N321 Care Plan # 2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 06/14/2021	**Patient Initials** AK	**Age** 50	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Unemployed	**Marital Status** Divorced	**Allergies** cephalexin, clindamycin, sulfamethoxazole-trimethoprim, tetracycline, nitrofurantoin
Code Status FULL	**Height** 5’5”	**Weight** 136 kg (299 lb. 14.4 oz)	

Medical History (5 Points)

Past Medical History: Angina at rest, asthma, chronic heart failure (CHF), high cholesterol, transient ischemic attack (TIA), tachycardia.

Past Surgical History: Appendectomy, cardiac surgery procedure (cardiac catheter), cesarean section.

Family History: Mother: stroke, abdominal aortic aneurysm, melanoma, hypertension (HTN). Father: diabetes, kidney failure, HTN.

Social History (tobacco/alcohol/drugs): Current everyday cigarette smoker. The patient states she smokes "0.5 packs/day" and "quit for a year in 2019" then started back "when COVID hit in 2020." The patient states they never used smokeless tobacco. The patient states she does not use drugs or use alcohol and claims to "not like being around people who drink alcohol."

Assistive Devices: None

Living Situation: The patient lives with her 13-year-old daughter, and they do not have any pets.

Education Level: The patient completed high school.

Admission Assessment

Chief Complaint (2 points): Complains of chest pain with palpation.

History of present Illness (10 points): 50-year-old female patient presents to the emergency room (ER) of heart palpitations and chest pain. Patient states the pain has been “coming and going for the past two weeks.” Patient states the pain is “mostly in the center of the left side” of her chest and rates the feeling of “heaviness” a

4/10 using the numeric scale of 0-10. Patient states the pain has been intermittent, but patient states “they were more frequent tonight.” Characteristics are short burst of chest pain. Patient claims that she has not experienced any syncope, shortness of breath (SOB), no nausea, vomiting, or diarrhea (N/V/D). Patient also denies any pain radiating to her arm, back, or jaw. The patient states that the discomfort is associated with excessively sweating and because the symptoms were more severe and frequent and lasting longer, she decided to come to be evaluated. After coming to the hospital, an electrocardiogram (EKG) was done in the ER and was negative for acute myocardial infarction (MI). Her initial troponin was also normal.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Chest pain

Secondary Diagnosis (if applicable): N/A

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

According to Merk Manuals, a comprehensive medical information source, chest pain is a widespread complaint that can have many different causes. (Thompson & Shea, 2020). Pain is often perceived as originating from the chest because of the many organs (such as the heart, lungs, and esophagus) that share the same thoracic autonomic ganglia. (Thompson & Shea, 2020). The thoracic autonomic ganglia are spinal nerves that sometimes overlap and can cause referred chest pain. (Thompson & Shea, 2020). The actual pain could be coming from anywhere from the umbilicus all the way up to the ears. (Thompson & Shea, 2020). The thoracic organs can activate painful stimuli that can be perceived as the pressure in the chest. (Thompson & Shea, 2020). My patient came into the ER complaining of chest pain. Her EKG was negative for a MI, and her troponin levels were within the normal range, but she has a history of angina at rest.

According to Capriotti, angina can be described as stable or unstable. (Capriotti, 2020). Stable angina, also known as exertional angina, is chronic chest pain during exercise or emotional distress. It can be relieved with rest or nitroglycerin. Unstable angina, also known as pre-infarction, is like stable angina in only its ability to occur during exercise. Unlike exertional angina, pre-infarction angina can occur even during rest, with the pain being much more severe. (Capriotti, 2020). Capriotti states that pattern changes in distress signify that

different regions in the heart are becoming ischemic, making it a medical emergency. (Capriotti, 2020). Ischemia is described as tissue death from lack of blood flow.

