

**CLINICAL CARE PLAN & CARE MAP****Patient Data**

Student: Emita Shahbazi Date of Care: 10/15 Patient initials: JK Admit date: 10/14 Floor/room #      Allergies:       
Fosphenytoin, naproxen, penicillin, viox Code Status: Unknown

Demographics	Gender: F Age: 57 Height: 165 cm Weight: 90kg Primary language: English Spirituality: No Preference			
Vital signs	T: 38.4 HR: 111 RR: 19 BP: 100/69 O2sat: 95% Pain: 0/10 Pain scale type: Likert			
Admitting Dx	SOB chest pain			
PMHx	Chest pain, SOB, asthma, congestive heart failure, depressive disorder, dependent drug abuse, migraines, non-insulin dependant diabetes mellitus, sciatica, hypertension. Drinks alcohol, and uses marijuana and methamphetamine			
PSHx	2 Rt knee surgery, 4 Lt knee surgery, tonsils removal			
Surgery	Surgery this admission: Anioqram POD: 1			
	Advance directive: none	Isolation: n/a	VS Frequency: Q4	
Diet order: cardiac diet no added salt	Activity order: as tolerated partial assist	Vascular access: Right Antecubital Left Forarm	IVF: see medication list dobutamine and heparin	
Oxygen therapy: n/a	Foley: n/a	Feeding tube: n/a	Glucose checks: AC and at bedtime	
VTE prophylaxis: SCD heparin	Drains/tubes: n/a	Wounds/dressings: TR band on right arm from cath lab angio.	Telemetry: Yes	
Restraints: n/a	Safety issues: Fall risk	Braden: 21	D/C plan: Life vest follow up with surgeon and family practioner	

**Pathophysiology: required – evidence based reference(s) and citation(s).**

Methamphetamine is a stimulant that increases dopamine in the brain. It binds to dopamine transporters which blocks dopamine from reuptake causing it to overstimulate the postsynaptic neurons. This causes prolonged intense euphoria to be felt by the user. The pathophysiology of the cardiovascular system in methamphetamine abusers remains largely unknown. According to Kevil et al., (2019), acute meth use is associated with vascular constriction and vasospasm, whereas chronic use causes endothelial damage and pulmonary hypertension. Methamphetamine causes vasoconstriction, elevated blood pressure, acute vasospasm, and atherosclerotic cardiovascular disease. It also causes structural and electrical remodeling of cardiac tissue which can cause arrhythmias. Acute angina is associated with vasospasm of the coronary arteries, resulting in a decrease of blood flow to cardiac tissue.

Citation: Kevil, C. G., Goeters, N. E., Woolard, M. D., Bhuiyan, M. S., Dominic, P., Kolluru, G. K., ... Orr, A. W. (2019). Methamphetamine Use and Cardiovascular Disease. *Arteriosclerosis, Thrombosis, and Vascular Biology*, 39(9), 1739–1746. <https://doi.org/10.1161/atvbaha.119.312461>

<b>Lab and Diagnostic Test Data</b>
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LABS	Normal Range (Fill in Hospital Norms)	RESULT 1 (date & time)	RESULT 2 (date & time)	RESULT 3 (date & time)	Reason for abnormal lab values related to patient care & nursing implications	
<b>CBC</b>		10/14/2020 02:40	10/15/2020 0340		WNL patient is taking Heparain. Their RBC labs should be assessed prior to admnistraton of new Hepararin doasage. Heparain is an anticoagulant which will decrease clotting time.	
• WBC	4-11	7.2	6.2			
• RBC	3.8-5.2	4.08	3.89			
Hemoglobin (Hgb)	7-19	11.8	11.2			
Hematocrit (Hct)	35-47	36.1	34.5			
• MCV	80-98	88.5	88.7			
• MCH	27-32	29	28.8			
• MCHC	32-36	32.7	32.5			
• RDW	11.5-14.5	15	15.3			
PLT COUNT	130-300	185	156			
<b>WBC DIFF</b>					WNL Pt does not have any infections. WBC greater than 11 is an indication for infection, inflammation, tissue necrosis, or leukemic neoplasia. Trauma or stress may increase WBC count.	
NEUTROPHIL %	42-75	53	46			
BANDS %						
LYMPHOCYTE%	20-50	33.7	39.5			
MONOCYTE %	2-14	11.2	11.6			

