

Nursing Process Paper-Nursing 30040

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Client Profile:

K.W. a 67 year old female was admitted September 1st, 2012 for Aortic Valve Disorder following surgery with followed by an admitting diagnosis of Aortic Valve Stenosis. Her history includes Chronic ischemic heart disease unspecified (NOS), Diabetes with neurological manifestations (Type 1), Unspecified essential hypertension (NOS), Hypothyroidism (NOS), Unspecified Idiopathic Peripheral Neuropathy (NOS), Other and unspecified hyperlipidemia (NEC/NOS), Coronary atherosclerosis of autologous vein bypass graft, Coronary atherosclerosis of artery bypass graft, and Unspecified sleep apnea.

PubMed Health (2012) outlines Aortic Stenosis as:

The aorta is the main artery carrying blood out of the heart. When blood leaves the heart, it flows through the aortic valve, into the aorta. In aortic stenosis, the aortic valve does not open fully. This decreases blood flow from the heart. As the aortic valve becomes more narrow, the left ventricle has to increase pressure to pump blood out through the valve. To do this extra work, the muscles in the ventricle walls become thicker, which can lead to chest pain. As the pressure continues to rise, blood may back up into the lungs. Severe forms of aortic stenosis prevent enough blood from reaching the brain and the rest of the body. Aortic stenosis may be present from birth (congenital), but usually it develops later in life (is acquired). Children with aortic stenosis may have other congenital conditions. In adults, aortic stenosis usually occurs due to calcium deposits that narrow the valve. This is called calcific aortic stenosis, and it generally affects older people (Dugdale, Chen, & Zieve, 2012).

Black and Hawk (2009) described Heart failure as:

Is a physiologic state in which the heart cannot pump enough blood to meet the metabolic needs of the body. Heart failure results from changes in systolic or diastolic function of the left ventricle. The heart fails when, because of intrinsic disease or structural defects, it cannot handle

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a normal blood volume or, in the absence of disease, cannot tolerate a sudden expansion in blood volume. Heart failure is not a disease itself; instead the term refers to a clinical syndrome characterized by manifestations of volume overload, inadequate tissue perfusion, and poor exercise tolerance. Whatever causes the pump failure results in hypoperfusion of tissue, followed by pulmonary and systemic venous congestion, and it's often called congestive heart failure. Risk factors include intrinsic and extrinsic factors (p. 1430-1448). Without the patient's history I would have never known he was a heart failure patient. Her medications flagged my attention that clearly there was something going on with her heart, but during her assessment I didn't hear anything that suggested her situation wasn't being handled with the upper most care (p. 1430-1448).

Black and Hawk (2009) outlines Neuropathy as:

The most common chronic complication of diabetes mellitus. Nearly 60 % of diabetic clients experience it, because nerve fibers do not have their own blood supply, they depend on the diffusion of nutrients and oxygen across the membrane. When axons and dendrites are not nourished, their transmission of impulses slows. Sorbitol accumulates in nerve tissue, further diminishing both sensory and motor function. Both temporary and permanent neurologic problems may develop in clients with diabetes mellitus during the course of this illness. Nerve pain is different from other types of pain you may feel, such as pain from a sprained ankle or muscle ache. Nerve pain often feels like numbness, stabbing, tingling, or burning sensation that may keep clients up at night or stop them from doing daily tasks. Often referred to as diabetic peripheral neuropathy (p. 1104-1105).

Black and Hawk (2009) defined Hypertension:

As a persistent elevation of systolic and diastolic blood pressure (DBP) at a level of 90mm Hg or higher. Hypertension is characterized by type, cause, and severity. Most clients

with a combination of systolic and diastolic blood pressure elevation are diagnosed with primary hypertension, also known as essential or idiopathic hypertension. Blood pressure remains elevated and continues to rise over time because of a persistent, progressive increase in peripheral arterial resistance. The persistent raise in arterial resistance is due to inappropriate renal retention of salt and water or abnormalities of or within the vessel wall. Clients who develop hypertension from an identifiable cause- a specific disease state or problem – are diagnosed with secondary hypertension, and in many cases the underlying cause is correctable. Risk factors for hypertension include family history, age, gender, ethnicity, diabetes, stress, obesity, nutrients, and substance abuse. Ways in which to reduce hypertension include normalizing arterial pressure, lifestyle modifications, weight reduction, Na restriction, dietary fat modification, exercise, alcohol restriction, caffeine restriction, relaxation techniques, smoking cessation, K supplementation, and pharmacologic interventions and provider interventions. As a major risk for other cardiovascular conditions, although it does not usually produce symptoms of its own (p. 1290-1306). This patient had many markers that I gathered to outline a clear path to her having a history of hypertension. My concept map really was able focus on her hypertension with so many signs and symptoms and the physiology (p. 1290-1306).

Black and Hawk (2009) described Hypothyroidism as:

Deficiency of TH resulting in slowed body metabolism decreased heat production and decreased oxygen consumption by the tissues. Under activity of the thyroid gland may result form primary thyroid dysfunction or it may be secondary to anterior pituitary dysfunction. In primary hypothyroidism, TH levels are low and TSH levels are elevated indicating that the pituitary is attempting to stimulate the secretion of thyroid hormones but the thyroid is not responding. The thyroid needs iodine to synthesize and secrete thyroid hormones: T4, triiodothyronine, and thyrocalcitonin (calcitonin) (p. 1020-1024).

Black and Hawk (2009) outlines Coronary Artery Bypass Graft as:

Surgery involves the bypass of blockage in one or more of the coronary arteries using the saphenous veins, mammary artery, or radial artery as conduits or replacement vessels. During traditional CABG surgery, a median sternotomy incision is made so that the heart and aorta can be seen. The client is placed on cardiopulmonary bypass and the heart is stopped using a solution of iced saline containing potassium. Complications of CABG occur in 6 areas: cardiovascular complications include dysrhythmias, decreased cardiac output, and persistent hypotension. Hematologic complications include bleeding and clotting. They bypass machine leads to clot formation, so the blood is anti-coagulated, but this can lead to persistent bleeding (p. 1421-1424)

Assessment

BP: 135/55, Pulse ox: 92%, Respirations: 15, Temp: 98.4, HR: 68, Height: 162.6cm, Weight: 132.1kg; Braden Score: 19; Alert and Oriented Only x 3; responds when spoken to; Speech clear and appropriate. Skin warm and dry with instant recoil of turgor; capillary refill <3 seconds; no clubbing present. Intact basic cerebellar functioning; skull normocephalic, smooth with even hair distribution. Ears symmetrical without drainage. Patient does wear glasses, PERRLA 3mm; Sinus' without edema or tenderness, nares without deviation, mucosa pink and moist. Oral mucosa pink and moist; tongue center, artificial dentation present. Facial expression moderate/symmetrical; Trachea midline; thyroid and lymph nodes non-palpable; No JVD or Bruits present; +ROM to neck, arms, legs, moves upper extremities without difficulty, limited mobility in lower extremities; able to sense most light and sharp touch all over; S1S2 heart sounds, additional click of the mechanical or tissue valve that replaced the damaged valve, with regular apical of 72; Lungs are clear bilaterally with equal expansion; Respirations regular with easy and even expansion; abdomen soft, tender with active bowel sounds; no sputum present; bilateral, temporal, carotid, radial, brachial, pulse equal and regular (+2), femoral, popliteal,

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pedal pulses weak and regular (equal) (+1). Bilateral Patellar reflexes; +2 non pitting edema present in lower extremities and feet, warmth and redness; BM on 9//2012; consumed 100% breakfast; SOB/DOE with excretion; Pt. denies pain 0/10; 2x bed rails, bed alarm in place (risk for falls); Chest tube dressing change x 2, found on front lower lung area.

