N431 Care Plan # 2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
10/09/2020	TW	47	male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Disabled	Divorced, single	NKDA
Code Status	**Height**	**Weight**	
Full code	175.2 cm	121.2 kg	

Medical History (5 Points)

Past Medical History: Hypertension, obesity, type 1 diabetes, Rheumatic arteritis, Rheumatoid arthritis, back pain, hyperlipidemia

Past Surgical History: 9 back surgeries across his adult life. Dates not in chart and patient could not state dates because there were so many.

Family History: no family history

Social History (tobacco/alcohol/drugs): currently drinks alcohol 1-2 times a year since adolescence, no drug use or abuse, never smoked or used smokeless tobacco

Assistive Devices: independent, glasses at the bedside

Living Situation: lives with children at home

Education Level: no learning barriers, some college education

Admission Assessment

Chief Complaint (2 points):OBJ Chest pain, Shortness of breath

History of present Illness (10 points):. Patient presented to the ER complaining of chest tightness palpations, shortness of breath, and dizziness that is worse with exertion. Nothing has seemed to relieve the pain or breathing trouble. Symptoms presented about a month ago, although the Shortness of breath started about two weeks ago. The patient has a

history of type 1 diabetes and hypertension. Diagnostic testing did not show any acute coronary or pulmonary abnormalities, and labs showed normal cardiac markers.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):.Chest Pain

Secondary Diagnosis (if applicable):. Chronic back pain

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

Chest Pain (angina)

Chest pain, also referred to as angina, is pain or discomfort when the heart does not have enough oxygen pumping through the blood (American Heart Association, 2015). Angina is usually a symptom of an underlying heart problem. There are four main types of angina, including Stable angina, unstable angina, variant angina, and microvascular angina (American Heart Association, 2015).

The typical presentation and history assessed for a patient with angina include Onset, Location, Duration, Character, Aggravation/Alleviating factors, Radiation, and Timing (OLD CART) (Johnson & Ghassemzadeh, 2020). Some common symptoms that present alongside angina include Shortness of breath, nausea and vomiting, fever, diaphoresis, cough, dyspepsia, edema, calf pain or swelling, and recent illness (Johnson & Ghassemzadeh, 2020). Angina can also radiate to the patient's shoulders, arms, neck, jaw, or back ((American Heart Association, 2015). Risk factors for angina include prior myocardial infarction, family history of cardiac disease, smoking, hypertension, hyperlipidemia, diabetes, and periods of immobility(Johnson & Ghassemzadeh, 2020).

For the physical exam, it will be necessary to obtain a full set of vitals, blood pressure being of most importance. The blood pressure will be high during an episode of angina. The nurse may also see elevated respirations due to pain and trouble breathing, and an increased pulse rate. The nurse will want to check the patient's general appearance, observing closely for diaphoresis and distress, any skin lesions, jugular venous distention, palpate the chest for pain and crepitus, auscultate heart and lung sounds, do a full abdominal exam, and check extremities for any unilateral swelling, calf pain, edema, and symmetric, equal pulses.

Standard diagnostic testing includes Electrocardiogram (ECG), Chest X-ray, CBC, CMP, Troponin, and possibly a bedside ultrasound (Johnson & Ghassemzadeh, 2020). In the ECG, the nurse will monitor any signs of ST-elevation or any other abnormal heart rhythms. The expected values for Troponin should be between 0-0.4 ng/ml. An elevation in this level would indicate heart ischemia (Capriotti & Frizzell, 2016).

Treatment of angina includes lifestyle changes, medication to lower blood pressure (ACE inhibitors, BETA blockers). Also commonly prescribed is Nitroglycerin tablets. These will reduce chest pain; the patient will place one tablet under their tongue every 5 minutes until the pain is relieved. The maximum dose is three tablets, and make sure to call EMS after administering the first tablet (Capriotti & Frizzell, 2016). Other treatments include Cardiac procedures as well as cardiac rehab. Cardiac procedures commonly include a stress test, Echo, and a cardiac catheterization.