<b>CHEMISTRY</b>					Pt chemistry panel mostly WNL. Spiranalactone may decrease sodium levels and increase potassium. This lab panel is assessed for this pt specifically due to her heart failure. She was also NPO for one day due to her procedure. Overall Her nutritional levels are being met aeb her labs being stable.	
<b>Sodium</b>	136-145	134	135			
<b>Potassium</b>	3.5-5.1	4.4	4.4			
<b>Chloride</b>	98-107	106	105			
<b>CO<sub>2</sub>(bicarb)</b>	21-31	21	23			
<b>BUN</b>	7-25	31	35			
<b>Creatinine</b>	.6-1.2	1	1			
<b>GFR</b>	>=60	57.81	56.5			
<b>Glucose</b>	74-109	198	91 at 0930 and 171 at 1230			
<b>Calcium</b>	8.6-10.3	8.6				
<b>Iron</b>						
<b>Transferrin</b>						
<b>Iron/ Transferrin</b>						
<b>Phosphorus</b>						
<b>Magnesium</b>	1.9-2.7	2.1				
<b>Lactate</b>						
<b>Serum Ketones</b>						
<b>HbA1C</b>						
<b>LIVER PANEL</b>					Pt has HX of drinking alcohol as well as using meth. Her lab levels are WNL.	
<b>Total protein</b>						
<b>Albumin</b>	3.5-5.7	3.2				

<b>Bilirubin Total</b>	.2-1	<.3				
<b>Alk phosphatase</b>	34-104	69				
<b>HDL</b>	23-92		28			
<b>LDL</b>	1-100		83			
<b>AST</b>	13-39	24				
<b>ALT</b>	7-52	31				
<b>Lipase</b>						
<b>Amylase</b>						
<b>Ammonia</b>						
<b>Cholesterol</b>						
<b>Triglycerides</b>						
<b>Lactate</b>						
<b>Serum Ketones</b>						
<b>CARDIAC PANEL</b>						
<b>CPK</b>						
<b>CPK-MB</b>	< 3	< 3				
<b>Troponin</b>	0-.04	.64, .58 0655, .49 1200			Troponin labs are used as a cardiac cell marker. Troponin is a protein found in cardiac muscle. Elevated troponin levels indicate a breakdown and damage of cardiac cells and muscle. PT has HX of CHF. Increased level of troponin may indicate an MI or heart damage due to pts condition.	
<b>Myoglobin</b>						
<b>BNP</b>	0-100	1,509			BNP is a protein produced in the ventricles of the heart. It gets released with the change of pressure in the heart. . BNP levels are higher than normal when an individual has heart failure.	

<b>COAGULATION</b>						
<b>PT</b>	9.5-11.5	11.1				
<b>INR ratio</b>	Critical high >4	1				
<b>PTT</b>	25-35	25	59 (10/14 13:00) 46 at 1015		The patient was given heparin as an antiplatelet blood thinner due to her scheduled angiography. The PTT levels are observed and the heparin dosages are changed according to the PTT level according to the physicians order.	
<b>Fibrin level</b>						
<b>Fibrinogen</b>						
<b>Anti Factor Xa</b>						
<b>Bleeding time</b>						
<b>D-Dimer</b>						
<b>Drug levels</b>						
<b>UA collection type</b>						
<b>Urine color</b>						
<b>Urine appearance</b>						
<b>Specific gravity</b>						
<b>Urine Ph</b>						
<b>Urine glucose</b>						
<b>Urine bilirubin</b>						
<b>Urine blood</b>						
<b>Urine Ketones</b>						
<b>Urine Nitrites</b>						
<b>Urine Protein</b>						
<b>Urine Leukocytes</b>						
<b>URINE MICRO</b>						

<b>WBC HPF</b>						
<b>RBC HPF</b>						
<b>Nitrate HPF</b>						
<b>Epithelial</b>						
<b>Bacteria</b>						
<b>Mucous</b>						
<b>CULTURES</b>						
URINE CULTURE						
Urine Tox screen						
<b>CSF</b>						
• WBC						
• RBC						
• Glucose						
• Protein						
• Culture						
<b>Blood Cultures</b>						
<b>Stool Cultures</b>						
<b>Sputum Cultures</b>						
<b>Nasal Cultures</b>						
<b>ABG(FIO<sub>2</sub> + device)</b>						
<b>pH</b>						
<b>PO<sub>2</sub></b>						
<b>PCO<sub>2</sub></b>						
<b>Bicarbonate</b>						
<b>Oxygen Saturation</b>						
<b>Anion gap</b>						
<b>Tox Screen</b>						
<b>Therapeutic Drug Levels</b>						

