N441 Care Plan

Lakeview College of Nursing

Ana Punsalan

Demographics (3 points)

Date of Admission 2/3/2021	**Patient Initials** L.G.	**Age** 71	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** Lyrical (Pregabalin)
Code Status FULL	**Height** 5'10	**Weight** 263 lbs.	

Medical History (5 Points)

Past Medical History: Diabetes mellitus, Hypertension, Hypothyroidism, Restless leg syndrome, Neuropathy, Obstructive sleep apnea, Morbid obesity

Past Surgical History: Thyroidectomy, Sinus surgery, Cholecystectomy

Family History: Cancer – Mother & Father, Heart Disease – Father

Social History (tobacco/alcohol/drugs): Chews tobacco, occasionally use of alcohol, and denies use of illicit drugs.

Assistive Devices: L.G. does not have any assistive devices.

Living Situation: L.G. lives in a house with his wife.

Education Level: The highest level of education L.G. has is a GED.

Admission Assessment

Chief Complaint (2 points): Chest pain

History of present Illness (10 points): L.G. is a 71-year-old Caucasian male with a longstanding history of diabetes mellitus, hypertension, obesity, and sleep apnea who came to the hospital with sudden onset chest pain. L.G. reports that the pain began when getting out of bed that morning and lasted for two minutes. The pain is sharp, severe, and located over his left chest, and radiated to his left arm. Other associated symptoms include shortness of breath and pallor. His son brought him to the E.D., where he received one dose of nitroglycerin tablet. He

reported improvement of chest pain from the nitroglycerin treatment. Medications that L.G. is currently taking include aspirin, Plavix, Lovenox, furosemide (Lasix), and propranolol (Inderal). Diagnostic tests needed include a chest x-ray, EKG, and a carotid duplex.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Myocardial Infarction

Secondary Diagnosis (if applicable): N/A

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

Myocardial Infarction (MI)

Acute coronary syndrome (ACS) is known as the classification of various conditions related to an immediate reduction of blood flow to the heart (Sullivan, 2018). Acute myocardial infarction (MI) is an ACS that occurs when myocardial ischemia is prolonged. MI can be a STEMI if it is a transmural MI or an NSTEMI if it is subendocardial MI (Mayo Clinic, 2020).

MI's signs and symptoms include squeezing chest pain with radiation to the left arm, jaw, back, or epigastric region. Other signs and symptoms include pallor, dyspnea, and diaphoresis that commonly occurs with exertion (Mayo Clinic, 2020). L.G. complained of having chest pain that radiates to his left arm, shortness of breath, and lethargy. L.G. also appeared pale.

Expected findings related to MI include increased heart rate, fatigue, Levine’s sign, decreased LOC, pallor, diaphoresis, respiratory distress (Sullivan, 2018). L.G. has fatigue, respiratory distress, and appears pale.

Diagnostic testing for MI clients includes blood tests, ECG, stress test, echocardiogram, and cardiac C.T. scan (Mayo Clinic, 2020). L.G.’s blood test shows a chloride level of 89, troponin level of 0.6, a BNP level of 561, a D-Dimer level of 0.97, and a BUN level of 33. His

chest x-ray shows a small pleural effusion and left basilar atelectasis. His ECG shows NSTEMI characteristics – depressed S.T. wave, T wave inversion, no progression to Q wave, and partial blockage of the coronary artery. His results for the carotid duplex show less than 50% stenosis of the right and left internal carotid artery with mild calcified and noncalcified blocks.

Treatment available for MI includes aspirin, morphine, heparin, nitrates, beta-blockers, calcium channel blockers, cholesterol-lowering medications, ACE inhibitors, oxygen, and thrombolytic agents (Mayo Clinic, 2020). L.G. is currently taking lisinopril, aspirin, furosemide, and took nitroglycerin before coming to the hospital.

Pathophysiology References (2) (APA):

Mayo Clinic. (2020). *Heart attack*. https://www.mayoclinic.org/diseases-conditions/heart-attack/symptoms-causes/syc-20373106

Sullivan, D. (2018). *Acute myocardial infarction*. https://www.healthline.com/health/acute-myocardial-infarction

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	4.40-5.80	5.04	5.00	
Hgb	12.0-18.0	12.7	15.6	
Hct	37.0-51.0	40.2	46.4	
Platelets	140-440	198	227	
WBC	4.00-12.00	13.30	10.10	High levels due to myocardial damage (Pagana et al., 2019).
Neutrophils	40.0-68.0%	N/A	72.6	High levels due to myocardial damage (Pagana et al., 2019).