The patient presented to the ED with angina and shortness of breath. The patient is at risk for angina because of a history of type 1 diabetes since age 2, obesity, and hypertension. The patient has no family history of heart problems. The patient received a CBC, CMP, EKG, troponins, d-dimer, chest X-ray, stress echo, and went to the cardiac Cath lab. All tests came

back normal, and no ischemia is present in the heart. The patient is receiving oxygen and opioid pain medication to manage chest pain and chronic back pain. The patient is learning to take blood medications and stay on an adequate medication regimen and lifestyle changes that include a healthy heart diet consisting of low sodium, fats, and sugar (American Heart Association, 2015).

Pathophysiology References (2) (APA):

American Heart Association. (2015, July 31). *Angina (chest pain).* Heart.org. https://www.heart.org/en/health-topics/heart-attack/angina-chest-pain

Capriotti T. & Frizzell J.P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* F.A. Davis.

Johnson K. & Ghassemzadeh S. (2020, July 17). *StatPearls: Chest Pain* [Internet]. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK470557/?report=classic#_article-19382_s10_

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.28-5.56	5.30	--	Normal
Hgb	13-17	15.9	--	Normal
Hct	38.1-48.9	46.8	--	Normal
Platelets	149-393	224	--	Normal
WBC	4.0-11.7	8.3	--	Normal
Neutrophils	45.3-79.0	68.1	--	Normal
Lymphocytes	11.8-45.9	17.8	--	Normal
Monocytes	4.4-12.0	11.6	--	Normal
Eosinophils	4.4-12.0	4.6	--	Normal
Bands	<10%	--	--	--

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136-145	137	--	Normal
K+	3.5-5.1	4.3	--	Normal
Cl-	98-107	103	--	Normal
CO2	21-31	22	--	Normal
Glucose	74-109	164	135	The patient is type 1 diabetic with an insulin pump. The increased

				levels of glucose could be due to stress or disruption of normal routine due to diagnostic testing (Capriotti & Frizzell, 2016).
BUN	**7-25**	**12**	**--**	**Normal**
Creatinine	**0.70-1.30**	**1.05**	**--**	**Normal**
Albumin	**3.5-5.2**	**4.2**	**--**	**Normal**
Calcium	**8.6-10.3**	**9.4**	**--**	**Normal**
Mag	**1.5-2.5**	**--**	**--**	**--**
Phosphate	**2.5-4.5**	**--**	**--**	**--**
Bilirubin	**0.3-1.0**	**0.5**	**--**	**Normal**
Alk Phos	**34-104**	**80**	**--**	**Normal**
AST	**13-39**	**25**	**--**	**Normal**
ALT	**7-52**	**25**	**--**	**Normal**
Amylase	**30-110**	**--**	**--**	**--**
Lipase	**11-82**	**--**	**--**	**--**
Lactic Acid	**0.5-1**	**--**	**--**	**--**
Troponin	**0-0.4**	**0.00**	**--**	**Normal**
CK-MB	**5-25**	**--**	**7.01**	**Normal**
Total CK	**22-198**	**--**	**173**	**Normal**

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0-1	--	--	--
PT	11-13.5	--	--	--
PTT	30-40	--	--	--
D-Dimer	<500	<0.27	--	Normal
BNP	<100	11	--	Normal
HDL	>45	--	--	--
LDL	<100	--	--	--
Cholesterol	<170	--	--	--
Triglycerides	<150	--	--	-
Hgb A1c	<5.7%	--	--	--
TSH	0.4-4.0	--	---	--

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Clear yellow	--	--	--
pH	5-9	--	--	--
Specific Gravity	1.003-1.030	--	--	--
Glucose	negative	--	--	--
Protein	negative	--	--	--
Ketones	negative	--	--	--
WBC	negative	--	--	--
RBC	negative	--	--	--

Leukoesterase	**negative**	**--**	**--**	**--**

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	**--**	**--**	**--**
PaO2	**90-100**	**--**	**--**	**--**
PaCO2	**35-45**	**--**	**--**	**--**
HCO3	**22-26**	**--**	**--**	**--**
SaO2	**93-100**	**--**	**--**	**--**

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**negative**	**--**	**--**	**--**
Blood Culture	**negative**	**--**	**--**	**--**
Sputum Culture	**negative**	**--**	**--**	**--**
Stool Culture	**negative**	**--**	**--**	**--**

Lab Correlations Reference (APA):

Capriotti T. & Frizzell J.P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* F.A. Davis.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Stress Echo-normal sinus rhythm, no St wave changes

Chest Xray- normal heart size, stimulator device overlies the thoracic spine, lungs are clear, no visualized pneumothorax, or pleural effusion, osseus structures are intact, no acute cardiopulmonary process.