<b>DIAGNOSTIC TESTS</b>  ( ALL DIAGNOSTIC TESTS SHOULD BE HERE)						
<b>ECG</b>						
<b>X ray</b>						
<b>Angiography</b>						
<b>Heart Cath. Lab</b>						
<b>CT Scans</b>	10/14 0509	NO visible PE central pulmonary arteries enlarged compatible with pulmonary arterial HTN Small moderate size pleural effusion with compressive atelectasis Small patchy areas of left upper lobe ground glass and modular opacity which may be acute or chronic				



		post inflammatory or pneumonia Moderate to severe global cardiomegaly worse than prior study from 10/1 may be related to right heart failure Mild mediastinal lymphadenopathy				
<b>MRI</b>						
<b>Endoscopy</b>						
<b>Nuclear Scan</b>						
Medications						
Generic Trade Name Drug classification ( <i>Therapeutic &amp; Pharmacologic</i> )	Dose/Route Frequency Rate of Administration (if needed)	Action of Drug Purpose ( <b>specific to Pt</b> )	Possible Side Effects	Nursing Considerations related to patient care and teaching (What to assess, when to hold, what to teach, etc. Anything other than the side effects that the hospitalized patient needs to know.)		
G: Dobutrex T: Dobutamine <i>Th: inotropics</i> <i>Ph: adrenergics</i>	IV additive 500 mg [5 mcg/kg/min] mixed with 250 ml D5W IV infuse over 18.5 hr Rate 13.5 ml/hr	Purpose: Increase cardiac output without significantly increasing HR Action: Stimulates beta1 myocardial adrenergic	Possible side effects include: hypertension increased hr PVCs	Only administered through IV Use with nitroprusside may have synergistic effect on increasing cardiac output Beta blockers may negate the effect of dobutamine increase risk for arrhythmia or htn Monitor BP HR or ECG changes		

		receptors. Produces chronotropic, hypertensive arrhythmogenic and vasodilation effects		Palpate peripheral pulses assess appearance Monitor potassium- may cause hypokalemia If HR >120 decrease to 3mcg/kg/min (Call pharmacy first) IV site assessment
G: Hepalean T: heparin Th: anticoagulants Ph: antithrombotic	IV additive 25,000 units + ½ NS premix diluent 500 ml Duration 12 hr total volume 500 ml Loading dose 60units/kg IV push Initial infusion rate 12 units/kg/hr	Purpose: anticoagulant Action: Prevention of thrombus formation	Possible side effects include: Bleeding, thrombocytopenia	Adjustment scale based on PTT. below 35: 60 unit/kg IV Push bolus (MAX 4000 units) and increase rate by 4 units/kg/hr (MAX 400 units/hr) 35 - 45: 30 unit/kg IV Push bolus (MAX 3000 units) and increase rate by 2 units/kg/hr (MAX 200 units/hr) 46 - 70: NO CHANGE (THERAPEUTIC) 71 - 90: Decrease rate by 2 units/kg/hr, but do not decrease more than 200 units/hr above 90: HOLD infusion for 1 hr, then decrease rate by 3 units/kg/hr, but do not decrease more than 300 units/hr. Order baseline labs (prior to initiation of heparin): aPTT, PT/INR (if on warfarin therapy), CBC with differential Order aPTT 6 hours after bolus and 6 hours after any dosage change. If no dosage change is required following two consecutive aPTT's,

				change aPTT order to every 12 hours. After two consecutive aPTT's on every 12 hour schedule without dosage change, order aPTT every morning. IV site assessment
G: acetylsalicylic acid T: Aspirin <i>Th</i> : antipyretics, nonopioid analgesics <i>Ph</i> : salicylates	81 mg 1 tab chewed daily last given 0900	Purpose: Produce analgesia and reduce inflammation and fever by inhibiting the production of prostaglandins. Decreases platelet aggregation Action: Analgesia. Reduction of inflammation. Reduction of fever. Decreased incidence of transient ischemic attacks and MI.	Possible side effects include: GI bleeding, epigastric pain	Assess chest pain Assess for side effects Withhold if the following occurs; tinnitus, headache, hyperventilation, agitation, mental confusion, lethargy, diarrhea, and sweating.
G: Spironolactone T: Aldactone <i>Th</i> : potassium-sparing diuretics <i>Ph</i> : antagonist of aldosterone	25 mg = 1 tab oral Daily	Purpose Weak diuretic and antihypertensive response when compared with other diuretics. Conservation of potassium	Possible side effects include: hyperkalemia, hyponatremia, hyperchloremic Dizziness, headache	Monitor intake and output ratios. Monitor BUN, serum creatinine, and electrolytes. May cause increase serum magnesium, uric acid, BUN, creatinine, potassium, plasma renin activity, and urinary calcium excretion levels Assess BP Hr and ECG.

