N321 Care Plan # 2

Lakeview College of Nursing

Shawn Weber

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
03/01/2021	N.J.	68 y/o (03/03/1953)	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Divorced	Meperidine (vomiting)
Code Status	**Height**	**Weight**	
Full Code	164 cm	144 kg	

Medical History (5 Points)

Past Medical History: Hypertension, Diabetes Mellitus type II, Chronic Kidney Disease Stage 3, Gout, Lymphedema, Morbid Obesity, Psoriasis

Past Surgical History: Cesarian Section 1989, Appendectomy (1990) Hysterectomy (1998)

Family History: Maternal: Schizophrenia, Heart disease **Paternal**: Heart disease, Heart attack

Social History (tobacco/alcohol/drugs): No alcohol use, no tobacco use, no recreational drug use.

Assistive Devices: Client uses a walker to get around. She states she uses a commode at home.

Living Situation: Lives in a 2-bedroom apartment with eldest son.

Education Level: Graduated MacMurray College in Jacksonville, IL

Admission Assessment

Chief Complaint (2 points): Chest pain

History of present Illness (10 points): 67-year-old Caucasian female came to emergency department at Sarah Busch Lincoln Hospital with complaint of center of chest pain that had begun 5 days prior but had become gradually worse. Client described the pain to be “like her heart was being ripped out of her chest,” and that it had become unbearable before going to the emergency room. The pain is intermittent and has a “stabbing” feeling to it with a rating of 9/10. General movement and taking deep breaths make the pain worse. The only relief of the pain was

remaining motionless as possible. Client states that she felt “afraid to move” out of fear of exacerbating the pain more. Nitroglycerin did not help relieve the pain according to the client, though it did cause her to have nausea. In the E.D. client started to receive Norco 5/325, which brought her pain down to a “dull roar.”

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Non-cardiac Chest pain

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): Angina Pectoris is a type of chest pain that is caused when the muscles of the heart are not getting enough oxygen. While typically the signs and symptoms of angina pectoris are described as “pressure” or “tightness of the chest,” it can also manifest itself as a “sharp stabbing pain,” which matches how the client describes her pain. The severity (9/10) and long duration of the client’s pain led to her being admitted for further monitoring of her symptoms and ruling out of a possible Myocardial Infarction. An EKG was done in the E.D and 2 others were done after admission all showed Normal Sinus Rhythm. Cardiac Enzymes were drawn but were within normal limits, did not seem to show that the client had suffered any damage to myocardial tissue. Chest X-ray shown some vascular congestion but as of yet the client has not yet been diagnosed with heart failure. Nuclear stress test was also performed, and everything came back looking normal. All the labs and tests seem to imply that there was no myocardial infarction and its unknown if the pain was caused by cardiac issues. That her symptoms were not relieved by nitroglycerin supports that her chest pain is not typical angina pectoris. Non-Cardiac Chest pain could be due to a variety of different causes such as gastroesophageal reflux disease, skeletal problems, stomach issues, or even stress/anxiety. No clear cause of the pain has been diagnosed for this client, but her condition has seemed to be

stabilized and she feels comfortable/ready to return home. Treatment is just addressing the intermittent chest pain which has gone down in severity since her admission. The client has requested she be discharged with prescription for pain. It is hard to point out expected lab values and lab findings of her condition, since the cause has not been determined, but the findings appear to rule out cardiac issues. She is to follow up with her primary physician after her discharge for further exploration of the cause of her pain. The client theorizes she may suffer from a condition known as costochondritis. This is caused by the inflammation of of the cartilage that connects the sternum to the rib cage. The pain caused by costochondritis can mimic that of the pain of a heart attack. It can be caused by injury or arthritis. There is no lab/diagnostic test to confirm this condition. Typically they have other tests done to rule out other causes, as my client has had done. (I did not list costochondritis as a secondary diagnosis as it was not diagnosed by any medical professional, but it did seem interesting to add in as it would make sense as a possible cause). The stabbing and intermittent characteristics of the pain would also support the probable diagnosis of pericarditis.