Cardiac Catheterization- no abnormal findings or signs of blockage

Diagnostic Test Correlation (5 points):

The stress echo was done to check for any signs of a heart attack or worsening heart rhythm or changes in rhythm. The chest x-ray was checking for any signs of cardiomegaly, chest congestion, pneumothorax, or pleural effusion. The heart catheterization is checking the major arteries of the heart for blockage and making sure blood is pumping adequately through the heart (Capriotti & Frizzell, 2016)

Diagnostic Test Reference (APA):

Capriotti T. & Frizzell J.P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* F.A. Davis.

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

Home Medications (5 required)

Brand/Generic	Atorvastatin/ Lipitor	Carvedilol/ Coreg	Enoxaparin (Lovenox)	Insulin aspart (NovoLog) sliding scale	Lisinopril/ Prinivil
Dose	40 mg	300 mg	40 mg=0.4ml	141-199--> 2units 200-249-->4 units 250-299--> 7 units 300-349--> 10 units >349--> 12 units	40 mg
Frequency	daily	BID	daily	ACHS	daily
Route	PO	PO	SQ	SQ	PO
Classification	Antihyperlipidemic (Jones & Bartlett, 2020).	Beta-blocker, antihypertensive (Jones and Bartlett, 2020, pp 794).	Anticoagulant (Jones and Bartlett, 2020, pp 404).	Rapid acting insulin (Jones & Bartlett, 2020).	ACE inhibitor, antihypertensive (Jones & Bartlett, 2020)
Mechanism of Action	Inhibits cholesterol synthesis in the liver, increasing the breakdown of LDL cholesterol (Jones & Bartlett, 2020).	"Reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload." (Jones &Bartlett, 2020, pg. 187)	Inactivate factor Xa to prevent clot formation. (Jones and Bartlett, 2020).	Bind to the insulin receptors on muscle and fat cells and lower blood glucose by facilitating the cellular uptake of glucose and simultaneously inhibiting the output of glucose from the liver. (Jones & Bartlett, 2020).	"May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II. Angiotensin II is a potent vasoconstrictor that also stimulates adrenal cortex to secrete aldosterone." (Jones & Bartlett, 2020, pg. 716)
Reason Client Taking	Patient has a history of hyperlipidemia.	Pt has a history of HTN. (Jones and Bartlett, 2020, pp 794).	DVT prophylaxis	Type 1 Diabetic	hypertension
Contraindications (2)	Active hepatic disease or unexplained persistent elevated liver enzymes,	Acute heart failure. "Hypersensitivity to metoprolol, its	Major active bleeding. History of HIT or immune-mediated HIT within last 100	During episodes of hypoglycemia In patients with hypersensitivity to NOVOLOG or one of its	"concurrent Aliskiren use in patients with diabetes or patients with renal

	hypersensitivity to pravastatin or its components (Jones & Bartlett, 2020).	components, or other beta blockers" (Jones and Bartlett, 2020, pp 795).	days. (Jones and Bartlett, 2020).	excipients, (Jones & Bartlett, 2020).	impairment. Hereditary or idiopathic angioedema related to previous treatment with an ACE inhibitor," (Jones & Bartlett, 2020, pg. 716)
Side Effects/Adverse Reactions (2)	CV: chest pain ENDO: abnormal thyroid function (Jones & Bartlett, 2020).	CNS: confusion, CVA, dizziness, syncope, vertigo, weakness CV: hypertension, orthostatic hypotension EENT: blurred vision (Jones and Bartlett, 2020, pp 796).	GI: elevated liver enzymes HEME: thrombocytopenia RESP: pneumonia (Jones and Bartlett, 2020).	Skin: hot, sweaty, clammy -hypoglycemia	CV: arrythmias, hypotension, MI CNS: CVA, confusion
Nursing Considerations (2)	Use cautiously in patients with hepatic or renal impairment. Report unexplained muscle aches or weakness to prescriber (Jones & Bartlett, 2020).	"Use cautiously in patients with peripheral vascular disease because it may aggravate symptoms of arterial insufficiency. In Patients with diabetes mellitus it may mask signs of hypoglycemia, such as tachycardia, and may delay recovery" (Jones &	Use caution in pts with increased risk of hemorrhage. Don't give medication as an IM injection. Monitor vitals and watch closely for bleeding. (Jones and Bartlett, 2020).	When mixing rapid-acting insulin with a longer-acting insulin, always draw the rapid-acting insulin into the syringe first to avoid dosage errors (Jones & Bartlett, 2020). Give NovoLog 5-10 minutes before a meal (Jones & Bartlett, 2020).	"Be aware lisinopril should not be given to a patient who is hemodynamically unstable after an acute MI" (Jones & Bartlett, 2020, pg. 717). "Use lisinopril cautiously in patients with fluid volume deficit, heart failure, impaired renal function, or sodium depletion" (Jones & Bartlett, 2020,