Lymphocytes	18.0-49.0%	N/A	15.2	Low levels due to myocardial damage (Pagana et al., 2019).
Monocytes	3.0-13.0%	N/A	8.8	
Eosinophils	0.0-8.0%	N/A	2.8	
Bands	<1	N/A	0.6	

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-	135-145	138	140	
K+	3.5-5.2	4.1	3.8	
Cl-	98-108	89	94	Low levels due to myocardial damage (Pagana et al., 2019).
CO2	22-29	24	27	
Glucose	70-100	284	186	High levels due to diabetes (Pagana et al., 2019).
BUN	8-25	33	59	High levels due to myocardial damage (Pagana et al., 2019).
Creatinine	0.6-1.3	1.23	1.15	
Albumin	3.5-5.7	3.7	3.8	
Calcium	8.6-10	8.8	9.0	
Mag	1.5-2.6	N/A	N/A	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0.2-0.8	N/A	N/A	
Alk Phos	34-104	N/A	N/A	
AST	10-30	N/A	N/A	

ALT	10-40	N/A	N/A	
Amylase	23-85	N/A	N/A	
Lipase	0-106	N/A	N/A	
Lactic Acid	0.5-1.0	N/A	N/A	
Troponin	0-0.4 ng/mL	0.6	N/A	High levels due to myocardial damage (Pagana et al., 2019).
CK-MB	5-25 IU/L	N/A	N/A	
Total CK	22-198 U/L	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	0.8-1.1	1.1	N/A	
PT	10.1-13.1	12.5	N/A	
PTT	25-36	36	N/A	
D-Dimer	<0.5	0.97	N/A	High levels due to myocardial damage (Pagana et al., 2019).
BNP	<125	561	N/A	High levels due to myocardial damage (Pagana et al., 2019).
HDL	40-59	N/A	N/A	
LDL	100-129	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	<150	N/A	N/A	
Hgb A1c	2-5.6	7.9	N/A	High levels due to diabetes (Pagana et al., 2019).
TSH	0.4-4.0	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	Yellow Clear	Yellow Clear	N/A	
pH	5.0-8.0	6.0	N/A	
Specific Gravity	1.005-1.034	1.017	N/A	
Glucose	Negative	2+	N/A	High levels due to high blood sugar levels (Pagana et al., 2019).
Protein	Negative	Negative	N/A	
Ketones	Negative	Negative	N/A	
WBC	Negative	N/A	N/A	
RBC	Negative	N/A	N/A	
Leukoesterase	Negative	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	7.35-7.45	N/A	N/A	
PaO2	80-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	95-100%	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	Negative	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): A chest x-ray, an EKG test, and a carotid duplex are to help diagnose L.G. with MI.

Diagnostic Test Correlation (5 points):

A chest x-ray presents the chest's image to check the heart's size and blood vessels and look for fluid in the lungs (Pagana et al., 2019). L.G.'s chest x-rays show small pleural effusion and left basilar atelectasis.

An EKG helps providers diagnose a heart attack. Injured heart muscles do not produce electrical impulses and display on the EKG that it occurred or is in progress (Pagana et al., 2019). L.G.'s EKG shows NSTMI characteristics – depressed S.T. wave, T wave inversion, no progression to Q wave, and partial blockage of the coronary artery.

A carotid duplex assists in locating blockages in the carotid arteries (Pagana et al., 2019). L.G.'s results show less than 50% stenosis of the right and left internal carotid artery with mild calcified and noncalcified blocks.

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2019). *Mosby's diagnostic and laboratory test reference* (14th ed.). Elsevier.

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

Home Medications (5 required)

Brand/Generic	Losartan (Cozaar)	Gabapentin (Neurontin)	Lisinopril (Zestril)	Levothyroxine (Synthroid)	Tamsulosin (Flomax)
Dose	100 mg	600 mg	20 mg	112 mcg	0.5 mg
Frequency	Daily	3x Daily	Daily	Daily	Daily
Route	Orally	Orally	Orally	PRN	Orally
Classification	Antihypertensive	Anticonvulsant	Antihypertensive	Thyroid hormone replacement	Alpha blockers
Mechanism of Action	Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle.	Inhibits the rapid firing of neurons associated with seizures.	Reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II.	Replaces thyroid hormone.	Inhibits smooth muscle contraction in the bladder neck and prostate, prostatic capsule, and prostatic urethra, which improves the rate of urine flow and reduces symptoms of BPH.
Reason Client Taking	To manage hypertension.	To treat moderate to severe primary restless legs syndrome.	To treat hypertension.	To treat mild hypothyroidism.	To treat BPH.
Contraindications (2)	1. Concurrent aliskiren therapy in pts. w/	1. suicidal thoughts	1. hypersensitivity	1. acute MI 2.	1. orthostatic hypotension