Pathophysiology References (2) (APA):

Angina - Symptoms and causes. (2020, June 12). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/angina/symptoms-causes/syc-20369373

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed). F.A. Davis.

Costochondritis - Diagnosis and treatment - Mayo Clinic. (2020, April 22). Mayo Clinic - Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/costochondritis/diagnosis-treatment/drc-20371180

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	3.8-5.41	4.52	4.41	
Hgb	11.3-15.2	12.4	12.2	
Hct	33.2-45.3	38.3	38.0	
Platelets	149-393	221	223	
WBC	4.0-11.7	7.8	6.7	
Neutrophils	45.3-79.0	71.0	69.0	
Lymphocytes	11.8-45.9	17.7	19.2	
Monocytes	4.4-12.0	7.9	7.9	
Eosinophils	0.0-6.3	2.5	3.0	
Bands	0-6.0	N/A	N/A	

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	139	138	
K+	3.5-5.1	3.8	4.5	
Cl-	98-107	105	106	
CO2	21-31	27	26	
Glucose	74-109	132	110	Client has Type II Diabetes

				mellitus that is poorly managed. However, her A1c is in normal range so it may be abnormally high.
BUN	**7-25**	**19**	**18**	
Creatinine	**0.7-1.3**	**1.04**	**0.88**	
Albumin	**3.5-5.2**	**3.8**	**N/A**	
Calcium	**8.6-10.3**	**9.9**	**9.4**	
Mag	**1.6-2.4**	**1.9**	**1.8**	
Phosphate	**34-104**	**N/A**	**N/A**	
Bilirubin	**0.3-1.0**	**0.5**	**N/A**	
Alk Phos	**34-104**	**82**	**N/A**	
AST	**13-39**	**24**	**N/A**	
ALT	**7-52**	**23**	**N/A**	
Amylase	**30-110**	**N/A**	**N/A**	
Lipase	**11-82**	**N/A**	**N/A**	
Lactic Acid	**0.5-2.0**	**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	**0.86-1.14**	**1.00**	**N/A**	
PT	**11.9-15.0**	**13.5**	**N/A**	

PTT	**22.6-35.3**	**26.9**	**N/A**	
D-Dimer	**0-0.62**	**N/A**	**N/A**	
BNP	**0-100**	**N/A**	**N/A**	
HDL	**23-92**	**46**	**N/A**	
LDL	**<=100**	**73**	**N/A**	
Cholesterol	**<=199**	**155**	**N/A**	
Triglycerides	**<=149**	**178**	**N/A**	**Client has hyperlipidemia from poor diet/sedentary lifestyle.**
Hgb A1c	**0-6.4**	**6.0**	**N/A**	
TSH	**0.45-5.33**	**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**	**N/A**	**N/A**	**No UA collected**
pH	**5.0-8.0**	**N/A**	**N/A**	
Specific Gravity	**1.005-1.034**	**N/A**	**N/A**	
Glucose	**Neg-**	**N/A**	**N/A**	
Protein	**Neg-**	**N/A**	**N/A**	
Ketones	**Neg-**	**N/A**	**N/A**	
WBC	**0.0-5.0**	**N/A**	**N/A**	
RBC	**0-3**	**N/A**	**N/A**	
Leukoesterase	**Neg-**	**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	**No growth**	**N/A**	**N/A**	**No cultures obtained**
Blood Culture	**No growth**	**N/A**	**N/A**	
Sputum Culture	**No growth**	**N/A**	**N/A**	
Stool Culture	**No growth**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. (2nd ed). F.A. Davis.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray 03/01/21 mild pulmonary vascular congestion noted, no other abnormalities, EKG performed 02/28/21 Normal Sinus Rhythm, Nuclear Stress Test done 03/01/21 results normal. Cardiac Enzymes drawn and within normal limits.