		Bartlett, 2020, pg. 188). "Monitor patient's blood glucose level, as ordered, during carvedilol therapy because drug may alter blood glucose level," (Jones & Bartlett, 2020, pg. 188).			pg. 717).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor liver enzymes, BUN, creatinine, and lipoprotein levels prior to administration (Jones & Bartlett, 2020).	BP, apical pulse (Jones & Bartlett, 2020).	aPTT, PT, CBC, platelet count, fecal occult (Jones & Bartlett, 2020).	Blood glucose level, assess for signs and symptoms of heart failure (Jones & Bartlett, 2020).	Assess blood pressure and pulse frequently Monitor Potassium and Sodium levels (Jones & Bartlett, 2020)
Client Teaching needs (2)	Take at bedtime without regards to food. Notify prescriber immediately about muscle pain, tenderness, weakness, and other evidence of myopathy (Jones & Bartlett, 2020).	Take with food at the same time each day. Notify provider is pulse drops below 60 bpm (Jones & Bartlett, 2020).	Notify prescriber about bleeding, do not rub site after injection (Jones & Bartlett, 2020).	Give NovoLog 5-10 minutes before meals, (Jones & Bartlett, 2020). Be sure to check blood sugar level to ensure correct units to sliding scale are administered	Make sure the patient understands that this does not cure their hypertension, and this will be a lifelong therapy, take at the same time every day, monitor blood sugars closely and watch for hypoglycemia

Hospital Medications (5 required)

Brand/Generic	Oxycodone-acetaminophen (oxycodone)	Acetaminophen (Tylenol)	Naloxone (Narcan)	Docusate (Colace)	Ondansetron (Zofran)
Dose	10mg-325	1,000 mg	0.4 mg= 1ml	100 mg	4 mg
Frequency	Q6H	Q6H	Q2M PRN	PRN BID	PRN Q6H
Route	PO	PO	IV push	Oral	IV Push
Classification	Opioid analgesic	Antipyretic, nonopioid analgesic (Jones and Bartlett, 2020, pg. 9).	Opioid antagonist, antidote	Laxative, stool softener (Jones & Bartlett, 2020).	Antiemetic (Jones and Bartlett, 2020, pg. 915).
Mechanism of Action	"Alters perception of and emotional response to pain at spinal cord and higher levels of CNS by blocking release of inhibitory neurotransmitters, such as acetylcholine and gamma-aminobutyric acid." (Jones & Bartlett, 2020, pg. 934).	Inhibits cyclooxygenase to interfere with the PNS from generating pain impulses (Jones and Bartlett, 2020, pg. 10).	"Briefly and competitively antagonizes mu, kappa, and sigma receptors in the CNS, thus reversing analgesia, hypotension, respiratory depression, and sedation caused by most opioids" (Jones & Bartlett, 2020, pg. 850).	Decreases surface tension between oil and water in feces allowing more fluid to invade the stool, causing softer stool (Jones & Bartlett, 2020).	"Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine (probable cause of chemotherapy- and radiation-induced nausea and vomiting) and by blocking signals to the CNS. Ondansetron may also bind to other serotonin receptors and to mu-opioid receptors"
Reason Client	Severe pain	Temperature	Prescription of	Constipatio	Nausea/