Roughly 9 million people are estimated to suffer from angina in the United States, and there are 500,000 new diagnoses annually. (Capriotti, 2020). Capriotti states that more women are diagnosed with angina and that women often suffer from anginal equivalents. (Capriotti, 2020). Anginal equivalents are defined as symptoms of myocardial ischemia that diverge from classic angina pain. (Capriotti, 2020). These symptoms include difficulty breathing, diaphoresis, weakness, dizziness, fatigue, or epigastric pain. (Capriotti, 2020). My patient denied any dyspnea, weakness, dizziness, fatigue, or heartburn but did say that her chest pain worsened when she began sweating an abnormal amount. My patient also has a history of high cholesterol, which I believe is one of the causes of her angina. Hyperlipidemia, also known as high cholesterol, can cause plaque to build up in the coronary arteries, leading to endothelial injury in the arterial lining. (Capriotti, 2020). If a piece of the plaque breaks off into the bloodstream, it can obstruct blood flow to the heart and cause ischemia. (Capriotti, 2020). The patient also stated that she felt stressed about not seeing her family (especially her son) in over a year due to the pandemic. I believe that her emotional stress also plays a factor in her chest pain. Some risk factors for angina are cigarette smoking, hypercholesterolemia, hypertension, and obesity, all of which my patient has. Blood pressure measurements, electrocardiogram (EKG), echocardiogram, and cardiac troponin levels can help diagnose angina. (Capriotti, 2020). All of these tests were performed on my patient, and all came back normal. With no indication of what is causing her chest pain, the doctor ordered a stress test to be performed tomorrow. The stress test will either be exercising or walking on a treadmill hooked up to an EKG that will monitor the heart as the heart rate increases. Or using dobutamine or adenosine to mimic the cardiac muscle during exercise and the stress it has on the heart. The test can help detect ischemia that can be missed in a resting EKG. (Capriotti, 2020). The patient should wear comfortable clothing and shoes, get plenty of rest, avoid taking any beta-blockers, and avoid eating 2-4 hours before, avoiding alcohol or caffeine beforehand. The test can take about an hour to complete. Angina cannot be cured, but with treatment, symptoms can be relieved, and the progression of the disease can be slowed. (Capriotti, 2020). The principal medications used to treat angina are oxygen, nitrates, and aspirin. (Capriotti, 2020). Oxygen should only be administered to patients with

a SaO2 of less than 95%. (Capriotti, 2020). Nitrates are used to widen coronary arteries, allowing optimal blood flow to the heart's muscles, and are given as a tablet that dissolves under the tongue. (Capriotti, 2020). Aspirin is used to prevent blood from clotting and causing a heart block, but it increases the risk of bleeding. (Capriotti, 2020). My patient has been educated on the risk factors that can be modified, such as her smoking, high cholesterol, hypertension, stress, and diet. Her medications and alternative treatments are dependent on the results from her stress test tomorrow.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Chapter 16 Ischemic Heart Disease and Conduction Disorders. *Introductory Concepts and Clinical Perspectives* (pp.372-377). Philadelphia: F.A. Davis.

Thompson, A. D., & Shea, M. J. (2020, September). *Chest Pain - Cardiovascular Disorders*. Merck Manuals Professional Edition. https://www.merckmanuals.com/professional/cardiovascular-disorders/symptoms-of-cardiovascular-disorders/chest-pain.

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	**3.8-5.3 10(6)/ mcL**	**4.59**	**N/A**	**This lab value is within normal limits.**
Hgb	**12-15.8 g/dL**	**11.8**	**N/A**	**Low levels may be due to asthma. (Complete Blood Count [CBC], 2021).**
Hct	**36-47%**	**36%**	**N/A**	**This lab value is within normal limits.**
Platelets	**140-440 10(3)/mcL**	**258**	**N/A**	**This lab value is within normal limits.**
WBC	**4-12 10(3)/mcL**	**11.9**	**N/A**	**This lab value is within normal limits.**
Neutrophils	**47-73%**	**59.4**	**N/A**	**This lab value is within normal limits.**
Lymphocytes	**18-42%**	**33.1%**	**N/A**	**This lab value is within normal limits.**
Monocytes	**0.3-1 10(3)/mcL**	**5.2**	**N/A**	**Elevated monocytes may be due to depression or stress. (Wouw et al.,**