Aortic stenosis is the most common acquired heart valve lesion and surgery remains the standard treatment for AS (Davies, 2009, p.587). Risk factors for AS include “hyperlipidemia, diabetes and hypertension” (Tabloski, 2010, p.467). When the AV is replaced, they have high operative mortality. Those patients who survive their operation have improved functional status and good long term survival. Aortic stenosis results in in higher than normal pressure in the left ventricle as well as reduced cardiac output (Tabloski, 2010, p. 467). “Aortic stenosis increases afterload, placing increased stress on the heart, resulting in hypertrophy and is unable to overcome the increased afterload. Aortic valve replacement relieves the stenosis, decreasing the afterload and thereby the ventricular wall stress and preventing further deterioration of ventricular function” (George, Arnaoutakis, & Shah, 2011, p.121). “AS is thought to be caused by a chronic inflammatory process similar to that of atherosclerosis” (Hull, 2012, p.82), which can already be proved as part of K.W. medical/surgical history.

K.W. is on many different medications to control her heart condition and her health care team taught her that “oral anticoagulants such as warfarin are generally prescribed for patients with mechanical heart valves with their blood international normalized ration (INR) being monitored and adjusted by her doctor” (Wang, Yang, & Zhang, 2011, p.564). Low mood decreasing the motivation required for rehabilitation, social isolation reducing the adherence to medical advice or poor compliance in use of medications are possible mechanisms to explain why patients with depressive symptoms show a significant association with poorer recovery and

ability to perform activities of daily living following the procedure or surgery (Parker & Saheecha, 2011, p. 15).

This patient was admitted to Altercare Nobles Pond with an admitting diagnosis of Aortic Valve Disorder following surgery from Cleveland Clinic. The aortic valve is replaced through a surgery called a median sternotomy, where the doctor cuts through the sternum thru the pericardium. She was placed on cardiopulmonary bypass which pumps the lung and heart, which breathes for the patient and pumps the blood throughout while the doctor can replace the valve in her heart. The damaged aortic valve is replaced by a mechanical or a tissue valve. Medications for blood pressure can cause orthostatic hypotension or postural hypotension and other drugs used for preventing fluid volume overload and heart medications. It's important to teach the client in these situations to adjust from each position slowly, breathe deeply and keep both eyes open to prevent them from becoming dizzy. An important tool to evaluate syncope is the medical history, which usually uncovers the likely, because risk factors leading to falls in older people may be broadly classified into those that are extrinsic or intrinsic (Jones & Whitaker, 2011, p. 51).

Black and Hawk (2009) defined Syncope (fainting):

Which is defined as generalized muscle weakness and an inability to stand erect accompanied by loss of consciousness. It is a good measure of cardiovascular status because it may indicate decreased cardiac output, fluid volume deficits, or defects in cerebral tissue perfusion. (p. 1305). Although I didn't witness his syncope, I would agree with the numerous issues he has going on that it's only likely. Syncope was a side effect of a combination therapy of ACE inhibitors and Angiotensin Receptor Blocker which are known to reduce cardiovascular events (Berra & Miller, 2009, p.72). Syncope is also linked to Parkinson disease and cardiac problems (Amella, 2004, p. 44, & Smith & Buckwalter, 2005, p. 43). Many episodes are a

warning of manifestations such as rapid heart action, vision changes, weakness, dizziness, nausea, and diaphoresis. Medications and volume depletion (from diuretics, nausea, vomiting, diarrhea, and severe anemia) can cause syncope (Black and Hawk, 2009, p. 1362).

Concept Care Map:

MEDICATIONS:

Student: Cassandra Keen PT Initials: K.W.
 Age: 67 Gender: Female Admit: 9/1/12
 Code Status: Full Code Allergies: No Allergies
 DIET: Regular Activity: No Assist op w/ walker
 Admitting Diagnoses/Chief Complaint: Aortic Valve Stenosis (admitted post op)
 Nursing Diagnoses: Fluid Volume overload Impaired Physical Mobility

LAB VALUES / DIAGNOSTIC RESULTS:

BUN	10.7	28	22.7
4.7 F	2.1	1.18	25.7
7.3	2.5	27.9	25.7

Protime-17
 INR-1.3
 menocytes-0.94
 EOS 0.15
 BASO-0.05
 NA 139
 K-4.7
 Cl-107
 CO2 24
 BUN-28
 Creatinine-1.18
 BUN-Creat-24
 GFR-NF-55
 GFR-NF AK 4W
 CA-B.2 L

WBC-7.3
 RBC-3.81
 HMG10-8.6
 HMG10-37.9
 MCV-84.3
 MCH-31.6
 MCHC-31.6
 RDW-16.4
 Platelets-257
 Neutro-69.9
 Lymphs-23.3
 Mono-10

PAST MEDICAL / SURGICAL HISTORY:

Chronic ischemic heart disease unspecified (NOS)
 Diabetes with neurological manifestations (Type 1)
 Unspecified essential hypertension (NOS)
 Hypothyroidism (NOS)
 Unspecified Idiopathic Peripheral Neuropathy (NOS)
 Other and unspecified hyperlipidemia (NEC/NOS)
 Coronary atherosclerosis of autologous vein bypass graft
 Coronary atherosclerosis of artery bypass graft
 Unspecified sleep apnea

ASSESSMENT DATA:

PT does have a will & power of Attorney
 Alert and oriented x3. Responde verbal
 Speech to, Speech clear and appropriate
 Skin warm and dry w/ moist feel of turgor. Capillary refill < 3 seconds
 No clubbing. Intact peripheral functioning. Skull normocephalic, smooth
 w/ even hair distribution. No symmetry. Noct drainage. Glasses to correct
 limited vision. Oropharynxes: PERLL 3mm. Sinus w/ Tort edema or
 tenderness. Mucosa pink and moist. Oral mucosa pink and moist, tongue
 center. Full dentition present. Facial expression moderate/symmetrical
 Thyroid and lymph nodes nonpalpable. Trachea midline. No JVD or bruits
 present. Full ROM to upper extremities, limited mobility to lower extremities.
 MAE's (not steady) Able to sense and perceive shape and light touch all over
 tissue/
 S1S2 heart sounds. Additional click of the mechanical valve. w/ Leader Amplitude of 3-4
 Resonance percussed throughout Posterior lung fields. Respiratory equal and even.
 Abdomen soft, tenderness. w/active BS x4 Quads. tympani present throughout
 Bilateral temporal, Carotid, radial, brachial +2 pulses equal & regular, heparal.
 Popliteal- posterior. Pedal pulses +2 even. Bilateral ankle reflexes +2. edema
 present in lower extremities & feet; BUN 21.4 12/12; chest tube Drsg change
 x2. sound on front lower lung area; consumed 100% of meal; SOB/DOE w/
 ↑ activity; PT complains of NO Pain
 Pt lives alone; PT/OT support to ↑ PT's mobility;

TREATMENTS:

Weekly SKIN Assess
 PT/OT 5x/WK for 4wks
 Bilateral top 1/2 side rails
 Elevate heels
 Reposition q2hrs
 Fluid Restriction
 Incentive Spirometer 5 mins
 Foley/BSC
 Assist devices
 Socklet
 Elevate BIL & Jomin BID
 Chest tube Sling -cleanse w/
 NS betadine & cover w/
 DRB BID Q800/1400