Diagnostic Test Correlation (5 points): EKG and cardiac enzymes were ordered due to client's chief complaint of chest pain, to rule out a possible myocardial infarction. Cardiac enzymes, Troponin, Myoglobin, and creatine kinase are all biomarkers that are found in the blood whenever myocardial necrosis occurs. All her lab values were within normal limits and EKGs showed normal sinus rhythm. Chest X-ray was ordered to confirm the size of the heart and vessels, as well as check for fluid in the lungs. Her X-ray did not show any remarkable deviations. A stress test is performed to measure the function of the heart muscles when it is working harder. Nuclear stress test was done for this client. She was given drugs to mimic the

effects of exercise. This test can be done to diagnose coronary artery disease or diagnose hearth rhythm problems. There were no remarkable findings from her test.

Diagnostic Test Reference (1) (APA):

Heart attack - Diagnosis and treatment - Mayo Clinic. (2020, June 16). Mayo Clinic - Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/heart-attack/diagnosis-treatment/drc-20373112

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

Home Medications (5 required)

Brand/ Generic	**Xarelto/ Rivaroxaban**	**Zyloprim/ Allopurinol**	**Glucophage/ Metformin**	**Januvia/ Sitagliptin phosphate**	**Nitroglycerin**
Dose	**20mg**	**300mg**	**500mg**	**100mg**	**0.4mg**
Frequency	**Daily**	**Daily**	**BID**	**Daily**	**PRN Chest Pain**
Route	**PO**	**PO**	**PO**	**PO**	**Sublingual**
Classification	**Factor XA inhibitor, anticoagulant**	**Xanthine oxidase inhibitor**	**Biguanide/ Antidiabetic**	**Dipeptidyl peptidase-4 inhibitor**	**Nitrate**
Mechanism of Action	**Blocks the active site of factor Xa which plays an active role in blood coagulation**	**Inhibits uric acid production by inhibiting xanthine oxidase**	**Promotes storage of extra glucose as glycogen in the liver. Improves the glucose use by adipose tissue and skeletal muscle by increasing transport across cell**	**Inhibits the DPP-4 enzyme to slow the inactivation of incretin hormones.**	**Interacts with nitrate receptors of the vascular smooth muscle cell membrane, causing venous dilation.**

			membranes.		
Reason Client Taking	**Reduce risk of blood clots**	**Antigout, treat symptoms of gout**	**Reduce blood glucose levels in type 2 diabetes mellitus**	**Control glucose levels in type 2 diabetes mellitus**	**Vasodilator, relive angina**
Contraindications (2)	**Active bleeding, hypersensitivity**	**Hypersensitivity, cautions with liver disease renal failure lactation and pregnancy**	**Advanced renal disease, use of iodinated contrast media within 48 hrs.**	**Hypersensitivity/ pancreatitis**	**Angle-closure angina, concurrent use of phosphodiesterase inhibitors.**
Side Effects/Adverse Reactions (2)	**Cerebral hemorrhage, GI bleeding**	**Hepatic necrosis, renal failure**	**Diarrhea, renal failure**	**Irregular heartbeat, hypoglycemia**	**Arrhythmias, hypotension**
Nursing Considerations (2)	**Monitor client's renal and hepatic function during therapy, monitor for signs and symptoms of hypersensitivity**	**Give med after meals, maintain urine output 2L a day**	**Monitor bowel sounds, monitor labs (BUN, CR)**	**Monitor effects of drug therapy by checking blood glucose levels, assess client's renal function**	**Plan nitro-free times of about 20 hr a day to prevent tolerance, store containers in dark away from sunlight.**

Hospital Medications (5 required)

