N441 Care Plan

Lakeview College of Nursing

Teah Rasche-Hill

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/1/2021	JH	81	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widowed	Amoxicillin, Ether, Isosorbide, Gabapentin, Statins
Code Status	**Height**	**Weight**	
Full Code	5'9"	176lb 1.6 oz	

Medical History (5 Points)

Past Medical History: Age-related nuclear cataract of right and left eye (6/4/2018), Arthritis, A-fib, Barrett's esophagus, CAD, carcinoma, chronic pain, constipation, enlarged prostate, GERD, and degenerative disc.

Past Surgical History: Turp: sinus surgery, Tonsillectomy, HC elect stim for guide with nerve destruction, Gallbladder, Colon, Eye, Coronary Artery Bypass Graft (CABG),

Family History: Mother (Aneurysm), Sister & Brother (Cancer), and Father (Heart Attack).

Social History (tobacco/alcohol/drugs): No history of using tobacco, smokeless tobacco, alcohol, or illicit drugs.

Assistive Devices: Uses no assistive devices while in the hospital or at home.

Living Situation: Lives at home in Danville alone as wife has passed away.

Education Level: Client has an Associate's degree.

Admission Assessment

Chief Complaint (2 points): Chest Pain

History of present Illness (10 points):Client came in the emergency room (ED) at OSF-Danville after suffering from chest pain for a few months. He stated that "in the last week it has gotten worse and more constant then in past". He stated that at worst the pain is a 10/10 but most of the time it is a 4/10 on a numeric pain scale. He had no nausea, vomiting, headache, or dizziness. Client does have a history of a coronary artery bypass graft surgery (CABG) due to coronary artery disease (CAD) in the early 2000's. He was then transferred to OSF-Urbana to have a cardiac catheter done to see if there are any blockages old or new that need to be cleaned out. Client didn't say that there weren't any relieving factors with his chest pain as he says, "it comes while I am sleeping at night and it comes when I am moving around the house". He did take nitroglycerine medication that has been prescribed to him for angina pain and it would alleviate it for some time. It would then come back hours or days later.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):Unstable Angina

Secondary Diagnosis (if applicable):N/A

Pathophysiology of the Disease, APA format (20 points): My client was admitted to the hospital for unstable angina that had been occurring on and off for the past few months. It recently in the past week or so has become worse, more constant, and more intense. The client rated a 10/10 at moments throughout the week. Before being transferred to OSF Urbana from Danville they did some test. Troponin was tested and came back negative; an

EKG was done and showed the client rhythm as a 1st degree heart bock with PR interval of .224 but showed no ST/T wave changes. Danville also did a computerized tomography (CT) of the chest to rule out the client having a pulmonary embolism. CT didn't show any signs of a pulmonary embolism (PE). This is where Danville decided a Cardiac catheter was recommended due to the client's history of Coronary artery disease and a Coronary artery bypass graft surgery done previously in the early 2000's.

Unstable angina is diagnosed by two ways either chest pain that is occurring for the first time for a client or chest pain is more severe than it has ever been in the past. This is diagnosed for clients who have chronic angina. Unstable angina occurs from several pathophysiologic processes by cardiac muscle cells are suffering ischemia from a lack of oxygen. This can be from a coronary artery can be blocked from a blood clot the obstructs blood going into the heart muscle (Capriotti & Frizzell, 2016). An accumulation of hardening atherosclerotic plaque ages and solidifies and is fragile. This plaque then breaks away and gets stuck in a smaller arteriole. Last cause of angina deals with anemia. The body doesn't have enough red blood cells or hemoglobin to carry the oxygen. There isn't enough blood circulating oxygen throughout the body which cause not enough blood being reached to the cardiac muscles. This causes ischemia which leads to the angina. Now this ischemia can cause stable or unstable angina.

Some physical findings that one might notice with angina are clenched fist over the sternum (Capriotti & Frizzell, 2016). This is also known as a positive Levine's sign (Capriotti & Frizzell, 2016). One will also see a pallor, dyspneic, diaphoretic, weak pulses, hyperlipidemia, heart rate can be normal, tachycardia, or bradycardia (Capriotti & Frizzell, 2016). One could also see extra heart beats or an irregular rhythm. In the case of

my client, he had hyperlipidemia, an irregular heart rhythm, and some episodes of bradycardia. Some diagnostic testing that is used to diagnose unstable angina and coronary artery disease are an ECG which can ST segment elevation or depression and it will show it over the leads over the area of ischemia (Swearingen, 2016). In my client's case the ECG showed no ST segment elevation or depression, but it did show that my client rhythm was a 1st degree heart block. An echocardiogram is used to assess the ventricular function, chamber size, valvular function, ejection fraction, wall motion, and hemodynamic measurements. My clients had one done while in Danville and it showed the anterior wall is mildly hypokinetic, estimate ejection fraction is 50-55%, Grade 1 diastolic dysfunction, and mild tricuspid, mitral, and aortic valve regurgitation. Troponin level was drawn and came back 0.030 which is within the normal range. Lab work also showed my client had higher triglycerides at 167 and this shows that my client is at an increased risk of his arteries hardening due to the increased number of fat in the blood (Swearingen, 2016).