Assessment Data**Functional Health Patterns**

AREA OF HEALTH	SUBJECTIVE DATA	OBJECTIVE DATA	INDIRECT DATA	INTERPRETATION (effective patterns or barriers/potential barriers)
HEALTH-PERCEPTION HEALTH-MANAGEMENT (general survey, perceived health and well-being, self-management strategies, utilization of preventative health behaviors and/or services.)	Client opens up and explains how she was getting ready to go shopping and have lunch with a friend and felt sick. She decided to go to the doctors because she felt very tired and nausea.	It was determined that the client's heart needed surgery to be repaired and had a shunt placed in, which can be heard when listen to the heart sounds.	The client could have had a MI or heart attack therefor causing a number of problems from that attack.	This patient didn't let her situation go unnoticed and potentially saved her own life because she chose to see it for what it was. The patient is alive and may always keep this in her uppermost mind when she has problems in the future.
NUTRITIONAL –METABOLIC (patterns of food and fluid consumption, weight, skin turgor, nails, hair, etc.)	The client talks about how she loves all food and has no desire to stop eating when she knows she should.	She has edema in the lower extremities with swelling and fluid overload. Client has gain weight since entering the facility.	Her metabolic state isn't has fast as someone of a young age	Eating overload which affects the patient's self-esteem barriers. The need to eat fulfills some desire for something that she is unable to overcome.
ELIMINATION (patterns of excretory function and elimination of waste; relevant labs, medications, impacting, etc.	Patient struggled to maintain a bladder and bowel elimination although she struggled to get to the restroom and stated she had a hard time going when a nurse was in the restroom with her.	The client was on a foley and wearing depends until she was able to go on her own. Patient struggled getting to the restroom which required the assistance of 1-2 people.	Potential issue for UTI or bowel obstruction caused by limited mobility.	This patient is overweight, has heart problems, HTN, apnea and is now presented with a hard time getting to the restroom.

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<p>ACTIVITY-EXERCISE (patterns of exercise and daily living, self-care activities include major body systems involved such as cardio, respiratory, musculoskeletal)</p>	<p>Client expressed a desire to lose some of the weight she has gained since being in this facility. Patient expressed little interest in self-care activities.</p>	<p>Client didn't physically show me that she had an interest to lose weight given the fact of how much she was eating with no physical activity. She was usually in bed watching TV></p>	<p>With her weight this can cause problems not just for herself but for those trying to provide care.</p>	<p>Client is overweight, with severe health concerns that are affected by her weight, limited mobility, and continuing heart problems.</p>
<p>SLEEP-REST (patterns of sleep, rest, relaxation, fatigue)</p>	<p>The client stated she hasn't had a sex life in over 18 years.</p>	<p>The client appeared nervous and uncomfortable about a young person or someone else in general asking her about her private life.</p>	<p>The client isn't having the relationship or connection that comes with intimacy.</p>	<p>This client is not able to express a sexual need that her mind and body may have desire for. The patient isn't married and this is a concern without this connection.</p>
<p>COGNITIVE-PERCEPTUAL (patterns of thinking and ways of perceiving environment, orientation, mentation, neuro status, glasses, hearing aids, etc.)</p>	<p>The client complains of being tired and drained. She discusses all the things that she use to do before and how she is unable to do them now.</p>	<p>I observed how when I first met her when she was admitted after surgery, how much restful and alive she looked. But by 2 months there she looked sad and tired.</p>	<p>I also noticed that she spent more time in bed throughout the day then she did when I was first there and she was in a chair or more mobile</p>	<p>KW runs the concern for so many issues because she is depression and miserable, no support channel. So many issues means delayed healing, and potential for further issues because of her health.</p>
<p>SELF-PERCEPTION SELF-CONCEPT (patterns of viewing and valuing self; body image and psychological state)</p>	<p>She talked about all the successful things she had accomplished throughout her life. She had full dentures, was using a wheel chair and required glasses for near blindness.</p>	<p>The client appeared very intelligent, discussed all her accomplishments and was very proud of her life. Tried to hide her deteriorating health issues but still talked about things she loved</p>	<p>She had the thought process to heal and was smart enough to understand but could simply be affected by her heart failure</p>	<p>If her situation continues to worse than her mental state is potential at risk which could potentially result in mental deterioration limiting her from recovering.</p>

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<p>ROLES-RELATIONSHIPS (patterns of engagement with others, ability to form and maintain meaningful relationships, assumed roles; family communication, response, visitation, occupation, community involvement)</p>	<p>KW engages with everyone and loves to talk about things in her life. Not very good at listening to others talk. She talks about her daughters and her friends along with her pets and how much she care for them. She doesn't appear to have communication with her children or family based on the fact no one visits her or brings cards.</p>	<p>The patient had no visitors or interactions with family or friends. Suggests the client is very lonely and needs interactions with others in order to feel fulfilled or satisfied, clearly showing that she doesn't have a supportive channel to use as an outlet.</p>	<p>This lack of interaction with other humans to release stress and to feel accepted can lead to depression and hopelessness.</p>	<p>Potential complication for stress overload, suicide, hopelessness, which can go on to cause other issues with her health. Major barrier against her recovery.</p>
<p>SEXUALITY-REPRODUCTIVE (testes, breasts, abdominal-genitourinary; satisfaction with present level of interaction with sexual partners)</p>	<p>Values the improvement to go home, but is extremely self-conscious, which is shown by her putting herself down.</p>	<p>The patient did little to help in her recovery, felt hopeless, stayed in bed, grimaced in pain by her delayed recovery.</p>	<p>If the patient is unable to gather the hope and strength to recover she will remain in this facility.</p>	<p>The patient is open for self-care, valuing of self-image, numerous psychological complications.</p>
<p>COPING (stress tolerance, behaviors, patterns of coping with stressful events and level of effectiveness, depression, anxiety)</p>	<p>KW expressed over several sessions the need to recover and return home. There appears to be no support channel. She talks about the situation and the feeling of concern if she is unable to care for herself once discharged.</p>	<p>Observed the mental appearance from week to week. The weight gain, the physical struggle, and the stress of what her continued situation is doing.</p>	<p>Will need support when she leaves the facility, possible counseling in order to cope</p>	<p>With the concern for recovery: The client is subjected to many issues. She is open for depression, immobility, weight gain, alternative outlets that may be unhealthy.</p>

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VALUES-BELIEF (patterns of belief, values, and perception of meaning of life that guide choices or decision; includes but is not limited to religious beliefs)	Pt didn't believe in God, but believe that somewhere somehow there was a higher power. Discussed of her life, her family and her kids. The love of her pets and for friends.	Pt didn't appear to have any religious beliefs or superstitions and accepted her situation with a desire to heal and return home.	No in direct data to support this information.	She may decide the need for a relationship with God, and may be unable to pass on or may be holding on because she may feel a sense that she is missing some sort of meaning in her life.
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Lab Information & Diagnostic test results:**Bolded items are suggestive to the client**

Lab Test	Test Results	Normal Range	Interpretation
Basophils	0.05	0-1	Basophils are involved in: (1) Lysosomes that contain enzymes needed for relief of histamines; (2) Allergic responses with release of histamine, kinins, and slow-reacting substance of anaphylaxis; (3) Release of heparin to prevent blood clotting. Basophils contain hyaluronic acid, a protective ingredient to insure a normal inflammatory process.
Blood Urea Nitrogen	28 H	5-20	Increases can be caused by excessive protein intake, kidney damage, certain drugs, low fluid intake suggesting dehydration, intestinal bleeding , exercise, or prerenal failure or heart failure. Diabetes mellitus, uncontrolled Starvation/dehydration/diarrhea. Congestive heart failure (decreased renal circulation). GI hemorrhage and obstruction

Calcium	8.2 L	8.8-10.3	Suggests cancer (which he has recovered from): that can cause hypercalcemia when it spreads to the bones and causes the release of Calcium from the bone into the blood or when cancer increases calcium levels. It could also suggest prolonged immobilization when I find possible because of his mental status (Dementia was clear during my assessment of his alert and orientation).
Carbon Dioxide	24	19-25	The CO2 level is related to the respiratory exchange of carbon dioxide in the lungs and is part of the bodies buffering system. Generally when used with the other electrolytes, it is a good indicator of acidosis and alkalinity .
Chloride	107 H	95-105	Elevated levels are related to acidosis as well as too much water crossing the cell membrane . Decreased levels with decreased serum albumin may indicate water deficiency crossing the cell membrane (edema) .
Creatine	1.18 H	0.5-1.4	Elevated levels are sometimes seen in kidney disease due to the kidneys job of excreting creatinine, muscle degeneration, and some drugs involved in impairment of kidney function. Also in patients with shock, leukemia, SLE, acute MI, CHF, diabetic neuropathy .
Eosinophils	0.15 L	1-3	An absolute eosinophil count is a blood test that measures the number of white blood cells called eosinophils. Eosinophils become active when you have certain allergic diseases, infections, and other medical conditions. A lower-than-normal eosinophil count may be due to: over production of certain steroids in the body (such as cortisol)
GFR-AA	55 L	110-130	the GFR EST is a blood test used to estimate the glomerular filtration rate without performing a 24 hour urine for creatinine clearance. It is a calculation involving the patient's serum creatinine, age, and sex. In adults the GFR should be somewhere between 100 and 130, while in children it should be about 110. Since the GFR is a measure of the kidney's function it is used to help classify kidney disease.

