Nursing Diagnosis (3 pts)	Intervention (4 pts)	Rationale (4 pts)	Outcome (1 pt)
Problem Nursing diagnosis (exact NANDA-I wording) **Related to (r/t)** Etiology or cause of problem • The "related to" portion of the statement • There should only be *one* cause stated per nursing diagnosis • The etiology *cannot* be a medical diagnosis • No related to for "at risk" diagnoses **As evidenced by (AEB)** (also called defining characteristics) • The "as evidenced by" portion of the statement • These are determined through your *assessment* of the patient • For potential or "at risk" diagnoses, identify the risk factors that predispose the individual to a potential problem.	• There should be at *least* four interventions with associated rationale • The interventions can be strictly nursing based or collaborative (e.g., medication for nausea as ordered by MD) • Interventions need to be specific: what, when, how much, and how often (must include frequency/ scheduled times) and must address/support the identified nursing diagnosis 1. 2. 3. 4.	• Explain why you are performing each listed intervention. • Evidence based • Should correspond with intervention 1. 2. 3. 4.	**Was the goal met, or not met?** • Evaluation occurs to determine whether or not the goals were met • Evaluation should occur at the end of the shift. • If the goal was not met or was partially met, the student should discuss why it was not met and state what should be done differently, if anything. • Must include time/date and should directly correspond to the goal.
Goal (2 pts)			Patient History (1 pt)
The patient will… *Must directly relate to the nursing diagnosis.* **Specific**: What needs to be accomplished? **Measurable**: How will the nurse, patient, and/or family know that the goal has been met? **Attainable**: Can the goal be met with the resources available? **Realistic**: Does the patient and/or family have the physical, emotional, and mental capacity to meet the goal? **Time-specific**: When will the goal be achieved? Must include date/time.			Patient information that supports the nursing diagnosis and care plan. May include labs, diagnostic tests, history, and assessment findings.

Reference

NANDA-I Care Plan

Tips for writing nursing diagnoses and developing nursing care plans.

Use the *problem-etiology-symptom (PES) method* when writing nursing diagnoses. Start with the nursing diagnosis itself, followed by the etiologic factors (cause of the problem). Finally, identify the major signs/symptoms (defining characteristics) that are appearing in the patient (as evidenced by).

PROBLEM-FOCUSED DIAGNOSIS

Problem-Focused Diagnosis related to _____ (Related Factors) as evidenced by _____ (Defining Characteristics).

Problem-Focused Diagnosis Example: Anxiety related to situational crises and stress (related factors) as evidenced by restlessness, insomnia, anguish and anorexia (defining characteristics).

In the case of risk diagnoses, no etiologic factors apply, so identify risk factors that predispose a patient to a potential problem for risk diagnoses, or evidence that suggests a potential for health promotion (defining characteristics) for a health promotion diagnosis.

RISK DIAGNOSIS

For risk diagnoses, there are no related factors (etiological factors) as the nurse is identifying a vulnerability in a patient for a potential problem; the problem is not yet present. Therefore, identify the risk factors that predispose the individual to a potential problem.

The correct statement for a NANDA-I nursing diagnosis would be: **Risk for _____ as evidenced by _____ (Risk Factors).**

Risk Diagnosis Example: Risk for infection as evidenced by inadequate vaccination and immunosuppression (risk factors).

Reference

What meds can use for this — What i monitor

Signs and Symptoms for this disease:	Diagnostic Tests Surgery and other Interventions to diagnose, treat or monitor this disease:	Medications used to manage this disease:	Nursing Interventions for patients with this disease:
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4	4.	4.	4.
5.	5.	5.	5.
6.	6.	6.	6.
8.	7.	7.	7.
9.	9.	9.	9.
10.	10.	10.	10.

make sure you do 10

Critical Thinking Flow Sheet for Nursing Students

Medical Diagnosis (Disease): _____

Pathophysiology:

THE *NORMAL* ANATOMY AND PHYSIOLOGY OF THIS ORGAN/BODY SYSTEM AFFECTED BY THIS DISEASE IS:

THE WAY THE ANATOMY AND/OR PHYSIOLOGY HAS BEEN *CHANGED* IN THIS DISEASE IS:

Clinical Case Study

Caring for Clients With Disorders of Coronary and Peripheral Blood Vessels

April Smith, an 82-year-old female client, is at the independent living facility and had planned on going to a senior outing for breakfast and shopping when she activated her emergency alert button she wears around her neck. When the emergency response system called, she stated in gasping words, "I can't get my breath!" She denies any chest pain or abdominal pain but has had some upper back pain since yesterday. The vital signs at the scene were T, 96° F; BP, 190/100 mm Hg; HR, 120 beats/minute; RR, 30 breaths/minute. She is diaphoretic and pale. The emergency response team placed oxygen at 2 L per nasal cannula on her and had her take an aspirin 325mg per emergency physician's orders. They inserted two 18-gauge IVs and had normal saline at keep vein open rate. The labs obtained by the squad were as follows: the CBC within normal limits (WNL); coagulation profile WNL; renal profile BUN 27 mm/dL, creatinine 1.6 mg/dl, BUN/Creat ratio 21:1 and the first set of cardiac enzymes, which consisted of Troponin T which was 1.8mcg/L, Troponin I which was 5.9mcg/L, Myoglobin 527mcg/L, Total CK 450units/L, CK-MB 23ng/ml, Cholesterol 320mg/dL, HDL 20mg/dL, LDL 188mg/dL, VLDL 92 mg/dL, Triglycerides 162mg/dL, and CPK 200ng/ml. She weighs 124 lbs. The initial ECG reveals ST elevation in the anterior and inferior areas. The oxygen did not help alleviate the shortness of breath, but the SaO_2 remained 96%. At the emergency department, the nurse reviewed the client's past medical history, noting she had an ischemic stroke 3 months ago. She had received tPA for that incident, and the symptoms had resolved. She has been taking an aspirin 81mg a day, a beta-blocker for her hypertension: atenolol 25 mg once a day, and atorvastatin 20 mg once daily. The client received nitroglycerin IV and morphine 4mg IVP with

some relief of the symptoms. The cardiologist evaluated the client via a cardiac angiogram and discovered 99% blockage in the right coronary artery and 95% blockage in the left anterior descending artery. The client had an angioplasty with two stents placed in the two affected coronary arteries. The client was then placed on Plavix 75mg daily and aspirin was increased to 325 mg daily, atenolol d/c'd and ordered metoprolol 25 mg daily, her NS is infusing at 75ml/hr. The client must be monitored closely for 24 hours on telemetry. The LPN/LVN working on the telemetry unit needs to closely manage the client's care, watching for any potential complications.

Vital Signs:

1 Temp: 96F, B/P: 190/100 mmHg, HR: 120 bpm, RR: 30 bpm, O2Sats: 96% on 2L NC

11 Temp: 98F, B/P: 182/96 mmHg, HR: 98 bpm, RR: 26 bpm, O2Sats: 95% on 2L NC

3 After procedure:

Q 15 min x 4:

T: 98.1F, B/P 164/80, HR: 76, RR: 20, O2Sats 96% on 2L NC

T: 97.8F, B/P 156/78, HR: 72, RR: 20, O2 Sats 96% on 2L NC

T: 97.8F, B/P 148/76, HR: 70, RR: 20, O2Sats 97% on 2LNC

T: 97.9F, B/P: 138/72, HR: 70, RR: 20, O2Sats 97% on 2 L NC

Q 30 min x 2:

T: 97.9F, B/P: 136/70, HR: 68, RR: 18, O2Sats 97% on 2L NC

Additional RXs ordered: lovenox 0.75 mg/kg every 12 hours, NTG tabs, Vasotec 10 mg daily

Labs:

Put in labs on the does she did pt which

CBC, Coagulation panel, renal profile (BUN, creatinine, BUN/creat ratio, BNP, cardiac enzymes (troponin, myoglobin, Total CK, CK-MB), lipid panel (triglycerides, HDL, LDL, VLDL)

Diet: Heart healthy (low fat, low cholesterol)

a. Explain the client's symptoms and the rationale for the treatment the client received.

b. What nursing management should the client receive while on the telemetry unit?

c. Prepare a care plan for this patient's care.

d. What kind of education does this patient need?