I think it is important to note that my client is on some medications to help with CAD and his angina. My client was prescribed nitroglycerine to be taken as needed to help reduce angina pain that can occur for my client. He is also taking carvedilol which is a beta-blocker that helps with angina as well as irregular heart rhythm which my client had both. Isosorbide mononitrate was also given to my client to help with angina pain. These medications are beneficial to help stabilize my client to be able to be discharged.

My client has a history of CAD and had a CABG in early 2000's. This caused cardiac team to want to do a cardiac catheterization to make sure my client didn't have any more blockages that are causing this unstable angina. The client while in my care had the cardiac catheterization and it was reported after procedure that it was clean. He is to be

discharged later today with cardiac rehab to help the client due to his past cardiac history of CAD and CABG performed in the past. With the education and the new medication regimen and cardiac rehab the client will be getting are all steps to help stabilize the clients CAD and unstable angina.

Pathophysiology References (2) (APA):

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

Swearingen, P. L. (2016). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, psychiatric nursing care plans*. Elsevier/Mosby.

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	3.80-5.30	4.03	3.64	Is low due to dietary deficiency as he is NPO due to procedure being done today (Kee.,2017).
Hgb	13.0-16.5	13.4	12.3	Is low due to nutritional deficiency as he is NPO due to procedure being done today (Kee.,2017).
Hct	38-50%	39.1%	35.4%	Is low due to dietary deficiency as he is NPO due to procedure being done today (Kee.,2017).
Platelets	140-440	216	208	
WBC	4-12	7.60	4.70	
Neutrophils	47-73%	69.6%	64.3%	

Lymphocytes	**18-42%**	**18.4%**	**22.0%**	
Monocytes	**4-12%**	**10.0%**	**10.8%**	
Eosinophils	**0-8%**	**1.1%**	**2.2%**	
Bands	**0-1%**	**0.9%**	**0.7%**	

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-	**137-145**	**139**	**139**	
K+	**3.6-5.0**	**3.7**	**3.8**	
Cl-	**98-107**	**103**	**104**	
CO2	**22-32**	**26**	**26**	
Glucose	**65-99**	**114**	**115**	**Elevated due to an acute stress response to being in pain and hospitalized (Kee.,2017).**
BUN	**9-21**	**9**	**17**	
Creatinine	**0.7-1.3**	**0.94**	**1.03**	
Albumin	**3.5-5.7**	**4.6**	**N/A**	
Calcium	**8.4-10.2**	**9.6**	**9.1**	
Mag	**1.7-2.2**	**2.0**	**2.1**	
Phosphate	**N/A**	**N/A**	**N/A**	
Bilirubin	**0.2-0.8**	**0.8**	**N/A**	
Alk Phos	**34-104**	**59**	**N/A**	
AST	**13-39**	**88**	**N/A**	**Elevated due to skeletal muscle trauma and multiple traumas due to the unstable angina he has had**

				for several months (Kee.,2017).
ALT	**7-52**	**45**	**N/A**	
Amylase	**N/A**	**N/A**	**N/A**	
Lipase	**N/A**	**N/A**	**N/A**	
Lactic Acid	**N/A**	**N/A**	**N/A**	
Troponin	**0.000-0.040**	**0.030**	**N/A**	
CK-MB	**N/A**	**N/A**	**N/A**	
Total CK	**N/A**	**N/A**	**N/A**	

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	**N/A**	**N/A**	**N/A**	
PT	**N/A**	**N/A**	**N/A**	
PTT	**N/A**	**N/A**	**N/A**	
D-Dimer	**N/A**	**N/A**	**N/A**	
BNP	**N/A**	**N/A**	**N/A**	
HDL	**>40**	**41**	**N/A**	
LDL	**<130**	**115**	**N/A**	
Cholesterol	**<200**	**189**	**N/A**	
Triglycerides	**<150**	**167**	**N/A**	**Elevated due to risk of arteriosclerotic occlusive coronary disease and peripheral vascular disease (Kee.,2017).**
Hgb A1c	**N/A**	**N/A**	**N/A**	
TSH	**N/A**	**N/A**	**N/A**	