GFR-Non AA	46 L		If the patient is African American the equation is adjusted to account for an African American's greater muscle mass. A Non- AA or non- African American would not require the adjustment. GFR (glomerular filtration rate) Non- AA (African American)
Hematocrit	27.9 L	40-54%	The patient is dehydrated related to diarrhea (anemia), and already experiencing a decrease in Hemoglobin due to blood loss. Which this tends to mirror RBC results.
Hemoglobin	8.6 L	13.5-18	Blood levels are low due to loss of blood. Can also be related to HTN, Dementia , and seizures which are all chronic medical conditions. Also mirrors RBC results.
INR	1.7 H	0.76-1.27	The PT may be ordered when a person who is not taking anticoagulant drugs has signs or symptoms of a bleeding disorder , which can range from nosebleeds, bleeding gums, bruising, heavy menstrual periods, blood in the stool and/or urine to arthritic-type symptoms (damage from bleeding into joints), loss of vision, and chronic anemia.
Lymphocytes	22.3	24-44	Lymphocytes react to the toxic by-products of protein metabolism. A leukocyte with a single nucleus that is second in abundance to neutrophils in the peripheral blood. They originate from the erythroblasts of the spleen, tonsils, thymus and bone marrow. Must assess in the context of the total WBC and WBC profile.
MCV	84.3	80-100	a measure of the average red blood cell volume. Corpuscular Volume Indicates RBCs are smaller than normal (microcytic); caused by iron deficiency anemia or thalassemias, for example.
MCHC	31.6	31-37	Mean Corpuscular Hemoglobin Concentration. May be low when MCV is low; decreased MCHC values (hypochromia) are seen in conditions such as iron deficiency anemia and thalassemia.
Mono	10 H	3-8%	Monocytes are secondary defense cells. Potentially from just having open heart surgery.

Neutrophils	64.9	48-73%	If this lab was abnormal then labs could be linked to infection, inflammation, autoimmune disorders, tissue death, trauma, heart attack, burns, chemo, stress, exercise, leukemias, or bone marrow damage.
Platelets	257	150-450	A low platelet count, also called thrombocytopenia, may be caused by a number of conditions and factors. The causes typically fall into one of two general categories: Disorders in which the bone marrow cannot produce enough platelets and Conditions in which platelets are used up (consumed) or destroyed faster than normal, or Long-term bleeding problems, Massive blood transfusion, prosthetic heart valve, Thrombotic thrombocytopenic purpura (TTP), Celiac disease, Vitamin K deficiency.
Potassium	4.7	3.5-5.0	Potassium is the major intracellular cation. Very low value: Cardiac arrhythmia. Decrease in K is seen usually in states characterized by excess K ⁺ loss, such as in vomiting, diarrhea, villous adenoma of the colorectum, certain renal tubular defects, hypercorticoidism, etc. Redistribution hypokalemia is seen in glucose/insulin therapy, alkalosis (where serum K ⁺ is lost into cells and into urine), and familial periodic paralysis. Drugs causing hypokalemia include amphotericin, carbenicillin, carbenoxolone, corticosteroids, diuretics, licorice, salicylates, and ticarcillin. F.W. was experiencing Glucose/insulin therapy and was having diarrhea and that would be my reason for the decrease K.
Prottime	17 H		The prothombinase time, or time to coagulation. High chance of bleeding
RBC	3.31 L	4.6-6.2	The patient is malnourished, inflammation of the intestines, deficient in nutrients, acute/chronic bleeding, edema, which can be cause of a number of factors.
RDW	16.4 H	<14.5	Red cell distribution width, is a calculation of the variation in the size of RBCs. Indicates mixed population of small and large RBCs; immature RBCs tend to be larger. For example, in iron deficiency anemia or pernicious anemia, there is high variation (anisocytosis) in RBC size (along with variation in shape – poikilocytosis), causing an increase in the RDW.

Sodium	139	135-145	A high blood sodium level is almost always due to inadequate water intake and dehydration . Symptoms include dry mucous membranes, thirst, agitation, restlessness, acting irrationally , and coma or convulsions if the sodium level rises to extremely high concentrations. In rare cases, hyponatremia may be due to Cushing syndrome or a condition caused by too little ADH called diabetes insipidus.
WBC	7.3	5-10,000	This lab value was a little high suggesting a possible outcome of infection, inflammation , allergies, asthma, tissue death, stress , or exercise.

Reference: (Deglin & Vallerand, 2007)
 (Edwards, N., Baird, 2005)
 (Kaslow, 2012)
 (McAuley, 2012)

Medication Information:

Drug Name (Generic / Trade name)	Drug Action / Purpose	Normal Dose Range	Major Side Effects	Nursing Considerations	Interpretation Why taking MED
Acetaminophen / Tylenol 650mg PRN	Inhibits the synthesis of prostaglandins that may serve as mediators of pain, primarily in the CNS. Tx for patient is mild to moderate pain Increased temperature	Common dosages are 325, 500 and 650 mg. DOSING: The oral dose for adults is 325 to 650 mg q 4-6 hours. The max daily dose is 4 grams. Oral dose for a child is based on child's age, range is 40-650 mg q 4 hours. When admin as a suppository, adult dose is 650 mg q 4-6 hours. Children, dose is 80-325 mg q 4-6 hours depending on age.	When used appropriately, side effects are rare. The most serious side effect is liver damage due to large doses, chronic use or concomitant use with alcohol or other drugs that also damage the liver.	PO Route: Admin to pt crushed or whole; chewable may be chewed. Give with food or milk to decrease GI symptoms; give 30mins b4 or 2 hr after meals; absorption may be slowed.	Mild to moderate pain or fever