Brand/ Generic	**Zofran/ Ondansetron**	**Cozaar/ Losartan**	**Toprol-XL/ Metoprolol**	**Protonix/ Pantoprazole**	**Norco/ hydrocodone/acetaminophen**
Dose	**4mg**	**25mg**	**50mg**	**40mg**	**5mg/325mg**
Frequency	**Q6H PRN nausea**	**Daily**	**Daily**	**Daily**	**Q6H PRN pain**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Selective serotonin receptor antagonist, antiemetic**	**Angiotensin II receptor blocker**	**Beta-adrenergic Blocker**	**Proton pump inhibitor**	**Opioid analgesic**
Mechanism of Action	**Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine**	**Blocks binding of Ang II to receptor sites in muscle tissues. Ang II is a vasoconstrictor and blocking it lowers BP**	**Inhibits stimulation of beta-receptor sites located in the heart resulting in decreased cardiac excitability, output, and myocardial oxygen demand**	**Interferes with gastric acid secretion, by inhibiting the proton pump in gastric parietal cells.**	**It is believed to act on the opiate receptors of the central nervous system, causing depression of the CNS. The exact MOA of hydrocodone is unknown.**
Reason Client Taking	**To prevent/ relieve nausea**	**Manage hypertension**	**Manage hypertension**	**To treat GERD**	**To relieve severe pain**
Contraindications (2)	**Concomitant use of apomorphine, congenital long QT syndrome**	**Concurrent aliskiren therapy, hypersensitivity**	**Acute heart failure, cardiogenic shock, HR > 45/min, asthma**	**substituted benzimidazoles (i.e. omeprazole), concurrent therapy with rilpivirine containing products**	**Hypersensitivity to norco or other opioids, history of opioid dependence**
Side	**Hypotensio**	**Hypotension,**	**Arterial**	**Pancreatitis,**	**Lightheadedness,**

Effects/Adverse Reactions (2)	**n, serotonin syndrome**	**thrombocytopenia**	**insufficiency, hepatitis**	**hypomagnesemia**	**nausea, constipation**
Nursing Considerations (2)	**Assess for hypokalemia as it can exacerbate prolong WT interval, Monitor EKG for clients with heart conditions.**	**Monitor BP and renal function, periodically check clients serum potassium**	**Use caution in clients with heart failure as metoprolol can worsen, Ask client if they have asthma before administering**	**Monitor PT or INR during treatment if patient is on an anticoagulant. May cause acute interstitial nephritis, monitor urine output.**	**Do not give with other medicines containing acetaminophen, monitor client for respiratory depression**

Medications Reference (1) (APA):

Learning, J. &. (2019). *2020 nurse's drug handbook*. Jones & Bartlett Learning.

Norco (Hydrocodone Bitartrate and acetaminophen): Uses, dosage, side effects, interactions, warning. (2020, August 12). RxList. https://www.rxlist.com/norco-drug.htm#description

Assessment

Physical Exam (18 points)

GENERAL (1 point):	**A&O to person, place, time, situation**
Alertness:	**A/O*4**
Orientation:	**No signs of distress, client is pleasant to speak to.**
Distress:	
Overall appearance:	**Client is morbidly obese, prefers to be seated in chair rather than in the bed.**
INTEGUMENTARY (2 points):	
Skin color:	**Clients skin is pale/ appropriate for age/race.**
Character:	**Skin has wrinkles and is intact. Diabetic dermopathy on clients left leg/foot.**
Temperature:	**Warm/dry, cool at lower extremities.**
Turgor:	**<2 sec**