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	N/A	N/A	N/A	
pH	N/A	N/A	N/A	
Specific Gravity	N/A	N/A	N/A	
Glucose	N/A	N/A	N/A	
Protein	N/A	N/A	N/A	
Ketones	N/A	N/A	N/A	
WBC	N/A	N/A	N/A	
RBC	N/A	N/A	N/A	
Leukoesterase	N/A	N/A	N/A	

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	N/A	N/A	N/A	
PaO2	N/A	N/A	N/A	
PaCO2	N/A	N/A	N/A	
HCO3	N/A	N/A	N/A	
SaO2	N/A	N/A	N/A	

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	**N/A**	**N/A**	**N/A**	
Blood Culture	**N/A**	**N/A**	**N/A**	
Sputum Culture	**N/A**	**N/A**	**N/A**	
Stool Culture	**N/A**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Kee, J. L. F. (2017). *Pearson handbook of laboratory & diagnostic tests with nursing implications*. Boston: Pearson.

Normal ranges were pulled from EPIC.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

2/1/2021- Chest X-ray single view portable

Impression: Lungs normal

Heart: normal in size Aorta appears unremarkable

2/1/2021- Adult Trans thoracic echo 2D complete

Impression: Left ventricle size normal

- **Left ventricular systolic function is low normal.**
- **Anterior wall is mildly hypokinetic.**
- **Estimate ejection fraction is 50-55%.**
- **Grade 1 diastolic dysfunction**
- **Mild tricuspid regurgitation, mitral regurgitation, and aortic valve regurgitation.**

2/1/2021- CT Chest Scan

- **Could not be seen as this was done at OSF-Danville but it was noted that it was done to rule out a pulmonary embolism (PE). A PE was not found in the lungs.**

2/1/2021- Electrocardiogram (ECG)

Impression: Shows 1st degree heart block with PR interval of 224 but no ST/T wave change.

Diagnostic Test Correlation (5 points):

These diagnostic test correlate to my client as the test above are used to diagnosed what is going on. Unstable angina can be diagnosed by an abnormal ECG my client's ECG showed irregular heart rhythm (1st degree heart block), CT was to rule out PE which could cause chest pain which would be a reason for the chest pain my client was having (Capriotti & Frizzell, 2016). An echo was done to see if the heart was performing well as well as checking to see if any damage to the heart or any blockages are noted (Capriotti & Frizzell, 2016). This is to rule out and blood clot or blockage as my client past medical history shows coronary artery disease (CAD). All these tests were done to rule out certain diagnosis and ultimately lead to my client have unstable angina.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	**Nitrostat (nitroglycerin)**	**Glucophage (metformin)**	**Coreg (carvedilol)**	**Zyrtec (cetirizine)**	**Proscar (finasteride)**
Dose	**0.4mg**	**500 mg**	**6.25mg**	**10mg**	**5mg**
Frequency	**PRN**	**Bid**	**Bid**	**Daily**	**Daily**
Route	**Sublingual tablet**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Antianginal**	**Antidiabetic**	**Beta-blocker**	**Antihistamine**	**Genitourinary/ Benign prostatic hyperplasia agent**
Mechanism of Action	**Relaxes the smooth muscle and blood vessels in the body. This helps by increasing the amount of blood and oxygen that reaches the heart. Making the heart not have to work as hard which reduces chest pain.**	**Decreases hepatic glucose production, decreases intestinal absorption of glucose, and improves insulin sensitivity by increasing peripheral glucose uptake and utilization.**	**Binds to beta adrenergic receptors on cardiac myocytes. This prevents a response to the sympathetic nervous system causing a decrease in heart rate and contractility.**	**Blocks the action of histamine that causes allergic symptoms.**	**Blocks 5-alpha reductase that converts testosterone to its metabolite in the liver. This is responsible for benign prostatic hyperplasia and hair loss.**
Reason Client Taking	**Client is taking this medication due to history of**	**Client is taking this due to being diabetic.**	**Client has a history of CAD and heart issues.**	**Client has allergies and takes it to keep allergies**	**Client has been diagnosed in past with enlarged**