<p>Albuterol Sulfate Nebulization / AccuNeb, Proventil, Proventil HFA, Proventil Repetabs, Ventolin, Ventolin HFA, Volmax 2.5mg / 3L (QID 0800/1200/1600 /2000)</p>	<p>In low doses, acts relatively selectively at beta2-adrenergic receptors to cause bronchodilation and vasodilation; at higher doses, beta2 selectivity is lost, and the drug acts at beta2 receptors to cause typical sympathomimetic cardiac effects.</p>	<p>Tablets—2, 4 mg; ER tablets—4, 8 mg; syrup—2 mg/5 mL; aerosol—90 mcg/actuation; solution for inhalation—0.083%, 0.5%, 1.25 mg/3 mL, 0.63 mg/3 mL; capsules for inhalation—200 mcg</p>	<p>CNS: Restlessness, apprehension, anxiety, fear, CNS stimulation, hyperkinesia, insomnia, tremor, drowsiness, irritability, weakness, vertigo. CV: Cardiac arrhythmias, tachycardia, palpitations, PVCs (rare), anginal pain. Dermatologic: Sweating, pallor, flushing. GI: Nausea, vomiting, heartburn, unusual or bad taste. GU: Increased incidence of leiomyomas of uterus when given in higher than human doses in preclinical studies. Resp: Respiratory difficulties, pulmonary edema, coughing, bronchospasm, paradoxical airway resistance with repeated, excessive use of inhalation preparations</p>	<p>History: Hypersensitivity to albuterol; tachyarrhythmias, tachycardia caused by digitalis intoxication; general anesthesia with halogenated hydrocarbons or cyclopropane; unstable vasomotor system disorders; hypertension; coronary insufficiency, CAD; history of stroke; COPD patients who have developed degenerative heart disease; diabetes mellitus; hyperthyroidism; history of seizure disorders; psychoneurotic individuals; lactation Physical: Weight; skin color, temperature, turgor; orientation, reflexes, affect; P, BP; R, adventitious sounds; blood and urine glucose, serum electrolytes, thyroid function tests, ECG</p>	<p>Relief and prevention of bronchospasm in patients with reversible obstructive airway disease Inhalation: Treatment of acute attacks of bronchospasm Prevention of exercise-induced bronchospasm Unlabeled use: Adjunct in treating serious hyperkalemia in dialysis patients; seems to lower potassium concentrations when inhaled by patients on hemodialysis</p>
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<p>Aspirin-81 / Bayer 81mg (0800)</p>	<p>produce analgesia and reduce inflammation and fever by inhibiting the prod of prostaglandins</p>	<p>IV: for each route: pain/fever: PO: rect. (adults): 325-1000mg q 4-6 hr (not to exceed 4g/day) Extended release tab. 650mg q8hr or 800mg q 12 hr Inflam: PO: adult 2.4g/day initially; increased to maint dose of 3.6-5.4g/day in divided doses (up to 7.8g/day for acute rheumatic fever) MI: PO: adult 80-325mg/ once daily suspected acute MI- 160 mg as soon as MI is suspected.</p>	<p>-EENT: tinnitus -GI: GI bleeding, dyspepsia, epigastric distress, nausea, abdominal pain, anorexia, hepatotoxicity, vomiting Hemat: anemia, hemolysis Derm: rash, urticaria</p>	<p>- pts who have asthma, allergies, nasal polyps or are allergic to tartrazine are at an increased risk for developing hypersensitivity rxns. -pain: assess pain and limitation of movement, note type, location, and insensitivity before and after administration -Fever: assess Fever and note associated signs (diaphoresis, tachycardia, malaise, chills)</p>	<p>-inflammatory disorders -Rheumatoid arthritis -Osteoarthritis -mild to moderate pain -Fever -prophylaxis of transient ischemic attacks and MI</p>
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<p>Clopidogrel / Plavix 75mg (0800)</p>	<p>Inhibits platelet aggregation by blocking ADP receptors on platelets, preventing clumping of platelets.</p>	<p>Recent MI or stroke: 75 mg PO daily. Acute coronary syndrome: 300 mg PO loading dose, then 75 mg/day PO with aspirin, given at a dose from 75–325 mg once daily.</p>	<p>CNS: Headache, dizziness, weakness, syncope, flushing CV: Hypertension, edema Dermatologic: Rash, pruritus. GI: Nausea, constipation, diarrhea, GI bleed. Other: Increased bleeding risk</p>	<p>History: Allergy to clopidogrel, pregnancy, lactation, bleeding disorders, recent surgery, hepatic impairment, peptic ulcer Physical: Skin color, temperature, lesions; orientation, reflexes, affect; P, BP, orthostatic BP, baseline ECG, peripheral perfusion; R, adventitious sounds</p>	<p>Treatment of patients at risk for ischemic events—history of MI, ischemic stroke, peripheral artery disease Treatment of patients with acute coronary syndrome</p>
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<p>Docusate Sodium / Colace 100mg (BID 0800/2000)</p>	<p>Promotes incorporation of water into stool, resulting in softer fecal mass.</p>	<p>Tablets: 100 mg. Capsules: 50 mg, 100 mg, 120 mg, 240 mg, 250 mg. Syrup: 20 mg/5 ml. Liquid: 150 mg/15 ml. Enema: 283 mg/5 ml. In combination with: stimulant laxatives.</p>	<p>EENT: throat irritation GI: mild cramps Derm: rashes</p>	<ul style="list-style-type: none"> - Assess: cause of constipation - is fluid, fibre or exercise missing from lifestyle; fluid balance. - Evaluate therapeutic response (decreased constipation). - Drug should be discontinued if D8or vomiting occur. - Administer alone for better absorption. - Do not administer within one hour of other drugs, antacids or milk. - Tablets/solution to be taken with full glass of water. - Do not use undue force when giving enema. 	<p>Prevention of constipation in pt who should avoid straining after surgery. To counteract effects of narcotics.</p>
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<p>Furosemide / Lasix 40mg IV (240ml)</p>	<p>Rapid-acting potent sulfonamide "loop" diuretic and antihypertensive with pharmacologic effects and uses almost identical to those of ethacrynic acid. Exact mode of action not clearly defined; decreases renal vascular resistance and may increase renal blood flow</p>	<p>In adults, treatment is usually begun with ½ - 1-2 tablets daily; the maintenance dose is ½-1 tablet daily. PO 20-80 mg/day in am may give another dose in 6 hr., up to 600 mg/day</p> <p>IM/IV 20-40 mg, increased by 20 mg q2h until desired response</p>	<p>CNS: Blurred vision, dizziness, headache, vertigo EENT: Hearing loss, tinnitus. CV: Hypotension GI: upset, Anorexia, Constipation, diarrhea, dry mouth, dyspepsia, increased liver enzymes, nausea, pancreatitis, vomiting GU: Increased BUN, excessive urination, nephrocalcinosis. Derm: Steven-Johnson Syndrome, toxic epidermal necrolysis. Hemat: Aplastic anemia, agranulocytosis. F&C: Abnormal electrolytes, Gout, hypergalcaemia, rash, photosensitivity, atraemia, kalaemia, magnesia, increased NA excretion, hyperuricaemia</p>	<ul style="list-style-type: none"> • Monitor weight, BP, and pulse rate routinely with long term use and during rapid diuresis. Furosemide can lead to profound and electrolyte depletion. • Monitor fluid I&O and electrolyte, BUN, and CO2 level freq. • Watch for signs of hypokalemia such as muscle weakness and cramps • Advise patient to immediately report ringing ears, severe abdominal pain, or soar throat and fever which may indicate furosemide toxicity. 	<p>Fluid volume overload for the edema forming in her leg. Used to reduce the swelling and fluid retention caused by various medical problems, including heart or liver disease. It is also used to treat high blood pressure. It causes the kidneys to get rid of unneeded water and salt from the body into the urine.</p>
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<p>Gabapentin / Gabarone, Neurontin 600mg (TID 0800 /1200 /1600)</p>	<p>Mechanism of action is not known. May affect transport of amino acids across and stabilize neuronal membranes.</p>	<p>300 mg once daily on first day, 300 mg twice daily on second day, then 300 mg three times/day on day 3, may then be titrated upward as needed up to 600 mg three times/day.</p>	<p>CNS: confusion, depression, drowsiness, anxiety, dizziness, hostility, malaise, vertigo, weakness EENT: abnormal vision, nystagmus. CV: hypertension. GI: anorexia, flatulence, gingivitis MS: arthralgia. Neuro: ataxia, altered reflexes, hyperkinesia, paresthesia Misc: facial edema</p>	<p>Assess location, characteristics, and intensity of pain periodically during therapy.</p>	<p>Gabapentin is in a class of meds called anticonvulsants. Gabapentin relieves the pain of PHN by changing the way the body senses pain.</p>
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<p>hydrocodone-acetaminophen / Vicodin 5-500mg PRN (5-7 1-tab, 8-10 2-tabs)</p>	<p>Bind to opiate receptors in the CNS. Alter the perception of and response to painful stimuli while producing generalized CNS depression pain</p>	<p>Oral (doses should be titrated to appropriate analgesic effect): Antitussive (hydrocodone): 0.6 mg/kg/day in 3-4 divided doses. A single dose should not exceed 10 mg in children >12 years, 5 mg in children 2-12 years, and 1.25 mg in children <2 years of age Analgesic (acetaminophen): Refer to Acetaminophen monograph Adults: Analgesic: 1-2 tablets or capsules every 4-6 hours or 5-10 mL solution every 4-6 hrs PRN</p>	<p>confusion, sedation, hypotension, constipation</p>	<p>Observe patient for excessive sedation, respiratory depression</p>	<p>Relief of moderate to severe pain; antitussive (hydrocodone)</p>
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<p>Lispro / Humalog mix 75-25 (BID 0800/2000)</p>	<p>Lowers blood glucose by stimulating glucose uptake in skeletal muscle and fat Inhibits lipolysis & proteolysis Enhance portein synthesis Rapid acting insulin</p>	<p>initial dose: 0.2-0.6 u/kg/day usual maint.: 0.5-1.2 u/kg/day</p>	<p>ENDO: hypoglycemia. Local: lipodystrophy, pruritus, erythema, swelling, MISC: allergic reactions including anaphylaxis</p>	<p>Assess for s/s of hypoglycemia, and hyperglycemia periodically throughout use of med. Monitor body weight</p>	<p>To control hyperglycemia in patients with Type 1 and 2 diabetes</p>
<p>Levothyroxine / Synthroid 88mcg (0800)</p>	<p>Replacement of or supplement to endogenous thyroid hormones. – principle effect is increasing metabolic rate of body tissues.-promote gluconeogenesis-increase utilization and mobilization of glycogen stores-stimulate protein synthesis-promote cell growth and differentiation-aid in the development of the brain and CNS</p>	<p>PO: adults: Hypothyroidism-50mcg as a single dose initially; may be increased q2-3wks by 25 mcg/day; usual maintenance dose is 75-125mcg/day (1.5 mcg/kg/day) –IV, IM: adults: Hypothyroidism-50-100mcg/days a single dose</p>	<p>usually only seen when excessive doses cause iatrogenic hyperthyroidism: CNS: headache, insomnia, irritability. CV: angina pectoris, arrhythmias, tachycardia. GI: abdominal cramps, diarrhea, vomiting Derm:sweating Endo: hyperthyroidism, menstrual irregularities Metab: heat intolerance, weight loss MS: accelerated bone maturation in children.</p>	<p>apical pulse and blood pressure prior to and periodically during therapy. For tachyarrhythmias and chest pain. - administer with a full glass of water, preferably before breakfast to prevent insomnia. –initial dose is low, especially in geriatric/ cardiac pts. Dose is increased gradually, based on thyroid function tests. For difficulty swallowing, tablets may be crushed and</p>	<p>–replacement in hypothyroidism to restore normal hormonal balance -suppression of thyroid cancer</p>