Rashes:	**Brown discoloration caused by the edema of the lower extremities.**
Bruises:	**None**
Wounds:	**None**
Braden Score:	**17 (Mild risk)**
Drains present: Y☐ N ☒	
Type:	**N/A**
HEENT (1 point):	
Head/Neck:	**Head sits upright centered with C-spine.**
Ears:	**Clear**
Eyes:	**Sclera is white**
Nose:	**Nostrils are clear with no deviation or drainage.**
Teeth:	**Client's teeth all appear to be intact, no signs of edema in clients mouth**
CARDIOVASCULAR (2 points):	.
Heart sounds:	**Audible S1, S2/lubdub. No heart murmur noted**
S1, S2, S3, S4, murmur etc.	
Cardiac rhythm (if applicable):	**N/A, client not currently on telemetry.**
Peripheral Pulses:	**Radial pulse +3, Pedal pulse +2**
Capillary refill:	**Cap refill < 3 secs**
Neck Vein Distention: Y ☐ N ☒	
Edema Y ☒ N ☐	**+1 edema bilaterally in client's lower extremities, +2 edema in client's right ankle.**
Location of Edema:	
RESPIRATORY (2 points):	**Auscultated lung sounds anterior/posterior.**
Accessory muscle use: Y☐ N ☒	
Breath Sounds: Location, character	**Lung sounds are clear bilaterally in all 5 lobes. Client takes shallow breaths. Claims she does not currently have any shortness of breath.**
GASTROINTESTINAL (2 points):	**Normal diet, client says she could eat better in line with her diabetes.**
Diet at home:	
Current Diet	**Regular Diet**
Height:	**163 cm**
Weight:	**143 kg**
Auscultation Bowel sounds:	**Normoactive sounds in all four quadrants**
Last BM:	**03/03/2021 @ 0930, diarrhea**
Palpation: Pain, Mass etc.:	**No pain on palpation.**
Inspection:	**Client has ascites of abdomen.**
Distention:	**Abdominal area is distended.**
Incisions:	**No new incisions.**
Scars:	**5-inch scar, midline with naval, from hysterectomy**
Drains:	**No drains present**
Wounds:	**No wounds present.**
Ostomy: Y ☐ N ☒	
Nasogastric: Y ☐ N ☒	

Size: **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**N/A** **N/A**
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** **300mL** **N/A**
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☒**	**Client has good sensation of upper extremities. Lower extremities client has limited sensation. client states no feeling of pain, numbness, or tingling.** **Full range of motion upper extremities, Limited lower extremities.** **Client uses a walker and commode at home, ambulates with a gate belt in hospital.** **+5 strength upper, +4 lower** **Needs help pivoting from chair to commode and wiping.** **70 (High risk)** **Client needs assistance when ambulating.**
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 has good control of movements all extremities.** **Equal strength** **Client is oriented to person, place, situation, time** **Client's mental status is alert, engaged with my questions.** **Speech is clear/easy to understand.** **Sensory function intact.** **Full level of consciousness.**

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 well to her situation, is ready to leave the hospital as soon as possible.** **No developmental deficiency noted.** **No religious affiliation/agnostic.** **Client is divorced, lives in a two-bedroom apartment with her eldest son. Client does not feel in any sort of danger at home, but she does fear that her and her son have very unhealthy lifestyles diet/exercise wise.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:08	**68**	**122/81**	**18**	**36.1 (temporal)**	**95 (Room air)**
9:45	**95**	**119/74**	**20**	**36.3C (temporal)**	**97 (Room air)**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:08	**Numeric**	**Chest**	**4/10**	**“Stabbing”**	**Seated in chair where it is more comfortable if she holds still, nurse offered her Norco but she denied it.**
9:45	**Numeric**	**NA**	**0/10**	**NA**	**NA**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock

Size of IV:	20 G
Location of IV:	Right AC
Date on IV:	03/02/2021 @ 2200
Patency of IV:	No fluids, IV flushes, saline locked.
Signs of erythema, drainage, etc.:	Skin above IV sight hard, but IV still flushes, and gives blood. No pain or erythema.
IV dressing assessment:	Tegaderm

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
240mL water	**300 mL voided**

Nursing Care

Summary of Care (2 points)

Overview of care: Passed meds around 0845. At 0930 assisted client up to her commode to void/defecate. Helped client clean herself, changed her disposable undergarments and helped her back to her chair.

Procedures/testing done: Bedside glucose check performed at around 0800, blood sugar of 122. Client states that it's "pretty good for her."

Complaints/Issues: Client inquired about discharge. Nurse claims she was just waiting for the discharge orders to be put in, and she's likely to leave later today.

Vital signs (stable/unstable): Vital signs are stable.

Tolerating diet, activity, etc.: Client ate all of her breakfast. Tolerates movement well. Needs walker or assistance to ambulate on her own.