		Action Causes loss of sodium bicarbonate and calcium while saving potassium and hydrogen ions by antagonizing aldosterone		
G: Pepcid T:Famotidine <i>Th</i> : antiulcer agents <i>Ph</i> : H2 receptor antagonist	20 mg = 1 tab oral daily last given 0900	Purpose: Decrease excessive gastric secretion Action: Selectively block histamine H2 which inhibits basal and stimulated gastric acid secretion	Possible side effects include: Dizziness confusion	Unlabeled uses: Prevention of stress ulceration or aspiration pneumonitis IV assessment Flush with NS before and after medication administration Abdominal assessment
G: Lasix T: Furosemide <i>Th</i> : diuretic <i>Ph</i> : Loop diuretic, antihypertensive	40 mg=4 ml injection IV push q12hr	Purpose: Reduce edema hypertension subsequent mobilization of excess fluid Action: Inhibits sodium and chloride reabsorption at the proximal and distal tubules as well as the	Possible side effects include: Possible side effects include: Excessive urination fluid and electrolyte imbalances	Skin assessment for edema. Bladder scan if pt is not urinating Check pt electrolyte labs Monitor Input and Output levels IV site assessment

		ascending loop of Henley		
<p>G: insulin lispro  T: Humalog sliding scale  <i>Th</i>: antidiabetics, hormones  <i>Ph</i>: pancreatic</p>	<p>Subs TID AC and Q bedtime Use sliding scale  2 Units administered in upper left arm at lunch time</p>	<p>Purpose: Control of hyperglycemia in diabetic patients  Action: Lowers blood glucose by: stimulating glucose uptake in skeletal muscle and fat, inhibiting hepatic glucose production. Other actions of insulin: inhibition of lipolysis and proteolysis, enhanced 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>Possible side effects include: hypoglycemia</p>	<p>MEDIUM DOSE Algorithm: For patients requiring 40 to 80 units of insulin daily.  <b>FOR USE ON ADULT (NON-PREGNANT) PATIENTS</b>  For FSBG below 70 --&gt; follow hypoglycemia protocol.   Prandial FSBG  :  Additional Insulin    below 140  = 0 unit   140 - 199  = 2 units   200 - 249  = 4 units   250 - 299  = 6 units   300 - 349  = 8 units   above 349  = 12 units  Do not hold if NPO.  Assess for symptoms of hypoglycemia (anxiety; restlessness; tingling in hands, feet, lips, or tongue; chills; cold sweats; confusion; cool, pale skin; difficulty in concentration; drowsiness; nightmares or trouble sleeping; excessive hunger; headache; irritability; nausea; nervousness  Rotate injection site</p>
<p>G: nitroglycerin  T: Minitran  <i>Th</i>: :antianginals</p>	<p>.4mg/hr patch extended release daily</p>	<p>Purpose: Increases coronary blood flow by dilating</p>	<p>Possible side effects include: Dizziness</p>	<p>Assess BP, pain, ECG  Label the patch</p>