			<p>placed in 5-10mL of water and administered immediately via dropper or spoon; do not store suspension. – Direct IV: reconstitute the 200mcg and 500mcg vials with 2 or 5mL, respectively, of 0.9% NaCl without preservatives (diluent usually provided). 100mcg/mL. Shake well to dissolve completely. Administer solution immediately after preparation; discard unused portion. Rate: administer at a rate of 100mcg over 1min. do not add to IV infusions; may be admin through Y-tube</p>	
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<p>Lidocaine/ Lidoderm adhesive patch, medicated 5% 700mg / patch on/off 12hrs</p>	<p>Type 1 antiarrhythmic: Decreases diastolic depolarization, decreasing automaticity of ventricular cells; increases ventricular fibrillation threshold. Local anesthetic: Blocks the generation and conduction of action potentials in sensory nerves by reducing sodium permeability, reducing height and rate of rise of the action potential, increasing excitation threshold, and slowing conduction velocity.</p>	<p>IM: Arrhythmia: Use only the 10% solution for IM injection. 300 mg in deltoid or thigh muscle. Switch to IV lidocaine or oral antiarrhythmic as soon as possible. IV bolus: Arrhythmia: Use only lidocaine injection labeled for IV use and without preservatives or catecholamines. Monitor ECG constantly. Give 50–100 mg at rate of 20–50 mg/min. One-third to one-half the initial dose may be given after 5 min if needed. Do not exceed 200–300 mg in 1 hr.</p>	<p>Antiarrhythmic with systemic admin. CNS: Dizziness or light-headedness, fatigue, drowsiness, tremors, unconsciousness, twitching, vision changes; may progress to seizures. CV: Cardiac arrhythmias, cardiac arrest, vasodilation, hypotension. GI: Nausea, vomiting. Hypersensitivity: Rash, anaphylactoid reactions. Resp: Respiratory depression and arrest. Other: Malignant hyperthermia, fever, local injection site reaction</p>	<p>History: Allergy to lidocaine or amide-type local anesthetics, CHF, cardiogenic shock, second- or third-degree heart block, Wolff-Parkinson-White syndrome, Stokes-Adams syndrome, hepatic or renal disease, inflammation or sepsis in region of injection, lactation, pregnancy Physical: T; skin color, rashes, lesions; orientation, speech, reflexes, sensation and movement (local anesthetic); P, BP, auscultation, continuous ECG monitoring during use as antiarrhythmic; edema; R, adventitious sounds; bowel sounds, liver evaluation; urine output; serum electrolytes, liver and renal function tests</p>	<p>As antiarrhythmic: Management of acute ventricular arrhythmias during cardiac surgery and MI</p>
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<p>Metoprolol Tartrate / Lopressor 25mg HR <55 (BID 0800/2000)</p>	<p>Blocks stimulation of beta1 (myocardial)-adrenergic receptors. Does not usually affect beta2 (pulmonary, vascular, uterine)-adrenergic receptor sites.</p>	<p>antihypertensive/antinal – 25-100mg/day as a single dose initially or 2 divided doses; may be increased q 7 days prn up to 450mg/day (for angina, give in divided doses). Extended release products are given once daily. MI-25-50mg (starting 15 min after last IV dose) q 6hr for 48 hr, then 100mg twice daily for a min of 3mo. Heart failure – 12.5mg-25mg once daily, can be doubled every 2 wk up to 200mg/day. Migraine prevention 50-100mg 2-4 times daily. IV adults- MI-5mg q 2 min for 3 doses, followed by oral dosing.</p>	<p>Fatigue, weakness, anxiety, depression, dizziness, drowsiness, insomnia, memory loss, mental status changes, nervousness, nightmares, BRADYCARDIA, CHF, PULMONARY EDEMA, hypotension, peripheral vasoconstriction.</p>	<p>Take apical pulse and BP before administration. Report to physician significant changes in rate, rhythm, or quality of pulse or variations in BP prior to administration. Monitor BP, HR, and ECG carefully during IV administration. Expect maximal effect on BP after 1 wk of therapy. Take several BP readings close to the end of a 12 h dosing interval to evaluate adequacy of dosage for patients with hypertension, particularly in patients on twice daily doses. Some patients require doses 3 times a day to maintain satisfactory control. Observe hypertensive patients with CHF closely for impending heart failure: Dyspnea on exertion, orthopnea, night cough, edema, distended neck veins.</p>	<p>decreased blood pressure and heart rate. Decreased frequency of attacks of angina pectoris. Decreased rate of cardiovascular mortality and hospitalization in patients with heart failure.</p>
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<p>Milk of Magnesia / Phillips Milk of Magnesia 400mg / 5mL PRN</p>	<p>Constipation Are osmotically active in GI tract, drawing water into the lumen and causing peristalsis</p>	<p>30-60 mL/day regular, concentrated 10-30 mL/day</p>	<p>diarrhea</p>	<p>Assess patient for abdominal distention, presence of bowel sounds, and usual pattern of bowel function. Administer on empty stomach for more rapid results. Follow all oral laxative doses with a full glass of liquid to prevent dehydration and for faster effect. Do not administer at bedtime or late in the day Electrolyte imbalance, or no longer constipated Assess color, consistency, and amount of stool produced</p>	<p>Antacid, Saline Laxative</p>
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<p>Insulin / Novolog 100 unit / mL ac/hs (0800/1200/1700/1800)</p>	<p>Lowers blood glucose by stimulating glucose uptake in skeletal muscle and fat and inhibiting hepatic glucose production. Insulin also inhibits lipolysis and proteolysis and enhances protein synthesis. A rapid-acting insulin with more rapid onset and shorter duration than human regular insulin; should be used with an intermediate- or long-acting insulin.</p>	<p>sc 0.25-0.7units/kg/d</p>	<p>Allergic reactions. Endocrine: Hypoglycemia, hypokalemia. Skin: Injection site reaction, lipodystrophy, pruritus, rash.</p>	<p>Monitor for S&S of hypoglycemia (see Appendix F). Initial hypoglycemic response begins within 15 min and peaks 45–90 min after injection. Lab tests: Periodically monitor fasting blood glucose and HbA1C. Withhold drug and notify physician if patient is hypokalemic.</p>	<p>Diabetes mellitus</p>
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<p>Omega 3 Fatty Acids / Eicosapentaenoic acid, Docosahexaenoic acid (0800)</p>	<p>The mechanism of action of omega-3-acid ethyl esters is not completely understood. Potential mechanisms of action include inhibition of acetyl-CoA and increased peroxisomal beta-oxidation in the liver.</p>	<p>Fish oil appears to have positive effects on existing heart disease. It also may lower the risk for developing heart disease. Omega-3 fatty acids found in fish oil help lower triglycerides, lower blood pressure, reduce the risk of blood clots, improve the health of arteries and reduce the amount of arterial plaque, which narrows arteries and causes heart disease.</p>	<p>Back pain, flu syndrome, unspecified pain. GI: Diarrhea, dyspepsia, eructation, nausea, vomiting. Metabolic/Nutritional: Increased total cholesterol and/or LDL levels, weight gain. Skin: Rash. Special Senses: Halitosis, taste disturbances.</p>	<p>Monitor for S&S of hypersensitivity in those with known allergy to fish. Monitor diabetics for loss of glycemic control. Lab tests: Baseline and periodic lipid profile. Note: Poor therapeutic response after 2 mo is an indication to discontinue drug. Monitor blood levels of anticoagulants with concurrent therapy.</p>	<p>Triglyceride lowering is the most consistent effect observed. Uses. Adjunct to diet to reduce hypertriglyceridemia.</p>
<p>Polyethylene Glycol / Miralax 1pack (0800)</p>	<p>Acts as an osmotic agent, drawing water into the lumen of the GI tract. Indicated for evacuation of the GI tract without water or electrolyte imbalance.</p>	<p>17 g (diluted in 8 fluid ounces water, juice, soda or coffee) orally once a day</p>	<p>Abdominal bloating, cramping, flatulence, nausea</p>	<p>Assess patient for abdominal distention, presence of bowel sounds, and usual pattern of bowel function.</p>	<p>constipation</p>