	CAD and having unstable angina.			**suppressed.**	**prostate.**
Contraindications (2)	**1.Circulatory failure 2.Acute MI**	**1.Advanced renal disease 2.Metabolic acidosis**	**1.Severe bradycardia 2. Asthma**	**1.Glaucoma 2.Liver problems**	**1.Female clients. 2.Age (childhood)**
Side Effects/Adverse Reactions (2)	**1.Weakness 2.Dizziness**	**1.Headache 2.Anemia**	**1.Angina 2.Dizziness**	**1.Dizziness 2.Dry mouth**	**1.Dizziness 2.Hypotension**
Nursing Considerations (2)	**1. Use medication cautiously in clients who are elderly as this puts them at an increase risk for falls and hypotension. 2. Place this medication underneath the tongue and make sure it dissolves completely.**	**1. Give medication with food to help reduce risk of GI reactions. 2.Withhold medication if client becomes dehydrated, gets hypoxemia, or sepsis as these increase the chance of lactic acidosis**	**1.This medication isn't routinely held for major surgery due to the benefits outweighing the risk. 2.If client has heart failure expect to also give digoxin, diuretic, and ACE inhibitor.**	**1.Assess respiratory status for wheeze or tightness of the chest. 2.Cetirizine is good at reducing rhinorrhea and sneezing, but less effective at reducing nasal congestion**	**1.This medication affects PSA levels. 2. Pregnant female healthcare workers should not handle broken tablets because of potential adverse effect on male fetus.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**1. Make sure to check client for any allergies and get a complete health history, drug, and**	**1.Make sure to check client's glucose before giving this medication. 2. Monitor**	**1.Check blood glucose levels before giving medication as this can alter blood glucose**	**1. Check to make sure client doesn't have allergies to this medication. 2. Monitor client BP**	**1.Make sure the client has had a urologic evaluation prior to starting therapy. 2. Make sure that a**

	alcohol history. 2. Obtain vitals and do an ECG to check for frequency and severity of angina.	**renal to make sure GFR is above 30 ml/min.**	**levels. 2. Check blood pressure as this medication can cause dizziness, orthostatic hypotension, and light-headedness.**	**for orthostatic hypotension before taking this medication as it can cause orthostatic hypotension to become worse.**	**digital rectal exam has been performed before medication has been started.**
Client Teaching needs (2)	**1.Educate client on signs and symptoms of angina pectoris including chest fullness, pain, pressure, possible sweating and nausea. 2. Make sure to keep medication in original container and to keep it out of hot areas as this can affect the medication.**	**1.Make sure to educate client to avoid drinking alcohol while on this medication as it can increase hypoglycemia and lactic acidosis (Jones & Bartlett Learning, 2019). 2.Take medication as directed and do not change the dosage or frequency unless instructed.**	**1.Notify provider if a 5 lb. gain occurs in two days. 2.Monitor glycemic control closely because drug may increase blood glucose level or mask symptoms of hypoglycemia.**	**1.Use this medication with caution while driving and operating machinery as it can cause drowsiness and for one to be less alert. 2.Make sure to continue to take this medication even when symptoms are not occurring. This means the medication is working.**	**1.This medication can cause sexual dysfunction problems including decreased libido, erectile dysfunction, and male infertility. 2. Educate the importance of routine follow-ups to make sure drugs effectiveness.**

Hospital Medications (5 required)

Brand/Generic	**Protonix**	**Aspirin**	**IMDUR**	**Lopressor**	**Zofran**

	(pantoprazole)	(acetylsalicylic acid)	(isosorbide mononitrate)	(metoprolol tartrate)	(Ondansetron)
Dose	**40mg**	**81 mg**	**30mg**	**25 mg**	**4mg**
Frequency	**Daily**	**Daily**	**Daily**	**Bid**	**PRN**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Proton-pump inhibitor**	**Anti-inflammatory, antiplatelet, antipyretic, nonopioid analgesic**	**Antianginal/ vasodilator**	**Antianginal/ antihypertensive**	**Antiemetic**
Mechanism of Action	**Inhibits the final step in gastric acid production. This covalent binding prevents acid secretion for up to 24 hours or longer.**	**Blocks cyclooxygenase that is needed for prostaglandin synthesis. By blocking this it helps subside the inflammatory symptoms as well as relieving pain.**	**Acts as a donor of nitric oxide. Nitric oxide causes relaxation of vascular smooth muscle via the stimulation of guanylyl cyclase.**	**Blocks the action of certain natural chemicals in the body such as epinephrine on the heart and blood vessels. Helps to lower the heart rate, blood pressure, and strain on the heart.**	**Is a dopamine-receptor antagonist. Blocks serotonin centrally in the chemoreceptor trigger zone and in the intestine. This reduces nausea and vomiting.**
Reason Client Taking	**Client is taking because he has a previous diagnosis of GERD.**	**Client is taking this medication as he has a history of CAD and needs his blood to be thin.**	**Client is taking this due to having angina pectoris and unstable angina.**	**Client is taking due to past cardiac history of CAD and a CABG done in early 2000's.**	**Client was taking due to feeling nauseous while in the ER.**
Contraindicatio	**1.Low**	**1.Bleeding**	**1.**	**1.Acute**	**1. Congenital**