Taking		greater than 38.5°C or Mild or more severe pain	opioid analgesics	n	vomiting
Contraindications (2)	“acute or severe bronchial asthma or hypercarbia in an unmonitored setting or in the absence of resuscitative equipment, gastrointestinal obstruction, hypersensitivity to oxycodone or its components” (Jones & Bartlett, 2020, pg. 934).	“Hypersensitivity to acetaminophen or its components, severe hepatic impairment, severe active liver disease” (Jones and Bartlett, 2020, pg. 10).	“Hypersensitivity to naloxone or any of its components” (Jones & Bartlett, 2020, pg. 850) Do not mix with any other solution unless it is verified that the drugs are compatible (Jones & Bartlett, 2020)	Fecal impaction, intestinal obstruction (Jones & Bartlett, 2020).	“Concomitant use of apomorphine, congenital long QT syndrome, hypersensitivity to ondansetron or its components” (Jones and Bartlett, 2020, pp 916).
Side Effects/Adverse Reactions (2)	CNS: anxiety, dizziness, seizures CV: bradycardia, hypotension	GI: hepatoxicity, diarrhea, constipation HEME: hemolytic anemia (with long term use) (Jones and Bartlett, 2020, pg. 11).	CV: cardiac arrest, hypotension, ventricular fibrillation, ventricular tachycardia CNS: seizures (Jones & Bartlett, 2020)	CNS: dizziness and syncope CV: palpitations (Jones & Bartlett, 2020).	CNS: dizziness, syncope, weakness EENT: blurred vision, transient blindness GI: anorexia, constipation, diarrhea, elevated liver enzymes, intestinal obstruction (Jones and Bartlett, 2020, pp 917).
Nursing Considerations (2)	Excessive use can lead to addiction, use in caution with patients at risk for carbon dioxide retention (Jones & Bartlett, 2020)	Monitor renal function during long-term use. Monitor liver function. (Jones and Bartlett, 2020, pg. 11).	“Keep resuscitation equipment readily available during naloxone administration” (Jones & Bartlett, 2020, pg. 851) “Anticipate that rapid reversal of opioid effects can cause diaphoresis,	Long term use can cause bowel dependency, assess for laxative abuse (Jones & Bartlett, 2020).	“Know that if hypokalemia or hypomagnesemia is present, these electrolyte imbalances should be corrected before ondansetron is administered because of increased risk for QT-interval prolongation, which could

			nausea, and vomiting in addition to hypotension, pulmonary edema, seizures, and ventricular arrythmias" (Jones & Bartlett, 2020, pg. 851)		predispose the patient to develop torsade's de pointes" (Jones and Bartlett, 2020, pp 917). "Monitor patient closely for serotonin syndrome, which may include agitation, chills, confusion, diaphoresis, diarrhea, fever, hyperactive reflexes, poor coordination, restlessness, shaking, talking or acting with uncontrolled excitement, tremor, and twitching" (Jones and Bartlett, 2020, pp 917).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Check blood pressure, pulse and respirations prior to administering (Jones & Bartlett, 2020)	AST, ALT, bilirubin, creatinine, blood or urine albumin (Jones & Bartlett, 2020).	Check blood pressure, pulse, and respirations Check serum levels of opioid and monitor for any signs of withdrawal (Jones & Bartlett, 2020)	Auscultate bowel sounds.	QT interval, auscultate bowel sounds (Jones & Bartlett, 2020).
Client Teaching needs (2)	Take with food and explain the risk for addiction if taken for long periods of time. (Jones & Bartlett, 2020)	Tablets may be crushed or swallowed whole, do not exceed the recommended dose or take other medications containing acetaminophen	Instruct the patient of the adverse effects of naloxone and if opioid dependent encourage drug rehabilitation (Jones & Bartlett, 2020)	Do not use when experiencing abdominal pain, nausea, or vomiting. Take with a full glass of milk or	Place disintegrating tablet or oral soluble film on tongue and allow to dissolve before swallowing. Immediately report signs of hypersensitivity

		at the same time (Jones & Bartlett, 2020).		water (Jones & Bartlett, 2020).	such as a rash (Jones & Bartlett, 2020).