<p>Potassium Chloride (Kaylixir, Kay Ciel, Klorvess, Klotrix) 20/40 meq PO</p>	<p>Prevention and correction of potassium deficiency; when associated with alkalosis, use potassium chloride; when associated with acidosis, use potassium acetate, bicarbonate, citrate, or gluconate. IV: Treatment of cardiac arrhythmias due to cardiac glycosides.</p>	<p>Warning: Do not administer undiluted. Dilute in dextrose solution to 40-80mEq/L. Max infusion rate 10mEq/hr. for serum K of more than 2.5 mEq/L</p>	<p>Derm: Rash. GI: Nausea, vomiting, diarrhea, abdominal discomfort, GI obstruct, GI bleeding, GI ulceration or perforation Hematologic: Hyperkalemia – increased serum potassium, ECG changes (peaking of T waves, loss of P waves, depression of ST segment, prolongation of QTc interval) Local: Tissue sloughing, local necrosis, local phlebitis, and venospasm with injection</p>	<p>Arrange for serial serum potassium levels before and during therapy. Administer liquid form to any patient with delayed GI emptying. Administer oral drug after meals or with food and a full glass of water to decrease GI upset. Caution patient not to chew or crush tablets; have patient swallow tablet whole. Mix or dissolve oral liquids, soluble powders, and effervescent tablets completely in 3-8oz of cold water, juice, or other suitable beverage, and have patient drink it slowly. Caution patient not to use salt substitutes.</p>	<p>Electrolyte replacement. Preventing potassium deficiency or recovering from it. In her case with the lasix she is already receiving and that she has a heart condition, this balances out her potassium levels.</p>
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<p>Tramadol / Ultram 50mg q6hrs PRN</p>	<p>A centrally acting analgesic not related chemically to opiates. Precise mech is not known. Two complimentary mech may be applicable: It may bind to mu- Opioid receptors and inhibit reuptake or norepinephrine & serotonin. Analgesic effect is only partially antagonized by antagonist naloxone. Causes significantly less resp depression than morphine. In contrast to morphine, tramadol doesnt cause release of histamine. Produces dependence of mu- opioid type (i.e., dextropropoxyphene or codeine); however, there is little evid of abuse.</p>	<p>Patients who require rapid analgesic effect: 50-100 mg PO every 4-6 hr; do not exceed 400 mg/day</p>	<p>CNS: Sedation, dizziness or vertigo, headache, confusion, dreaming, sweating, anxiety, seizures CV: Hypotension, tachycardia, bradycardia Dermatologic: Sweating, pruritus, rash, pallor, urticaria GI: Nausea, vomiting, dry mouth, constipation, flatulence Other: Potential for abuse, anaphylactoid reactions</p>	<p>Control environment (temperature, lighting) if sweating or CNS effects occur Warning Limit use in patients or present history of addiction to or dependence on opioids You may experience these side effects: Dizziness, sedation, drowsiness, impaired visual acuity (avoid driving or task that require alertness); nausea, loss of appetite (lie quietly, eat frequent small meals) Report severe nausea, dizziness, severe constipation</p>	<p>Relief of moderate to moderately severe pain</p>
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<p>Warfarin / Coumadin 3mg / 3.5mg (qhs 2000)</p>	<p>Prophylaxis and treatment of Venous thrombosis, pulmonary embolism, atrial fibrillation with embolization, Management of MI's (decreases risk of death, decreases risk of subsequent MI, and decreases risk of future thromboembolic events.)</p>	<p>IV: 2.5-10mg per day for 2-4 days then adjust daily dose by results of prothrombin time or INR.</p>	<p>GI: Cramps, nausea. Derm: dermal necrosis. Hemat: BLEEDING. Misc: fever</p>	<p>Assess patient for signs of bleeding and hemorrhage (bleeding gums, nosebleed, unusual bruising; tarry, black stools; hematuria, falls in hematocrit or BP; guaiac-positive stools, urine or nasogastric aspirate). Assess patient for evidence of additional or increased thrombosis. Symptoms depend on area of involvement. Monitor for side effects at lower therapeutic ranges.</p>	<p>Prevention of thrombus formation and embolization after prosthetic valve placement.</p>
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Reference:

Deglin, J.H., Vallerand, A.H. (2007). *Davis's drug guide for nurses* (10th ed.).