ns (2)	**amounts of magnesium in the blood. 2.An autoimmune disease**	**problems 2. Asthma**	**Cerebral hemorrhage 2.Orthostatic hypotension**	**heart failure 2. Cardiogenic shock**	**long QT syndrome 2. Concomitant use of apomorphine**
Side Effects/Adverse Reactions (2)	**1.Dizziness 2. Joint pain**	**1. Confusion 2. Diarrhea**	**1.Weakness 2. Vertigo**	**1.Arrhthmias 2.Dizziness**	**1.Hypotension 2.Arrhthmias**
Nursing Considerations (2)	**1.This medication can cause abdominal pain and hyperglycemia. 2.This medication can decrease absorption of certain drugs.**	**1.Do not crush time-release or controlled release aspirin tablets. 2. Use an immediate-release aspirin in situations where a rapid onset of action is required such as MI.**	**1. Use with caution in clients who have hypovolemia or mild hypotension. 2. Monitor client for increased hypotension and reduced cardiac output.**	**1.Use with caution in clients with angina or hypertension who have congestive heart failure because beta blockers can depress myocardial contractility. 2.Assess ECG of clients who take metoprolol because they may be at risk for AV block.**	**1.Monitor closely for signs and symptoms of hypersensitivity due to it causing anaphylaxis and bronchospasm. 2.Monitor clients electrocardiogram as this medication can cause a prolonged QT interval.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**1.Assess symptoms of heart burn. 2. Assess liver enzymes before and while taking this medication.**	**1.Assess client's stool for tarry stool, coughing up blood, or coffee ground vomit as this is a sign to not give this**	**1.Monitor blood pressure before and often while on this medication as it can cause severe**	**1. Before starting therapy for heart failure expect to give an ACE inhibitor, digoxin, and a diuretic to stabilize patients.**	**1.Monitor for hypokalemia. 2.Monitor for hypomagnesemia.**

		medication. 2.Check INR levels before giving this medication.	**hypotension. 2. Check labs for hypovolemia.**	**2. Take an apical pulse before administering.**	
Client Teaching needs (2)	**1.You can take this medication with or without food. Whatever helps you not get GI upset. 2.Do not crush, chew, or break this tablet/ medication.**	**1. Do not take ibuprofen because it may reduce the cardioprotective and stroke preventative effects of aspirin. 2. Take this medication with food or after meals because it may cause GI upset if taken on an empty stomach.**	**1. Educate client to recognize signs and symptoms of angina, including chest pain, fullness, or pressure. 2. Educate client to change positions slowly to help reduce orthostatic hypotension.**	**1.Make sure to take this medication with food at the same time every day. 2.Notify provider if pulse falls below 60 beats per minute or is significantly lower than usual.**	**1.Report any signs of hypersensitivity such as a rash. 2. Seek immediate medical attention if client experiences persistent, severe, unusual, or worsening symptoms.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2019 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:**	Client is Alert and Oriented x4. He is in no apparent distress. He greeted me when I walked through the door with a smile on his face. He was

Distress: **Overall appearance:**	laying down in the bed with legs bent. He is skinny, upon appearance and his nails, skin, and hair look taken care of and no physical findings abnormal off what I have seen so far.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin was usual for ethnicity. Skin was loose, dry, and had no signs of tinting. Turgor is 1+ with no rashes or wounds. He did have bruising on his arms. He has no drains present and his Braden score is a 19. Skin was warm to touch on trunk, feet, and arms but his fingers were cold.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is normal cephalic with no vein distention on neck and thyroid midline on neck. PERRLA was done and was equal, round, reactive to light, and accommodation. Sclera white and conjunctiva was clear with no drainage. Nose was dry with no drainage. Septum is midline and no sinus tenderness with percussion. External ear was clean and intact. Hearing is well as he responded to my verbal cues. Teeth were intact with a few missing front teeth. Teeth are yellow but overall, well for his age. His mouth was pink, moist, intact, with uvula midline.
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:**	S1 and S2 noted with no murmurs, gallops, or rubs. While in my care he was in normal sinus rhythm while in my care but when in the emergency room his EKG showed he was in a 1st degree heart block with a PR interval of .224 but no ST/T wave changes. I did peripheral pulse's and radial pulse's and were 2+ in both arms and legs. Capillary refill was less than 3 seconds. Edema was 0 meaning no edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:**	Lungs are clear when auscultated. Breath sounds noted in all locations no wheezing, crackles, or rubs heard. Respirations were unlabored, regular, and he wasn't using his abdomen or accessory muscles. Client had no ET tube in during his stay at the hospital.