				2021).
Eosinophils	**0-0.4 10(3)/mcL**	**0.2**	**N/A**	**This lab value is within normal limits.**
Bands	**N/A**	**N/A**	**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-	**133-144 mmol/L**	**137**	**136**	**This lab value is within normal limits.**
K+	**3.5-5.1 mmol/L**	**2.9**	**3.1**	**Could be due to an adverse reaction of albuterol which can cause hypokalemia. (Jones &Bartlett, 2020).**
Cl-	**98-107 mmol/L**	**101**	**101**	**This lab value is within normal limits.**
CO2	**21-31 mmol/L**	**23**	**26**	**This lab value is within normal limits.**
Glucose	**70-99 mg/dL**	**126**	**118**	**The elevated levels could be due to an adverse reaction from some of the medication that the patient is taking, such as atorvastatin, which can cause hyperglycemia. (Jones &Bartlett, 2020).**
BUN	**7-25 mg/dL**	**7**	**8**	**This lab value is within normal limits.**
Creatinine	**0.5-1 mg/dL**	**0.75**	**0.73**	**This lab value is within normal limits.**
Albumin	**3.5-5.7 g/dL**	**3.6**	**N/A**	**This lab value is within normal limits.**
Calcium	**8.6-10.3 mg/dL**	**8.7**	**9.2**	**This lab value is within normal limits.**
Mag	**1.6-2.6 mg/ dL**	**1.2**	**N/A**	**Could possibly be due to an adverse reaction of omeprazole which can cause hypomagnesemia. (Jones &Bartlett, 2020).**
Phosphate	**N/A**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.2-0.8 mg/ dL**	**0.6**	**N/A**	**This lab value is within normal limits.**
Alk Phos	**34-104 u/L**	**112**	**N/A**	**Elevated levels could possibly be an adverse reaction to one or more of the medications that the client is taking, such as**

				enoxaparin. (Jones &Bartlett, 2020).
AST	**13-39 u/L**	**47**	**N/A**	**Since the AST levels are high while the ALT labs are normal, this could be an indicator that there is a problem outside of the liver (Comprehensive Metabolic Panel [CMP], 2021). The elevated levels may be an adverse reaction to one or more of the medications that the client is taking, such as venlafaxine. (Jones & Bartlett, 2020).**
ALT	**7-52 u/L**	**17**		**This lab value is within normal limits.**
Amylase	**N/A**	**N/A**	**N/A**	**N/A**
Lipase	**N/A**	**N/A**	**N/A**	**N/A**
Lactic Acid	**N/A**	**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**	**N/A**
PT	**N/A**	**N/A**	**N/A**	**N/A**
PTT	**N/A**	**N/A**	**N/A**	**N/A**
D-Dimer	**0-622 ng/mL FEU**	**543**	**N/A**	**This lab value is within normal limits.**
BNP	**N/A**	**N/A**	**N/A**	**N/A**
HDL	**N/A**	**N/A**	**N/A**	**N/A**
LDL	**N/A**	**N/A**	**N/A**	**N/A**
Cholesterol	**N/A**	**N/A**	**N/A**	**N/A**
Triglycerides	**N/A**	**N/A**	**N/A**	**N/A**
Hgb A1c	**N/A**	**N/A**	**N/A**	**N/A**
TSH	**N/A**	**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**	**N/A**
pH	**N/A**	**N/A**	**N/A**	**N/A**
Specific Gravity	**N/A**	**N/A**	**N/A**	**N/A**
Glucose	**N/A**	**N/A**	**N/A**	**N/A**
Protein	**N/A**	**N/A**	**N/A**	**N/A**
Ketones	**N/A**	**N/A**	**N/A**	**N/A**
WBC	**N/A**	**N/A**	**N/A**	**N/A**
RBC	**N/A**	**N/A**	**N/A**	**N/A**
Leukoesterase	**N/A**	**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**	**N/A**
Blood Culture	**N/A**	**N/A**	**N/A**	**N/A**
Sputum Culture	**N/A**	**N/A**	**N/A**	**N/A**
Stool Culture	**N/A**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (1) (APA):