	diabetes or renal impairment. 2. hypersensitivity	2. skeletal muscle disorder	2. Concurrent aliskiren therapy in pts. w/ diabetes or renal impairment.	Uncoordinated adrenal insufficiency	2. prostate cancer
Side Effects/Adverse Reactions (2)	1. diarrhea 2. hypotension	1. Anemia 2. Agitation	1. blurred vision 2. bronchospasms	1. muscle weakness 2. insomnia	1. Decreased libido 2. back pain
Nursing Considerations (2)	1. Know that in some pts., losartan is more effective when given in 2 divided doses daily; it may be used with other antihypertensives. 2. Periodically monitor pt.'s potassium levels to detect hyperkalemia.	1. Give drug at least 2 hrs after an antacid. 2. Don't exceed 12 hrs between doses on a 3x a day schedule.	1. Notify prescriber if pt. has persistent, nonproductive cough. 2. Monitor for dehydration, which can lead to hypotension.	1.. Therapy not used for treatment of obesity or for weight loss. 2. Overtreatment can increase cardiac contractility, cardiac wall thickness, and HR, which can precipitate angina or arrhythmias.	1. Give drug about 30 min after the same meal each day. 2. Be aware that if pt. doesn't take drug for several days, therapy should be resumed at 0.4 mg/dose, as prescribed.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain baseline status for weight, vital signs, overall skin condition, and laboratory tests like renal and hepatic function tests, serum electrolyte, and complete blood count (CBC) with differential to assess patient's response to therapy.	History – hypersensitivity to gabapentin; Physical – weight, temperature, skin color, lesions, orientation, affect, reflexes, pulse, respiratory, adventitious sounds, bowel sounds, normal output	BP, heart rate; BUN, serum creatinine, and potassium; consider baseline LFTs (if preexisting hepatic impairment); monitor for jaundice or signs of hepatic failure; if patient has collagen vascular disease and/or renal impairment, periodically monitor CBC with differential.	Skin lesions, color, T, texture; T; muscle tone, orientation, reflexes; P, auscultation, baseline ECG, BP; R, adventitious sounds; thyroid function tests	Monitor for signs of orthostatic hypotension; take BP lying down, then upon standing. Monitor pts. on warfarin therapy closely.
Client Teaching needs (2)	1. Instruct pts. to avoid potassium containing salt substitutes because they may increase risk	1. Urge pt. to take missed dose as soon as pt. remembers. If the next dose is in less than 2	1. Explain that lisinopril helps to control but doesn't cure hypertension and that pt. may	1. Inform pt. that therapy replaces a hormone that is normally produced by	1.. Instruct pt. not to chew, crush, or open capsules and to take

	of hyperkalemia. 2. Instruct pt. to notify provider if she has prolonged diarrhea, nausea, or vomiting.	hrs, tell pt. to resume regular schedule. Caution against doubling the dose. 2. Caution pt. not to stop drug abruptly.	need lifelong therapy. 2. Advise pt. to take lisinopril at the same time every day.	the thyroid and may probably need to take the medication for life. 2. Instruct pt. to separate antacids and calcium or iron supplements by at least 4 hrs. from levothyroxine doses.	drug about 30 min after the same meal each day. 2.. Advise pt. to position slowly to minimize effects of orthostatic hypotension .

Hospital Medications (5 required)

Brand/Generic	Aspirin (acetylsalicylic acid)	Clopidogrel (Plavix)	Enoxaparin (Lovenox)	Furosemide (Lasix)	Propranolol (Inderal)
Dose	81 mg	75 mg	40 mg	20 mg	80 mg
Frequency	Daily	Daily	Daily	3x Daily	Daily
Route	Orally	Orally	Orally	Orally	Orally
Classification	Anti-inflammatory	Platelet aggregation inhibitor	Antithrombotic	Antihypertensive	Anti-MI
Mechanism of Action	Inhibits platelet aggregation by interfering with production of thromboxane A2, a substance that stimulates platelet aggregation.	Blocks ADP, which deactivates nearby glycoprotein IIb/IIIa receptors and precents fibrinogen from attaching to receptors.	Inactivates clotting factors.	Inhibits sodium & water reabsorption & increases urine formation.	Decrease BP, HR, myocardial oxygen, and improves myocardial contractility.
Reason Client Taking	To reduce the severity of or prevent acute MI.	To reduce thrombolytic events, such as MI and stroke, in pts. with atherosclerosis documented by recent MI, peripheral artery disease,	To prevent ischemic complications of unstable angina and non-Q-wave MI.	To reduce edema caused by heart failure.	To manage hypertension