FiO2: **Total volume (TV):** **PEEP:** **VAP prevention measures:**	
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **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:**	At home he sticks to a diet that is balanced with fruits, vegetables, meats carbs, and protein. While in the hospital he is NPO until his Cardiac catheterization and after he came up from his procedure he went on a cardiac diet. He is 5'9" and weighs 176 pounds and 1.6 oz. Abdomen is soft, non-distended, and bowel sounds active in all four quadrants. No complaint of pain during palpation and no masses noted. His last BM was last night, and it was soft and formed. He did tell me he gets pain with bowel movements every now and then. He has no drains or wounds present currently.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	Client urinated in the morning and it was a light-yellow color and was clear. It had no sediment or purulent and he stated no pain with urination. He had no problems with emptying his bladder and his genital area was dry with no rashes or drainage. Client did say that he does sometimes suffer from having issues with emptying his bladder. Was dry and clean and had no apparent issues off visualization of genital area. No CAUTI prevention measures were needed.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 35** **Activity/Mobility Status:** **Independent (up ad lib)** ☐	Clients neurovascular status is alert and oriented x4. He responds to person, place, situation, and today's date. Musculoskeletal is a 4 as he can move all body parts with no problem. His ROM is active as he could move arms and legs without any pain or discomfort. His strength is equal in all extremities and is strong. He ambulated well but did state when changing positions to ambulate he felt weak with some dizziness. He scored a 35 on the Morse fall scale due to having

Needs assistance with equipment ☐ **Needs support to stand and walk** ☐	more than one medical diagnosis listed in his chart as well as having an IV apparatus inserted. This fall score puts him at a low risk for falls.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Client moves all extremities well, PERLA was done, and pupils were equal, round, and reactive to light and accommodation. Client had equal strength and both arms and legs bilaterally. He was A&O x4 and his mental status was intact as he could tell me about past and present when asked. Speech was well no slurring of speech. He followed my commands both simple and complex while doing the head-to-toe assessment. He was alert and awake and could answer my questions I asked and did so appropriately. I asked him to rate his pain on a scale of 0 to 10 meaning 10 being the worst pain he has ever been in and he rated it a 0 both times. He rated his paid a zero both times.
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):**	Client is coping with recent hospitalization well. He has listened to all healthcare staff well and wanted to do what needed to, to make sure he was healthy and okay. He has no issues developmentally as he is educated. He is a Christian but admits he hasn't been to church recently. He has family that checks in on him and home throughout the week to make sure he is doing well. While at the hospital he didn't have any visitors but stated he does have great support.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	**63**	**115/69**	**16**	**97.8 degrees Fahrenheit (temporal)**	**96% Room air**
1120	**58**	**119/68**	**15**	**97 degrees Fahrenheit (temporal)**	**98% Room air**

Vital Sign Trends/Correlation:

My client's vitals were stable while in my care. He did have a somewhat lower heart rate later in the day but nothing that we were worried about. His temperature throughout the day tended to be on the lower end but this seemed to be his baseline as this is how he had been his whole hospital stay. Clients vitals seem to be well and within normal limits. The heart rate at 1120 shows some bradycardia which one can see in clients who have unstable angina.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	**Numerical**	**N/A**	**0**	**N/A**	**N/A**
1042	**Numerical**	**N/A**	**0**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	IV is a 20-gauge located on the clients left lower arm. It was inserted 2/1/2021 and the IV is patent and flushes easy with good blood return. No signs of erythema or drainage. IV was clean, dry, and intact. No fluids or medication was being given at the time.
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	N/A

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
Client was NPO while in my care waiting for a Cardiac Catheterization that occurred around 0900.	**Client did urinate while in my care once before his procedure and it was not measure but was assessed for color and characteristics.**

Nursing Care

Summary of Care (2 points)

Overview of care: Upon my arrival to the floor, we went and got vitals on all of our patients. Client greeted me with a smile. He did report some dizziness, so we went ahead and did orthostatic vitals where is showed he does not have orthostatic hypertension. After that I went ahead and did oral care on the client as well as cleaning him up as he was having a procedure done today. Shortly after my client went down for his cardiac catheterization and was gone for about an hour. Upon his arrival back to the unit he was asked to lay flat for two hours and get routine vital checks. For the first hour I did vital checks on him every 15 mins and for the second hour we bumped it up to vitals every 30 min. Vitals were stable so client was able to sit up and order food and get some fluids in him as he was NPO since midnight last night for his procedure.