Nursing Diagnoses (Analysis, Documentation/Evaluation, Intervention (NIC), Planning-NOC)

Diagnosis	Goal(s)	Nursing Interventions	Rationales With References (EBP citation)
Statement: Actual Problem of Excess fluid Volume (overload)	STG- Decrease / Eliminate edema present in lower left leg within 1 Week	-Provide oral care q4hours (NIC: Oral Health Maintenance)	- helps stimulate thirst, can alleviate the sensation without increase in fluid intake
	LTG- Have an extended period of time free from edema such as one month or 6 months, which will be reevaluated at next appointment.	- Administer diuretic therapy as ordered and evaluate effectiveness of therapy and monitor volume in bag (NIC: Hypervolemia management)	- diuretics promote the diuresis of accumulated fluid. Should be increase in urine output, improved breathing, and weight loss
RT(Why): decreased cardiac output, and sodium and water retention		- Follow Sodium diet / Fluid restriction (Teaching family about monitoring and follows) (NIC: Hypervolemia management)	- Can decrease water retention. Fluid Restriction maybe used to decrease fluid intake, decreasing fluid volume excess
Supporting Data(AEB)	The client will demonstrate adequate fluid balance as evidenced by output equal to or exceeding intake within 96 hours, clearing breath sounds, and decreasing edema within 1 week.	-Assess JVD, Hepatomegaly, Abdominal pain (NIC: Fluid monitoring)	- elevated volumes in venal canal occur from inadequate emptying of the Right atrium, the excess fluid is transmitted to the JV, Liver, and abdominal distention
-Edema present in Lower extremity		-Monitor I & Os (q 4hours) and weight daily (NIC: Fluid monitoring)	- I&O balance reflects fluid volume status
-Color, Clarity, quantity of urine doesn't support fluid leaving body but rather pooling in other areas	NOC: Fluid Balance	- Assess for peripheral edema (NIC: Fluid monitoring)	- Heart failure causes venous congestion, resulting in increase capillary pressure, fluids leak out of capillaries (edema -legs) Venous return to the heart
- High Blood Pressure	Evaluation: Met On-going Not met	-Auscultate breathe sounds q 2 hours and PRN for crackles and monitor for frothy sputum production (NIC: Fluid monitoring)	- increase pulmonary capillary hydrostatic pressure exceeds oncotic pressure, fluid moves within the alveolar septum and supported by crackles and edema.
-Hypertension /DB			
-History of heart failure	On-going (Still Currently On Going)		Black & Hawks, 2009, p. 1442

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Diagnosis	Goal(s)	Nursing Interventions	Rationales With References (EBP citation)
Statement: Actual problem impaired physical mobility / Risk for falls	STG- create a mobility plan, with mobility devices and small mobility distances to the restroom and chair with in 96 hours	-Teach family and client to assist with transfers and ambulation	-Which prevents falls and injury especially with other contributing factors associated with clients health
	"The pt will ambulate w/ assistive devices 10ft to and from Bathroom within 48 hours"	-Obtain slip resistance shoes	-Prevents falls and maintains balance
RT(Why): related to decreased strength/Endurance	LTG- Encourage patient mobility with assist devices to ambulate down hallway, nurses station, etc.. Within 2 week	-Avoid physical restraints	-Non restraint adults tend to be less likely for falls
Supporting Data(AEB)	"The pt. will participate in PT within 72 hours"	-Consult PT and OT Rehab	-To create a plan to decrease BP, obesity, improve bone density, balance, muscle tone, CVS
-Discomfort		-Note emotional and behavioral responses	-To altered ability to over come anxiety, anger, frustration, and depression
-cardiac output			
-Impaired coordination, decreased muscle mass and strength	Evaluation: Met On-going Not met		
-No desire to self motivate			
Need for assistive devices	Not Met- Pts. mental stability prevented mobility to occur		
			Doenges, Moorhouse & Murr, 2010, pg. 816

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Diagnosis	Goal(s)	Nursing Interventions	Rationales With References (EBP citation)
Statement: Anxiety /Fear	STG- Discuss and create a plan to reduce anxiety and provide other outlets. Acknowledge anxiety within 1 week	Observe speech content, vocabulary, and communication patterns, e.g., rapid/slow, pressured speech; words commonly used, repetition, use of humor/laughter.	Provides clues about such factors as the level of anxiety, ability to comprehend what is currently happening, cognition difficulties, and possible language differences.
RT(Why): change in health status and separation from support channel	LTG- Remain anxiety free for over 1 month	Note narrowed focus of attention (e.g., patient concentrates on one thing at a time).	Narrowed focus usually reflects extreme fear/panic.
Supporting Data(AEB) '-Hypertension /DB '- High Blood Pressure		Assess degree/reality of threat to patient and level of anxiety (e.g., mild, moderate, severe) by observing behavior such as clenched hands, wide eyes, startle response, furrowed brow, clinging to family/staff, or physical/verbal lashing out.	Individual responses can vary according to cultural beliefs/traditions and culturally learned patterns. Distorted perceptions of the situation may magnify feelings.
Facial tension; sympathetic/parasympathetic stimulation (quivering voice, trembling, insomnia); extraneous movements (e.g., foot shuffling, hand/arm movements)	NOC: Anxiety or Fear Control	Acknowledge fear/anxieties. Validate observations with patient, e.g., "You seem to be afraid?"	Feelings are real, and it is helpful to bring them out in the open so they can be discussed and dealt with.
Expressed concern regarding changes in life events; dread of an identifiable problem recognized by the patient; fear of unspecific consequences	Evaluation: Met On-going Not met	Note palpitations, elevated pulse/respiratory rate.	Changes in vital signs may suggest the degree of anxiety the patient is experiencing or reflect the impact of physiological factors, e.g., endocrine imbalances.

Running head: NURSING PROCESS PAPER

Diagnosis	Goal(s)	Nursing Interventions	Rationales With References (EBP citation)
Statement: Self-Esteem, situational low	STG- encourage positive thoughts about self and activities that are rewarding with in 96 hours	Identify basic sense of self-esteem, image patient has of existential, physical, psychological self. Identify locus of control.	May provide insight into whether this is a single episode or recurrent/chronic situation and can help determine needs and treatment plan. It is helpful to know whether the individual's locus of control is internal or external to provide most helpful interventions.
RT(Why): Biophysical, psychosocial, cognitive, perceptual, cultural, and/or spiritual crisis, e.g., changes in health status/body image, role performance, personal identity; loss of control of some aspect of life	LTG- Develop a plan to successful increase self esteem through diet, exercise, weight loss, and personal image to overcome self esteem issues with in 1 month.	Observe and describe behavior in objective terms.	The patient's perception of a change in body image may occur suddenly or over time (e.g., actual loss of a body part through injury/surgery, or a perceived loss, such as a heart attack) or be a continuous subtle process (e.g., chronic illness, eating disorders, or aging). Awareness can alert the nurse to the need for appropriate interventions tailored to the individual need.
Supporting Data(AEB) '-Fear of rejection/reaction by others; projection of blame/responsibility for problems		condition might affect it.	All behavior has meaning, some of which is obvious and some of which needs to be identified. This is a process of educated guesswork and requires validation by the patient.
Rationalizes away/rejects positive feedback; negative self-appraisal in response to life events	NOC: Verbalize realistic view and acceptance of self in situation.	Discuss patient's view of body image and how illness/	Conveys sense of caring and can be helpful in identifying the patient's needs, problems, and coping strategies and how effective they are. Provides opportunity to duplicate and begin a problem-solving process.
Verbalization of negative feelings about the self (helplessness, uselessness); focus on past abilities, strengths, function or appearance; preoccupation with change/loss	Evaluation: Met On-going Not met	Observe nonverbal communication, e.g., body posture and movements, eye contact, gestures, use of touch.	Nonverbal language is a large portion of communication and therefore is extremely important. How the person uses touch provides information about how it is accepted and how comfortable the individual is with being touched.
Evaluates self as unable to handle situations/events; hesitant to try new things/situations; difficulty making decisions	On-going (have yet to reviewe her progress)		Doenges & Moorhouse, 2010, p. 297

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