Physician notifications: Client had not seen physician yet that day, waiting to be discharged.

Future plans for patient: Client has contacted her son, who is willing to pick her up from the hospital as soon as she's discharged.

Discharge Planning (2 points)

Discharge location: Client plans to be picked up by her eldest son whom she lives with. She will return to her apartment.

Home health needs (if applicable): No changes.

Equipment needs (if applicable): No changes.

Follow up plan: Patient will need to return to her primary care provider within 1 week of discharge to recheck bloodwork and potentially modify medications.

Education needs: Client should avoid stress/ physical exertion so as not to bring back her chest pain. Client admits that her diet and lifestyle do not manage her type II diabetes well. She should be put on a diet that she can follow to help her lose weight.

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

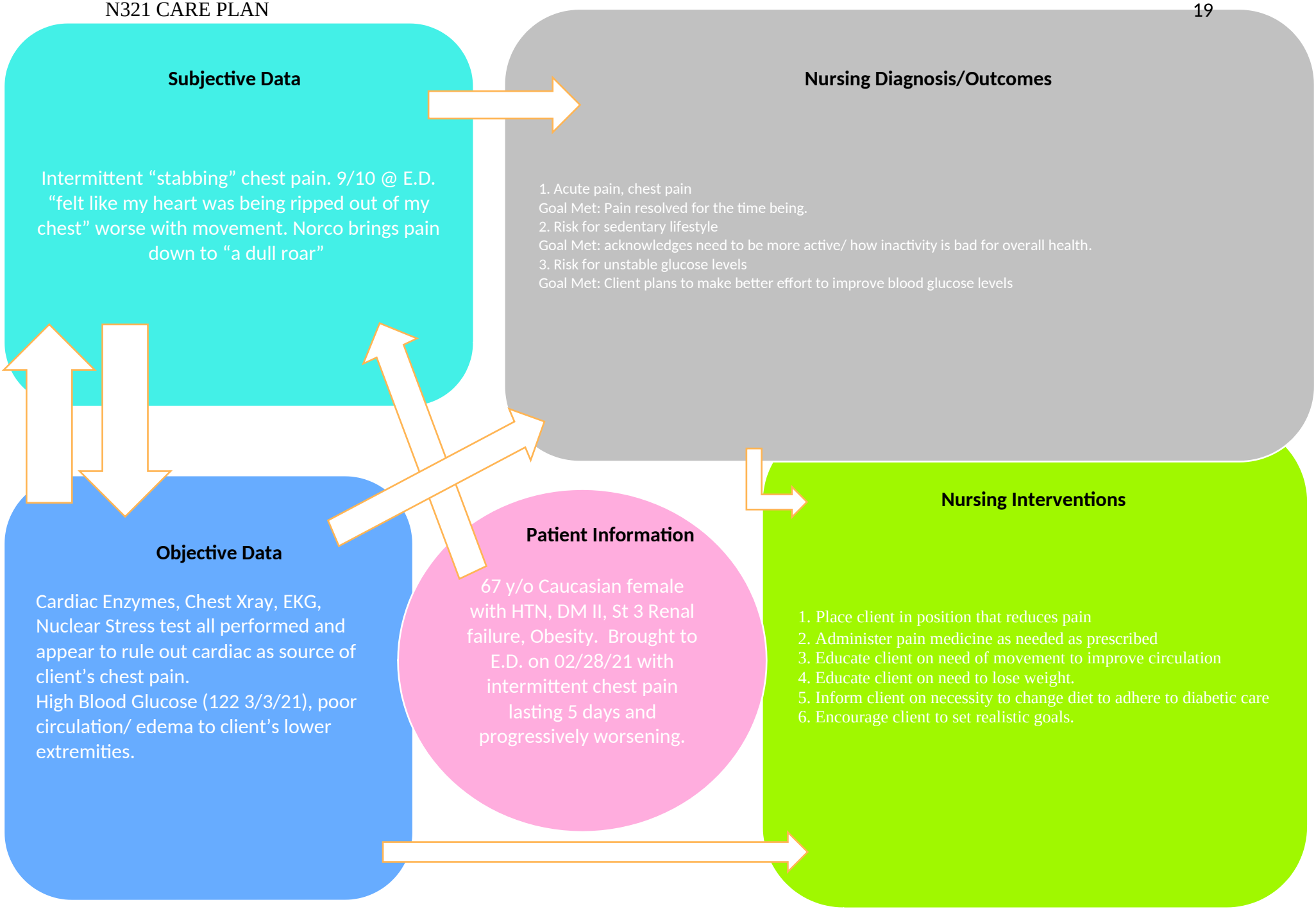
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. **Acute pain related to** pt's intermittent chest pain, of undetermined cause **as evidenced by** "4/10	**Client is suffering from intermittent sharp chest pain that is debilitating to daily life, making it difficult for her to move.**	**1. Place client in comfortable position.** **2.Administer pain medicine as prescribed.**	**1. Client left in comfortable neutral position in her chair. She states she would rather sit in there then the bed all the time.** **2. Client denied her Norco PRN pain though she did report some**