<i>Ph:</i> nitrates		coronary arteries and improving collateral flow to ischemic regions. Produces vasodilation Action: Relief or prevention of anginal attacks. Increased cardiac output. Reduction of BP	headache hypotension tachycardia	
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G: Lanoxin T: Digoxin <i>Th:</i> inotropics <i>Ph:</i> digitalis glycosides	125 mcg = 1 tab oral daily	Purpose Increased cardiac output (positive inotropic effect) and slowing of the heart rate (negative chronotropic effect). Action Increases the force of myocardial contraction. Prolongs refractory period of the AV node. Decreases conduction through	Possible side effects include: Bradycardia nausea fatigue	Monitor apical pulse for 1 full min before administering. Withhold dose and notify health care professional if pulse rate is <60 bpm in an ad Monitor intake and output ratios. Assess for peripheral edema and auscultate lungs for rales/crackles throughout therapy.
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		the SA and AV nodes.		
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<b><u>HEAD / NEURO</u></b>	
<b>L.O.C.</b>	A&Ox4 no signs of head trauma
<b>Optical</b>	Patient has glasses for up close reading. PERRLA
<b>Head and neck</b>	WNL
<b>Nose and Throat</b>	WNL
<b>Gross and Fine Motor</b>	Pt has full ROM
<b><u>RESPIRATORY</u></b>	
<b>Pulmonary</b>	RR 19 O2 sat 95%. Crackles in beginning of shift in upper lobes bilaterally. Lower lobes diminished. End of shift clear lung sounds upper lobes, lower lobes still diminished bilaterally.
<b>Breast and back</b>	On 5 lead ekg.
<b><u>CARDIO-VASCULAR</u></b>	
<b>Cardiac</b>	Irregular rate and rhythm. Tachycardic with PVCs and frequent PACs. Radial pulses 2+ bilaterally . Pedal pulses found with doppler
<b>Central</b>	n/a
<b>Peripheral</b>	n/a
<b><u>GASTROINTESTINAL</u></b>	
<b>Abdominal</b>	Bowel sounds present in all 4 quadrants. Abdomen soft upon palpation LBM day before yesterday



<b>Nutritional</b>	Cardiac low sodium diet
<b><u>GENITOURINARY</u></b>	
<b>Pelvic and rectal</b>	n/a
<b><u>MUSCULOSKELETAL</u></b>	Pt has full ROM.
<b><u>INTEGUMENTARY</u></b>	
<b>Skin / Hair</b>	Skin moist and warm to touch. Feet dry and calloused. IV in right Antecubital left Forearm. Nitro patch on left upper arm. Pt is obese no signs of edema. TR Band on her right arm from cath lab.

**SBAR REPORT:** (What did you report off to the RN upon end of shift)

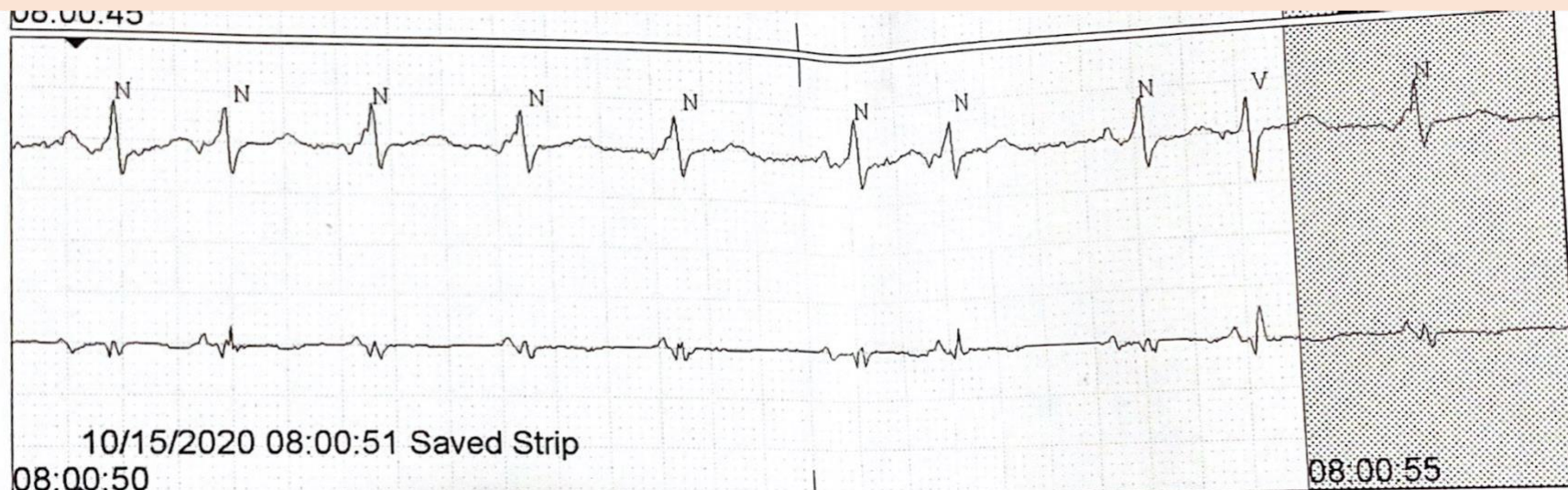
S: JK in room 96 is a 57 year old female admitted 10/14 for SOB and chest pain. She has an EF of 15-20%

B: She has a history of asthma methamphetamine use and diabetes. Her drug allergies are listed on the EHR. She has no complaints of pain or shortness of breath currently except for SOB when she gets up and walks around .