Procedures/testing done: Client went down for a cardiac catheterization at 0900. It was noted that it was clean and showed no signs of plaque buildup for his previous diagnosis of CAD and a CABG done in early 2000's.

Complaints/Issues: Client had no complains or issues while in my care.

Vital signs (stable/unstable):

Tolerating diet, activity, etc.: Client was doing well on his NPO diet for the first half of my care. Second half he was on a cardiac diet and was ordering lunch right before we ended our shift.

Physician notifications: Physician was not notified for anything. Physician did notify us that his cardiac catheterization was clean and that he would need to have cardiac rehab in his future due to his history of CAD.

Future plans for patient: Client are to have cardiac rehab due to his history of CAD and his CABG that was performed in early 2000's

Discharge Planning (2 points)

Discharge location: As far as I know client is being discharged home. Unless cardiac rehab is an institution that he would have to go to. I am unfamiliar with cardiac rehab and don't know it this would have to be a facility he would need to stay at for awhile or not.

Home health needs (if applicable): N/A

Equipment needs (if applicable):N/A

Follow up plan: Client is to follow up with cardiac doctor when he gets discharged. He is also to get routine care from his primary doctor and to report and abnormal findings or issues he is having to his physicians.

Education needs: Client should be educated about heart healthy choices and possible eating substitutions to make sure he doesn't get anymore blockages and issues. It is also important to educate the client on signs and symptoms of a heart attack. This way he knows when he should call for 911 or reach out to his primary care team.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

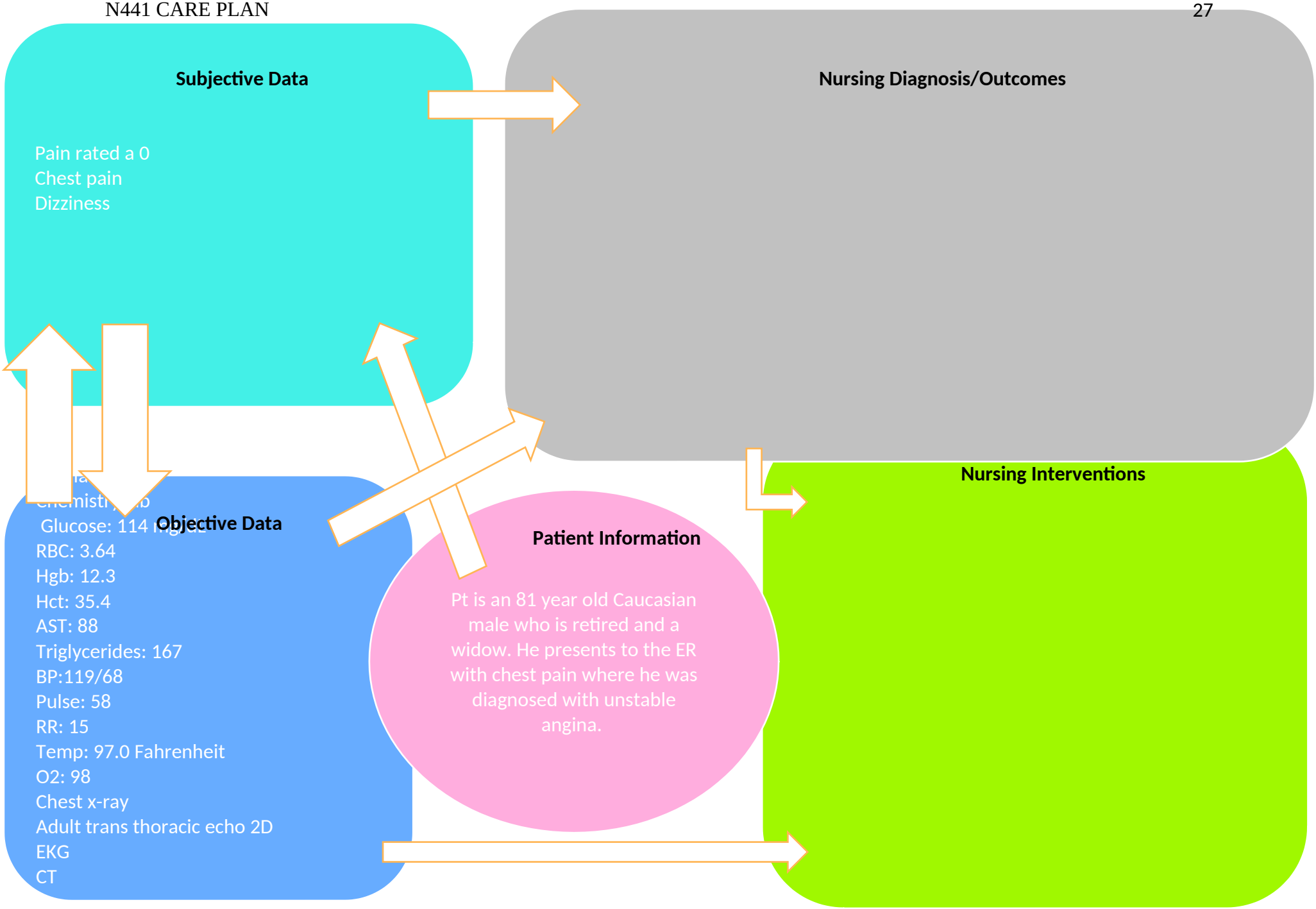
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to unstable angina as evidence by chest pain for several months	**I picked this nursing diagnosis due to my client presenting to the emergency room with chest pain He has a history of CAD which could be a reason why he has this acute pain.**	**1.Routine pain assessments to assess location, character, and severity of pain.** **2.Administer beta-blocker (metoprolol) to help reduce the workload of the heart and reduce the chest pain.**	**Client handled interventions well. He would answer pain assessment using the numerical scale. He also was happy to take medications after being educated on what it does for his health. Client took his metoprolol and goals were met. His pain was down to a 0 and his BP and HR were within normal range which is what we wanted to see.**
2. Activity intolerance related to dizziness and generalized weakness as evidence by position changes causing dizziness and the feeling of	**I picked activity intolerance due to my client feeling dizzy and weak upon initial morning assessment. This kept him staying in the same position in bed and not getting out of bed often.**	**1. Orthostatic vitals were done to make sure client didn't have orthostatic hypotension.** **2.Have the client do range-of-motion while in bed to assess cardiac**	**We did orthostatic vitals on client in the morning where he passed and doesn't have orthostatic hypertension. I did notice that a lot of the medications that my client is taking have adverse reactions which causes dizziness and hypotension. These medications are**

