 Pt's ECG rules an acute MI; Hx of rapid A-Fib/ flutter
aspirin (ASA) 325 mg, EC tab, PO, daily	Antipyretic, nonopioid analgesic, salicylate, decreases platelet aggregation	Decreases platelet aggregation thus reducing incidence of TIA and MI	For prophylaxis of TIA and MI, Pt is at risk due to history of HTN, A-Fib, DVT/PE
Keflex 500mg, cap, PO, QID	Anti-infectives (1st generation cephalosporin)	Binds to bacterial cell wall membrane, causing cell death	Prophylaxis?
digoxin (Lanoxin) 0.125 mg, tab, PO, daily	Antiarrhythmics, inotropics, digitalis glycosides	Increases the force of myocardial contraction, increases cardiac output and slows the heart rate	***Check apical HR 1st*** Pt has a Hx of rapid A-Fib/ flutter
diltiazem (Cardizem) 30mg, tab, PO, QID	Antianginal, antiarrhythmic (class IV), antihypertensive, Ca+ channel blocker	Inhibits transport of Ca into myocardial and vascular smooth muscle cells; also causes vasodilation.	***Hold if HR <60 or SBP<90; if HR> 120, give 60mg instead of 30mg*** Pt has a Hx of rapid A-Fib/ flutter and HTN
docusate (colace) 100mg, cap, PO, BID	Laxative, stool softener	Prevents constipation by promoting incorporation of water into stool resulting in softer fecal mass	Pt takes metoprolol which has constipation as a SE; hospitalization (new environment) can cause constipation
enoxaparin (Lovenox) 90 mg, syringe, subQ, Q12h	Anticoagulant, antithrombotics	Potentiates the inhibitory effect of antithrombin on factor Xa and thrombin; prevention of VTE	Pt has a Hx of DVT/ PE; Pt will have a PTCA on 2/13/12
Insulin glargine (Lantus)10units, injection, SUBQ, QHS *Long acting	Antidiabetic, hormone	Lowers blood glucose by stimulating glucose uptake in skeletal muscle and fat, inhibiting hepatic glucose production.	Pt has Type II DM
Insulin lispro (Humalog "High Risk") SS, AC & HS, SubQ *Rapid acting	Antidiabetic, hormone	Lowers blood glucose by stimulating glucose uptake in skeletal muscle and fat, inhibiting hepatic glucose production	Pt has Type II DM
Metoprolol (Toprol-XL) 50mg, ER, tab, PO, daily	Antianginal, antihypertensive, beta blocker	blocks stimulation of beta1 adrenergic receptors which ↓ HR and contractility which reduces cardiac output and lowers systemic BP	Pt has a Hx of HTN and rapid A-Fib/ flutter
nitroglycerin (NTG paste 2%) 0.5 inch ointment, Top, Q6H	Antianginals, nitrates	↑ coronary blood flow by dilating coronary arteries, produces vasodilation, ↑ cardiac output and ↓ BP	Pt has a Hx of HTN and CP
senna (Senekot) 1 tab, PO, QHS	Laxative	Active components of Senna alter water and electrolyte transport in the large intestine, resulting in accumulation of water and increased peristalsis	Pt has issues with constipation? (I didn't see this information in the Pt's chart)
simvastatin (Zocor) 40 mg, tab, PO, QH5	Lipid lowering agent, HMG-CoA reductase inhibitor	Competitively inhibit HMG-CoA reductase in the liver, leads to ↓ total and LDL cholesterol, ↓ TG	Pt has a Hx of HTN. Zocor is used for secondary prevention of cardiovascular events.
acetaminophen (Tylenol) 650 mg, tab or suppositry, PO or PR, Q4H PRN	Antipyretic, nonopioid analgesic	Inhibits synthesis of prostaglandins that may serve as mediators of pain and fever, mostly in CNS	PRN for mild pain (1-3)
Zofran/ 4mg/ Q8H PRN/ IVP **Administer undiluted Rate: over 30 seconds (preferably 2-5 minutes)**	Anti-emetic	Blocks the effects of serotonin at 5-HT3-receptor sites located in vagal nerve terminals and the chemoreceptor trigger zone in the CNS.	PRN for N/V
hydromorphone (Dilaudid) 1 mg, tab, PO, Q3H PRN,	Opioid agonist, opioid analgesic	Binds to opiate receptors in the CNS. Alters the perception of and response to painful stimuli and produces CNS depression.	*Hold if RR <10* PRN for moderate pain (4-7)

Morphine: 2-4 mg/ IVP/ Q2h/ PRN **Diluent: 5mL NS** **Rate: Administer 2.5-15mg over 5 min**	Opioid agonist, opioid analgesic	Binds to opiate receptors in the CNS. Alters the perception of and response to painful stimuli and produces CNS depression.	PRN for severe pain (8-10)
diltiazem (Cardizem) 60mg, tab, PO, QID PRN if HR>120	Antianginal, antiarrhythmic (class IV), antihypertensive, Ca+ channel blocker	Inhibits transport of Ca into myocardial and vascular smooth muscle cells; also causes Vasodilation.	PRN if HR> 120; Pt has a Hx of rapid A-Fib/ flutter and HTN

What medications is your client on at home?

- **Simvastatin 40mg daily**
- **Novolog with meals 10 units**
- **Aspirin 81mg daily**
- **Metaprolol 50 mg daily**
- **Pradaxa 150mg BID**

Please answer the following questions:

1. What are you on alert for today with this client?
2. What are the priority assessments to make on this client?
3. What complications may occur? What could go wrong?
4. What interventions will prevent these complications?

? #1	Hyperglycemia	VTE	Episodes of A-Fib
? #2	• FSBS AC & QHS • 3 P's: Polyphagia, polydipsia, polyuria • I&O's	• Assess calf for erythema, edema, pain (S/Sx of DVT) • Assess for SOB, anxiety, decreased O2 saturation (S/Sx of PE)	• Cardiac rhythm analysis Q4h as ordered • Compare apical and peripheral pulses • Focused cardiac assessment (heart sounds, rhythm) • Assess for S/Sx of A-Fib (palpitations, CP, dizziness, fatigue, etc.)

? #3	• HHNS 'Hyperosmolar Hyperglycemic Nonketotic Syndrome'	• DVT • PE-respiratory arrest • Death	• Episode of A-Fib non-responsive to medication (hence the need for cardioversion) • CVA • Cardiac arrest
? #4	• Diabetic diet • Monitor BS and insulin coverage PRN • Exercise (Ambulate)	• Ambulation • Leg exercises • 90 mg Lovenox SUBQ • 81mg Aspirin	• digoxin (Lanoxin) 0.125 mg, tab, PO, daily • diltiazem (Cardizem) 30mg, tab, PO, QID • diltiazem (Cardizem) 60mg, tab, PO, QID PRN if HR>120