A: Her last set of vital signs are temperature of 36.8 F , heart rate 65 bpm, RR 18 , BP 99 / 64, O2 sat 95%. Her last finger stick blood sugar was 171 we gave her two units of insulin before lunch. She's A&Ox4. She's a pleasant patient. She has irregular heart sounds. Her upper lobes sound clear and her lower lobes are diminished bilaterally. She is an IV in her right antecubital and left forearm. The right IV has dobutamine running and the left IV used to have heparin running yesterday for the angiogram. Her radial pulses are 2+ bilaterally . Her pedal pulses were found using a Doppler . She has a TR band on her right arm from when she went to the cath lab last night.

Everything looked okay according to the angiogram and there was nothing new noted. She has cardiomegaly and her ejection fraction is still around 20%. She's up to use the restroom by herself. Her last bowel movement was the day before yesterday and she had a total urine output of 1800 ml.

R: Continue to assess pt. Have the cardiac and diabetes education consultant come and speak to her. Have the life vest consultant speak with patient. The TR band will be removed 24 hours from her procedure.

**ECG Documentation- Used only 5<sup>th</sup> semester**

**Rhythm:** Atrial rhythm: Regular ☒ Irregular ☐ Ventricular rhythm: Regular ☐ Irregular ☒

**Rate:** Atrial Rate 120 Ventricular rate 120 PR interval .18 QRS interval .10 QT interval .3

**Conduction:** Is AV conduction normal? (Y/N) Y If not, why is it abnormal? \_\_\_\_\_

P wave normal? (Y/N) N QRS complex normal? (Y/N) Y Are all of the QRS complexes the same? (Y/N) N

Are there premature beats? (Y/N) Y Atrial ☐ ventricular ☒ Interpretation of rhythm: Tachycardia With PVC

Potential hemodynamic consequences of this rhythm and interventions for this rhythm: The ventricles are shutting quicker than the rest of the heart. This can cause pooling of blood increased myocardial oxygen demands, decreased cardiac output and potential for thromboembolism. Treatment for this rhythm is calcium channel blockers, and beta blockers. Anticoagulation should be used to prevent thromboembolism.

**(This form is used at the discretion of the clinical instructor; students will be assigned to use the Care Map or this alternative format)**

### Nursing Diagnoses

<b>Priority Assessments:</b>		<b>Circulation and Pain</b>
<b>ND #1 Decreased cardiac output r/t CHF</b>  <p style="text-align: center;"><b>AEB</b> Pt having 15-20% EF.</p>	<b>ND #2 Risk for bleeding r/t antiplatelet medication administration</b>	<b>ND #3 Risk for excess fluid volume r/t heart condition and continuous IV medication administration.</b>
<b>ND #4 Ineffective coping r/t drug use</b>  <p style="text-align: center;"><b>AEB</b> Pt uses methamphetamine, drinks alcohol, and uses marijuana.</p>	<b>ND #5 Readiness for enhanced knowledge</b>  <p style="text-align: center;"><b>AEB</b> Pt showing interest in care and asking questions about medication and life vest.</p>	<b>ND #6 Activity Intolerance r/t cardiac disorder</b>  <p style="text-align: center;"><b>AEB</b> Pt reporting SOB when getting up and not wanting to get out of bed unless they need to use the bathroom.</p>