Medications Reference (APA):

Jones and Bartlett. (2020). *Nurse's Drug Handbook* (19th ed.). Jones and Bartlett Learning LLC.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**alert and oriented X4** **No visible distress** **Overall appearance is consistent and normal**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Warm pink dry, no rashes bruises, turgor is elastic** **Right radial incision from Cath lab, TR band present, no bleeding, edema, or redness** **Braden Score: 22** **No drains present** **20 G IV- Left AC**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head/face/nose/eyes symmetrical at rest and with movement, no edema, redness or discoloration, no external drainage, nares patent, lips/oral mucosa pink, moist and intact** **No hearing impairment, no missing teeth, no dentures**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**Heart sounds are clear to auscultation .S1 and S2 present and absence of S3 and S4 (no murmur). Peripheral pulses are strong 2+ bilaterally in upper and lower extremities, normal sinus rhythm, no blockages presented in heart Cath, cap refill <3 secs, no JVD, no edema, chest pain is mild and has been reducing throughout hospital stay**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Regular depth and pattern, unlabored, expansion symmetrical, all lungs sounds are clear and equal bilaterally and throughout all lobes upon auscultation, no cough, initial SOB has since resolved, and no other signs of trouble breathing are present**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:**	**Regular diet at home** **Regular diet at hospital** **Height: 175.2 cm** **Weight:121.2 kg**

Auscultation Bowel sounds: **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Bowel sounds audible and normoactive in all four quadrants, no visible distention, abdomen is soft upon palpation, no incisions, scars, drains ,or wounds, no ostomy, no NG/PEG or feeding tubes.** **Last BM: 10/12/2020 in the morning** **And is passing flatus**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Yellow, clear, no odor, no pain with urination, no frequency, voids spontaneously, bladder is nondistended.** **No inspection of genitals** **No catheter present** **Output unmeasurable, 2 unmeasurable occurrences**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**No observed muscle weakness, no loss of sensation, no joint swelling, or tenderness, all extremities with symmetrical movement bilaterally** **Independent, up ad lib** **Strong (5/5) in all four extremities, full range of motion in all extremities** **Fall Risk: 0, low fall risk** **Does not need assistance with ADL's** **Stimulator device overlies thoracic spine and is ON**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:**	**MAEW- yes** **PERLA- yes** **Strength equal in all extremities** **Oriented x4** **Not confused** **No sensory deficits** **Conscious** **Patient can respond appropriately/follows**

Sensory: **LOC:**	**commands, is oriented to person, place, and time. Pupils are equal and reactive to light and accommodation. Patient has no difficulty with speech or swallowing. Patient uses no neurological devices and has no limits with eye, facial, limb movements. Patient displays no abnormal involuntary movements/posturing.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient remain calm, cooperative, and accepting, Plan of care review with the patient, care explained, choices provided, empathetic listening provided, support provided, questions answered and encouraged, thought and feelings acknowledged. No religious involvement, developmental level is appropriate to age, home life is supportive and caring. Patient uses distraction and talking to cope with pain levels, acknowledges the pain and its persistence in his life even though it never goes away, develops plans of action to manage daily life with pain.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0400	**75 bpm**	**134/80 right arm mean-98**	**18 breaths per minutes ;unlabored**	**36.6 C, oral**	**96% RA, right hand**
0830	**90 bpm**	**132/72 left arm mean-92**	**18 breaths per minute; unlabored**	**36.7 oral**	**96% RA, right hand**

Vital Sign Trends: Patients vital signs are consistent, stable, and within defined limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	**numeric**	**Chest, back**	**CP- 4/10 Back pain- 7/10**	**CP- aching Back pain- stabbing, chronic**	**Relaxing environment, lights down, distraction utilized, pain medications given, chronic stimulator ON**
1030	**numeric**	**Chest, back**	**CP- 0/10 Back Pain- 9/10**	**CP- aching Back pain- stabbing, chronic**	**Relaxing environment, lights down, distraction utilized, pain medications given, chronic stimulator ON**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G **Location of IV: left antecubital** **Date on IV: 10/10/2020** **Patency of IV: patent, flushed without difficulty** **Signs of erythema, drainage, etc.: no phlebitis, redness, pain, or signs of infiltration** **IV dressing assessment: transparent dressing dry and intact**	0.9% Normal Saline 100 ml/hr.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1000 ml in **(IV fluid, and oral intake)**	**No measurable output, patient is** **independent, voids independently**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was taken down to the cardiac Cath lab at 0700 at shift change. The Cath was completed with normal results and the patient returned to the floor around 0845. I completed my head to toes assessment and assisted the patient in ordering breakfast.