		or stroke.			
Contraindications (2)	1. allergy to NSAIDs 2. severe urticaria	1. active pathological bleeding 2. hypersensitivity	1. Active major bleeding 2. thrombocytopenia	1. Anuria unresponsive to furosemide 2. Hypersensitivity	1. asthma 2. cardiogenic shock
Side Effects/Adverse Reactions (2)	1. Confusion 2. ecchymosis	1. chest pain 2. abdominal pain	1. CHF 2. epistaxis	1. N/V 2. Vertigo	1. Anxiety 2. Muscle weakness
Nursing Considerations (2)	1. Don't crush timed-release or controlled-release tablets unless directed. 2. Ask about tinnitus. This reaction usually occurs when blood aspirin levels reach or exceeds maximum dosage for therapeutic effect.	1. Be aware that clopidogrel prolongs bleeding time; expect to stop it 5 days before elective surgery. 2. Monitor pt. who takes aspirin closely because risk of bleeding is increased.	1. Keep protamine sulfate nearby in case of accidental overdose. 2. Check serum potassium level for elevation.	1. Notify provider if pt. experiences hearing loss, vertigo, or ringing, buzzing, or sense of fullness in her ears. Drug may need to be discontinued. 2. Be aware that elderly pts. are more susceptible to hypotensive & electrolyte-altering effects & thus are at greater risk for shock & thromboembolism.	1. Because of drug's negative inotropic effect can depress cardiac output, monitor cardiac output in pts. with HF. 2. Monitor diabetic pt. taking an antidiabetic because medication can prolog hypoglycemia or promote hyperglycemia.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain complete history including allergies, cardiac, renal, gastro-intestinal, biliary, and hematologic, including chest x-ray, CBC, PT, PTT, BUN, creatinine, electrolytes, liver enzymes.	Monitor PT, PTT, INR	Monitor CBC including platelets and stool occult blood, assess s/s of bleeding	Skin color, lesions, edema; orientation, reflexes, hearing; pulses, baseline ECG, BP, orthostatic BP, perfusion; R, pattern, adventitious sounds; liver evaluation, bowel sounds; urinary output patterns; CBC, serum electrolytes (including calcium), blood sugar, LFTs, renal function tests, uric	1. BP, apical and radial pulses, I&O, daily weight, respiration, circulation in extremities.

				acid, urinalysis, weight	
Client Teaching needs (2)	1. Instruct pt. to take aspirin with food or after meals because it may cause GI upset if taken on an empty stomach. 2. Instruct pt. to stop taking aspirin and notify prescriber if any symptoms of stomach or intestinal bleeding occurs such as passage of bloody or tarry stools or if pt. is coughing up blood or vomit that looks like coffee grounds.	1. Advise pt. to notify prescriber promptly pt. experiences extreme skin paleness, fever, neurologic changes, purple skin patches, weakness, or yellowing of the eyes or skin. 2. Instruct pt. not to discontinue medication abruptly or without first consulting prescriber.	1. Emphasize the importance of complying with follow-up visits with prescriber. 2. Caution pt. not to rub the site after injection to minimize bruising.	1. Instruct pt. to take furosemide at the same time each day to maintain therapeutic effects. Urge pt. to take it as prescribed, even if pt. feels well. 2. Advise pt. to change position slowly to minimize effects of orthostatic hypotension & to take furosemide w/ food or milk to reduce GI distress.	1. Caution pt. not to change dosage without consulting prescriber & not to stop taking drug abruptly. 2. Advise pt. to consult prescriber before taking OTC drugs, especially cold products.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (18th ed.).