Revised: Medical Surgical Committee 5/17/19

Nursing Interventions Classification (NIC)		
ND	Interventions	Evaluation of response
<b>1. Decreased cardiac output r/t CHF AEB Pt having 15-20% EF.</b>	<b>Asses for fatigue, dyspnea edema, and chest pain.</b> <b>Medication administration</b> <b>Assess vitals Q4h and monitor ECG</b> <b>Provide restful relaxing environment</b> <b>Apply SCD</b> <b>Sodium restriction</b> <b>Monitor I&amp;O and Labs</b> <b>Gradually increase activity</b>	<b>No reports of pain fatigue or SOB. Pt has SOB while walking to and from the bathroom.</b> <b>Pt tolerating medication well.</b> <b>Pt is sleeping and resting while medical team is away from room</b> <b>SCDs on leg</b> <b>Pt is on low sodium diet at hospital</b> <b>Pt was educated on CHF and stated they read the provide handouts.</b>
<b>2. Risk for bleeding r/t antiplatelet medication administration</b>	<b>Fall prevention techniques such as fall band on wrist, fall risk sign at the door and on white board in pt room.</b> <b>Nonskid socks on, two side rails up, bed at lowest setting, and nurse call light near patient.</b> <b>Assess pTT lab and administer appropriate heparin dosage</b>	<b>No falls during shift or bleeding</b> <b>Pt adhered to prevention tips</b> <b>pTT levels checked; WNL and appropriate heparin dosages were administered.</b>
<b>3. Risk for excess fluid volume r/t heart condition and continuous IV medication administration.</b>	<b>Administer Lasix and spironolactone</b> <b>Monitor for pitting edema</b> <b>monitor I&amp;O</b> <b>Auscultate lung sounds and monitor vital signs</b> <b>Elevate head of bed to 30 to 45 degrees</b> <b>Monitor electrolyte lab levels</b>	<b>No sign of edema.</b> <b>Lung sounds clear after administering medications</b> <b>Patient urinated 1800 milliliters during day shift</b> <b>Electrolytes WNL for pt condition</b>

Revised: Medical Surgical Committee 5/17/19

<b>4. Ineffective coping r/t drug use AEB Pt uses methamphetamine, drinks alcohol, and uses marijuana.</b>	<b>Assess for contributing factors to ineffective coping Decrease symptoms of pain and stressors Administer medication</b>	<b>Pt reports no pain and is adhering to and tolerating course of care. Pt expresses interest in making lifestyle changes. Pt reports they have not used meth, alcohol or marijuana in one month.</b>
<b>5. Readiness for enhanced knowledge AEB Pt showing interest in care and asking questions about medication and life vest.</b>	<b>Assess patient's eagerness to engage in self care Provide patient with education handouts Ask patient if they have any questions Refer client to interdisciplinary health care members.</b>	<b>Pt expresses interest in care Pt stated they read their education hand outs Pt asks questions about medication. Pt is referred to diabetes and CHF nurse. A life vest representative spoke to pt during AM shift.</b>
<b>6. Activity Intolerance r/t cardiac disorder AEB Pt reporting SOB when getting up and not wanting to get out of bed unless</b>	<b>Assess patient's activity orders Observe pt while getting up Perform ROM exercise Allow for time for rest</b>	<b>Pt is able to walk to bathroom and back. She reports SOB when she is back in her bed after being up to use restroom. Pt does not have SOB while in bed. No reports of pain or coughing. Pt is resting when medical staff is out of pts room</b>

<p><b>they need to use the bathroom.</b></p>		
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<b>Student Clinical Self Appraisal</b>
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Course 4810 Instructor J. Merriam**Instructions:**

Please evaluate your performance during clinical today using the following concepts:

Client Advocate	Professional Demeanor	Flexible
Critical Thinking	Communication/rapport	Peer Support
Self-Initiated	Skills acquisition	Team Player
Safety	Organized	Educator
Leadership	Well-prepared	Dependable
Nursing Process	Knowledgeable	

<b>Areas of Strength Today (Date)_____</b>  <i>Self-Initiated/Leadership: I let all of the nurses know that I am available to assist them with any skill if need be</i>  <i>Ability to Prioritize I provided care and organized my day to my patient and then assisted with other patients.</i>  <i>Communication/rapport: I was able to effectively communicate with the patient and other individuals who were involved in her care.</i>  <i>Well-prepared: Care plan was filled out prior to clinical</i>  <i>Knowledgeable: I did my research on the patient's condition prior to giving care.</i>	<b>Areas Needing Growth-Include plan of improvement</b> <i>Client advocate: Advocated to the nurse about my patient's needs.</i>  <i>Leadership: I made my self available to all of the nurses and took charge in my patients care and charting</i>  <i>Technical skills: I practiced assessments, did med math, administered insulin, took out an NG tube (not my PT), removed IV's, and looked at EKG monitors.</i>  <i>Critical thinking: I was able to put together my prior knowledge of CHF and what my patient was presenting to enhance my knowledge on this condition.</i>
<b>Instructor Comments:</b>	