Procedures/testing done: Cardiac Catheterization, normal results

Complaints/Issues: no complaints other than pain

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: up ad lib, is tolerating diet and moves around spontaneously

Physician notifications: none

Future plans for patient: Follow up with primary care, possibly consult pain clinic

Discharge Planning (2 points)

Discharge location: Patient will be discharged home

Home health needs (if applicable): none

Equipment needs (if applicable): none

Follow up plan: Follow up with primary care in a month

Education needs: Educate on heart healthy diet, and ways to keep blood pressure down.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per	Evaluation

• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen	**dx)**	• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to chest pain as evidenced by subjective statement by the patient stating that he was in pain	**The patient was admitted with a chief complaint of chest pain**	**1.pharmacologic pain management-opioids** **2.Make the patient comfortable, quiet environment, lights off, TV/cellphone used as distraction**	**The patient responded well to the intervention's chest pain was relieved and back pain was not relieved. Although the patient stated that he is fine and is coping as well as can be expected.**
2. Chronic Pain related to history of back problems for 20 years as evidenced by patients stating that he is in pain all the time	**The patient has received 9 surgeries on his back for a multitude of reasons and is still complaining of pain.**	**1. assess descriptive characteristics of pain, including location, quality, intensity on scale of 1-10, what helps relieve the pain, and acceptable level of pain** **2.teach the patient relaxation techniques such as guided imagery, deep breathing, meditation, aromatherapy, and progressive muscle relaxation**	**Back pain was not relieved. Although the patient stated that he is fine and is coping as well as can be expected. The patient was able to use relaxation techniques to calm nerves and help pain level.**
3. Risk for constipation related to prescription opioid medications (no as evidenced by	**The patient takes opioids to manage back pain**	**1. Encourage fluid intake and increase in dietary fiber** **2 Assess bowel sounds and inspect/**	**The patient has had regular bowel movements and the nurse will continue to monitor for any signs of constipation**

for 'risk for diagnosis')		**palpate abdomen, encourage patient to tell the nurse of any changes in regularity or discomfort in the bowel**	
4. Impaired comfort related to pain as evidenced by inability to find a comfortable position that does not cause increased pain	**The patient has many positions that will cause more pain and finds it difficult to get comfortable in the hospital setting**	**1. monitor pain level and assess vital signs when in discomfort, as well as providing a relaxing atmosphere, pillows and other supports to help alleviate pressure on back** **2. pharmacologic pain management to keep the patient at a comfortable pain level** **2. frequent assessment of patients pain and comfort level throughout shift**	**The patient's vital signs were stable and pain level was not decreased but was managed with pain medication and nonpharmacologic techniques, frequent assessments were done in order to alter the plan of care to lower the pain levels and overall comfort.**

Other References (APA):

Capriotti T. & Frizzell J.P. (2016). *Pathophysiology: introductory concepts and clinical perspectives.* F.A. Davis.

Swearingen, P.L., & Wright, J.D. (2019). *All-in-One Nursing Care Planning Resource* (5th ed). Elsevier.

Concept Map (20 Points):

Subjective Data

Patient states that "it is hard to catch my breath sometimes, like breathing in takes effort. I have chronic back pain that usually sits between a 7-9/10 and even with medication it is not relieved. My chest pain is not nearly as bad as my back pain and is a 4/10"

Nursing Diagnosis/Outcomes

Outcomes:
The patient will have a pain level below 5/10 which is his stated acceptable pain level, and this level will be reached by the end of my clinical time
The patient will use nonpharmacologic pain relief methods once every hour during my clinical time
The patient will pick one high fiber item and drink a glass of water with each meal to help increase motility throughout the day.
The patient will change positions and use nonpharmacologic measures to relieve pain and increase comfort during my clinical time

Objective Data

-Vital signs are stable
- regular diet
-20G in L AC, patent
-0.9% NS running at 100 ml/hr.
-Implanted back muscle stimulator is ON
- no significant abnormal physical assessment findings
-TR band is on Right radius, no drainage, or signs of infection, continue to monitor
- patient is independent, up ad lib
- diabetic pump is with patients
-glasses at the bedside
- Braden Score:22
-low fall risk
-Pain meds are available PRN

Patient Information

7-year-old male presented to the ED on 10/09/2020 with chest pain and shortness of breath that has been present for a couple of weeks, and the chest pain over a month. No Known Allergies, full code, Caucasian, single, no employment (disability).

Nursing Interventions