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented x3; no apparent distress; looks his age; clean; pleasant; appears lethargic

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Skin is within patient's norm. Fair skin; warm, dry with some flaking; He is not diaphoretic. Temperature is within the average range. There is good skin turgor. No rashes, bruises, or wounds. **Braden Score: 18**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head & neck are symmetrical; trachea is midline without deviation; Auricle is moist & pink without lesions; sclera is white; conjunctiva is clear; PERRLA; lids are moist & pink; septum is midline; nose is moist, no bleeding, no polyps; sinuses are nontender; dentition is good
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:**	Normal rate, S1 & S2 without murmurs, gallops, or rubs; pulses are 2+ throughout; capillary refill less than 3 seconds; no cyanosis/edema; no clubbing noted; wearing compression stockings. ECG shows NSTEMI characteristics – depressed ST wave.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Respirations are regular even, nonlabored, symmetrical, no wheezes or crackles noted. Clear with scattered rales in the bases bilaterally. L.G. has NO ET Tube.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:**	 Food intake that exceeds body needs at home. Currently on a cardiac diet – 240mL ice chips. Height: 5'10 Weight: 263 lbs.

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:**	Normal bowl sounds are auscultated in all quadrants. Last BM: One day ago Abdomen is soft, nontender, no distention, no pain, no masses. No incisions, scars, drains, or wounds.
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:**	 Yellow Clarity – Clear Output: 100 mL Genitals appear pink & moist. Hand hygiene, aseptic catheter insertion procedure, proper foley catheter maintenance, foley catheter use surveillance
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 ☒**	CV II-XII are intact; Reflexes are 1-2+ throughout; Poor coordination; No pain, paralysis; No paresthesia; Not pallor; No swelling or increased pressure; Uses rolling walker and gait belt with ambulation. **Fall Score: 29**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -**	No facial deficits noted; 5/5 motor strength bilaterally. Alert & oriented to person, place, and time. Judgement and though content normal; speech is articulate; Sensory intact to light touch;

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	No LOC
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):**	Coping methods: watching TV, wife and son visits. Ego integrity, wisdom & the ability to participate in life with sense of satisfaction; L.G. is Baptist. L.G. lives with his wife.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	92	127/73	18	98.5°F	95% R.A.
1100	94	124/74	18	97.6°F	95% R.A.

Vital Sign Trends/Correlation: L.G.'s vitals are stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	N/A	0	N/A	N/A
1100	Numeric	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:**	N/A
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:**	Percutaneous central line-triple lumen 8.5 Right jugular vein (forearm) 02/04/2021 Flushed w/out difficulty; blood return No erythema or drainage Dressing is dry and intact. 02/09/2021 Use appropriate hand hygiene, adhere to aseptic technique, use chlorhexidine for skin preparation, use full-barrier precautions during central venous catheter insertion, avoid using femoral vein for catheters in adult patients, place a sterile gauze dressing or a sterile transparent semipermeable dressing over the insertion site

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
120 mL – ice chips (240mL)	100 mL – urine

Nursing Care

Summary of Care (2 points)

Overview of care: Got L.G.'s vitals at 0700 and 1100. Gave his morning medications and shots along with an RN. L.G. was cooperative but was very hungry. L.G. was not allowed to eat because he is NPO due to surgery. I was only able to give him ice chips.

Procedures/testing done: L.G. did not leave the floor for any procedures or have any testing done during my clinical rotation.

Complaints/Issues: L.G. complaints that he is hungry. (He is NPO).

Vital signs (stable/unstable): L.G.'s vital signs are within his baseline.

Tolerating diet, activity, etc.: L.G. tolerates diet and activity.

Physician notifications: Continue current medications. Continue increasing activity as tolerated.

Future plans for patient: Anticipate L.G. may need a possible inpatient rehabilitation stay for further therapy services.

Discharge Planning (2 points)

Discharge location: L.G.'s discharge location is to inpatient rehabilitation facility.

Home health needs (if applicable): L.G. does not need home health needs.

Equipment needs (if applicable): L.G. does not require any equipment needs.

Follow up plan: L.G. will continue to see BID for cardiac reconditioning, increasing activity as tolerated. L.G. will be seen by a PT 4 to 5 times per week to address impairments and functional limitations.

Education needs: Education on cardiac disease process, home exercise program, and discharge guidelines for recovery.