being weak.		**intolerance to activity.**	**nitroglycerine, carvedilol, cetirizine, finasteride, protonix, isosorbide mononitrate, and metoprolol tartrate. Client tolerated rang-of-motion exercises well but did state that has caused him to feel dizzier.**
3. Risk for decreased cardiac tissue perfusion related to interrupted arterial flow occurring with the cardiac catheterization .	**I choose this due to my client going down for a cardiac catheterization. I also choose this due to my client having lower RBC, Hgb, and Hct.**	**1.Upon arrival back to the unit we did routine vitals every 15 min for an hour and then for an hour we did it every 30 min.** **2 Every time we went in for vitals we assessed for cold extremities, decreased amplitude of peripheral pulses, cyanosis, changes in mental status, shortness of breath, and decrease in level of consciousness.**	**Client was laying supine in bed for two hours after cardiac catheter procedure and seemed to manage it well. He asked to turn the TV on to have some noise for when we were not in the room. Clients vitals were returning to baseline within the two hours post-op and tolerated us asking the same questions and doing assessments well.**
4. Risk for fall related to medications client is taking and more than one medical diagnosis listed on patients chart as well as a saline lock inserted.	**I put this due to my client feeling dizzy and having generalized weakness as well has the factors that caused his Morse fall score to be 35 which puts him at a low risk.**	**1.Put the patients call light in reach so that he could call us whenever needed.** **2. Hourly rounding on client between tech and nursing staff.**	**Client was very pleasant when we would check in on him. He had his call light next to him and would page us if needed.**
5. Risk for infection related to urinary	**My client has a past medical history of benign prostatic**	**1.Gave the client a bed bath prior to cardiac catheterization to**	**Client was very happy to get cleaned up in the morning before his cardiac catheterization. I**

retention and enlarged prostate	**hypertrophy.**	**help reduce the risk of infection.** **2. Monitor time intervals between voiding and document the quantity voided.**	**cleaned him up and allowed him to wash his face and genital area. We monitored his urine and how often he was urinating and if he felt like he empties it fully.**

Other References (APA):

Concept Map (20 Points):


Subjective Data
Pain rated a 0
Chest pain
Dizziness
Nursing Diagnosis/Outcomes
Nursing Interventions
Objective Data
Glucose: 114 mg/dL
RBC: 3.64
Hgb: 12.3
Hct: 35.4
AST: 88
Triglycerides: 167
BP:119/68
Pulse: 58
RR: 15
Temp: 97.0 Fahrenheit
O2: 98
Chest x-ray
Adult trans thoracic echo 2D
EKG
CT
Patient Information
Pt is an 81 year old Caucasian male who is retired and a widow. He presents to the ER with chest pain where he was diagnosed with unstable angina.