stabbing pain in the chest.			**pain and she states it helped before. She did not think it was severe enough for opioid use at the time.**
2. Risk for sedentary lifestyle related to inability to ambulate well on own **evidenced by** pain with movement and unsteady balance.	**Client is unable to move well on her own or without pain. Medical conditions such as her diabetes and hypertension are likely to become worse with sedentary life.**	**1. Educate client on need to be moderately active to promote better blood flow.** **2.Educate client on need to lose weight, to put less stress on her joints and allow for better ambulation.**	**1. Client says she will try to gradually increase activity.** **2. Client acknowledges her son and hers diet are poor and says she will make an effort to improve it for both of their sake.**
3. Risk for unstable blood glucose level related to clients Diabetes Mellitus **as evidenced by** elevated glucose levels.	**During client's hospital stay, blood glucose levels have been consistently above normal range. Client's diabetic dermopathy on left foot, and poor circulation show that her type II is taking a toll on client's peripheral circulation.**	**1. Educate client on need to follow appropriate meal plan.** **2 Set realistic goals client can meet.**	**1. Client agrees to make an effort to eliminate most of her bad eating habits.** **2. Client plans to follow up with her primary physician and wants to try to get her blood sugars closer to normal range.**

Other References (APA):

4 angina pectoris (Coronary artery disease) nursing care plans. (2019, May 31). Nurseslabs. https://nurseslabs.com/4-angina-coronary-artery-disease-nursing-care-plans/

Concept Map (20 Points):


Subjective Data
Intermittent “stabbing” chest pain. 9/10 @ E.D. “felt like my heart was being ripped out of my chest” worse with movement. Norco brings pain down to “a dull roar”
Nursing Diagnosis/Outcomes
1. Acute pain, chest pain
Goal Met: Pain resolved for the time being.
2. Risk for sedentary lifestyle
Goal Met: acknowledges need to be more active/ how inactivity is bad for overall health.
3. Risk for unstable glucose levels
Goal Met: Client plans to make better effort to improve blood glucose levels
Objective Data
Cardiac Enzymes, Chest Xray, EKG, Nuclear Stress test all performed and appear to rule out cardiac as source of client’s chest pain.
High Blood Glucose (122 3/3/21), poor circulation/ edema to client’s lower extremities.
Patient Information
67 y/o Caucasian female with HTN, DM II, St 3 Renal failure, Obesity. Brought to E.D. on 02/28/21 with intermittent chest pain lasting 5 days and progressively worsening.
Nursing Interventions
1. Place client in position that reduces pain
2. Administer pain medicine as needed as prescribed
3. Educate client on need of movement to improve circulation
4. Educate client on need to lose weight.
5. Inform client on necessity to change diet to adhere to diabetic care
6. Encourage client to set realistic goals.