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. Impaired gas exchange related to	L.G. has complained of	1. Assess respiratory rate, use	L.G. demonstrates improvement in gas

altered oxygen supply as evidenced by difficulty breathing.	having shortness of breath, lethargic, and appears pale.	of accessory muscles, signs of air hunger, lung excursion, cyanosis, and significant changes in vital signs. 2. Position the client in a High Fowler's position with head of the bed elevated up to 90°.	exchange as evidenced by nonlabored breathing and normal skin color.
2. Acute pain related to tissue ischemia as evidenced by reports of chest pain.	L.G. has complained of having chest pain.	1. Monitor and document characteristic of pain, noting verbal reports, nonverbal cues and BP or HR changes. 2. Obtain full description of pain from client including location, intensity (using sale of 0-10), duration, characteristics, and radiation.	L.G. verbalizes relief/control of chest pain within appropriate time frame for administered medications. L.G. displays reduced tension, ease of movement, and verbalizes non-pharmacologic regimen.
3. Risk for unstable blood glucose related to inadequate blood glucose monitoring practices as evidenced by blood glucose above normal levels.	L.G.'s blood glucose when admitted was 284.	1. Ensure client is knowledgeable about using his own blood glucose monitoring device. 2. Educate client about balancing food intake with physical activities.	L.G. identifies factors that lead to unstable blood glucose levels and verbalizes a plan in modifying identified risk factors to prevent shifts in glucose level.
4. Imbalanced nutrition related to food intake that exceeds body needs as	L.G.'s BMI is 37.7 which is >30.	1. Carry out and review daily food diary (caloric intake, types and	L.G. demonstrates a change in eating patterns and is involved in individual exercise program.

evidenced by weight is over optimum body weight.		amounts of food, eating habits). 2. Consult with dietitian to determine caloric and nutrient requirements for individuals weight loss.	
5. Risk for falls related to impaired physical mobility as evidenced by having poor balance and having difficulty walking.	L.G. uses a rolling walker and gait belt during ambulation. L.G. needs assistance in standing and walking.	1. Move items used by the client within easy reach, such as call light, urinal, TV remote, and telephone. 2. Make sure that the bed is at the lowest possible position.	L.G. uses the call light whenever he needs assistance and did not have any falling incidents.

Other References (APA):

Swearingen, P., & Wright, J. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier

Concept Map (20 Points):

Subjective Data

L.G. was admitted with chest pain and states, "the pain began when I was getting out of bed in the morning and consisted of a sharp pain that lasted two minutes."

Nursing Diagnosis/Outcomes

Diagnosis #1 Impaired gas exchange related to altered oxygenation as evidenced by difficulty breathing.
Outcome L.G. demonstrates improvement in gas exchange as evidenced by nonlabored breathing and normal skin color.
Diagnosis #2 Acute pain related to tissue ischemia as evidenced by reports of chest pain.
Outcome L.G. verbalizes relief/control of chest pain within appropriate time frame for administered medications. L.G. displays reduced tension, ease of movement, and verbalizes non-pharmacological regimen.
Diagnosis #3 Risk for unstable blood glucose related to inadequate blood glucose monitoring practices as evidenced by blood glucose above normal levels.
Outcome L.G. identifies factors that lead to unstable glucose levels and verbalizes a plan in modifying identified risk factors to prevent shifts in glucose levels.
Diagnosis #4 Imbalanced nutrition related to food intake that exceeds body needs as evidenced by weight is over optimum body weight.
Outcome L.G. demonstrates a change in eating patterns and is involved in individual exercise program.
Diagnosis #5 Risk for falls related to impaired physical mobility as evidenced by poor balance and having difficulty walking.
Outcome L.G. uses the call light whenever he needs assistance and did not have any falling incidents.

Objective Data

Chest X-ray shows reduced lung volumes w/ basilar atelectasis & vascular overcrowding.
ECG shows NSTEMI characteristics – depressed ST wave.
Chloride – 89,94
BUN – 33, 59
Troponin – 0.6
D-dimer – 0.97
Glucose 284, 186
Hgb A1c – 7.9
Urinalyses glucose – 2+

Patient Information

71-years-old
Admitted: 02/03/2021
Male, Caucasian
Retired
Married
Allergies – Lyrical (Pregabalin)
H: 5'10"
W: 263 lbs.
Code: Full Code

Nursing Interventions

Intervention #1:
Assess respiratory status & significant changes in VS.
Position client in High Fowler's position.
Intervention #2:
Monitor characteristic of pain, noting verbal reports & nonverbal cues & BP/HR changes.
Obtain full description of pain from client.
Intervention #3:
Ensure client knows how to use his own glucose monitoring device.
Educate client about balancing food intake & physical activities.
Intervention #4:
Carry out & review daily food diary.
Consult w/ dietitian to determine caloric & nutrient requirements for client.
Intervention #5:
Move items used by client w/in reach.
Make sure that the bed is at the lowest position.