Complete Blood Count (CBC). Understand the Test & Your Results. (2021). https://labtestsonline.org/tests/complete-blood-count-cbc.

Comprehensive Metabolic Panel (CMP). Understand the Test & Your Results. (2021). https://labtestsonline.org/tests/comprehensive-metabolic-panel-cmp.

Jones and Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed). Jones and Bartlett Publishers.

Wouw, M. van de, Sichetti, M., Long-Smith, C. M., Ritz, N. L., Moloney, G. M., Cusack, A.-M., Berding, K., Dinan, T. G., & Cryan, J. F. (2021, March 9). *Acute stress increases monocyte levels and modulates receptor expression in healthy females*. Brain, Behavior, and Immunity. https://www.sciencedirect.com/science/article/pii/S0889159121001070#:~:text=In%20particular%20activation%20of%20the,et%20al.%2C%202014).

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest x-ray (XR) single view portable, electrocardiogram (EKG), pregnancy test. Echocardiogram (ECHO) in progress.

Diagnostic Test Correlation (5 points): The chest XR showed no indication of shortness of breath (SOB) or acute lung disease. The EKG was consistent for someone with sinus tachycardia, with a heart rate (HR) of 111 beats per minute (bpm). There were no signs of ectopy, and the PR interval is 148 milliseconds. The EKG showed no ST elevation myocardial infarction (non-STEMI), but there was poor R-wave progression. With no elevation in cardiac markers hypertension (HTN) is not an issue at this point. Patient was told that she has heart failure, but the doctor states that he “sees no evidence of it clinically.” Patient’s pregnancy test came back negative. No results for ECHO at this time.

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). Chapter 17 Heart Failure. *Introductory Concepts and Clinical Perspectives* (pp.421-423). Philadelphia: F.A. Davis.

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

Home Medications (5 required)

Brand/Generic	Atorvastatin (LIPITOR)	clonazepam (klonoPIN)	Omeprazole (PRILOSEC)	Metoprolol tartrate (LOPRESSOR)	Albuterol sulfate (Ventolin HFA 108 (90 base) MCG/ACT aerosol solution)
Dose	40mg tablet	1mg tablet	20mg capsule delayed release	100mg tablet	Inhale 1-2 puffs (PFS)
Frequency	daily	3 times daily (TID)	One capsule twice daily (BID)	1 tablet (BID)	Every four hours (q4h) as needed for wheezing
Route	By mouth (PO)	PO	PO	PO	Inhale PO
Classification	Therapeutic: antihyperlipidemic	Pharmacologic: benzodiazepin	Therapeutic: antiulcer	Therapeutic: antianginal, antihypertensi	Therapeutic: bronchodilator

		e		ve	
Mechanism of Action	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown.	MOA although unknown, the drug is thought to prevent panic and seizures by potentiating the effects of gamma-aminobutyric acid (GABA), which is an inhibitory neurotransmitter.	It interferes with gastric acid secretion by inhibiting the hydrogen potassium adenosine triphosphatase enzyme system. This prevents additional hydrochloric acid from forming.	Inhibits stimulation of $beta_1$-receptor sites, located mainly in the heart, resulting in decreased cardiac excitability, cardiac output, and myocardial oxygen demand.	Albuterol attaches to $beta_2$-receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine triphosphate (ATP) to cyclic adenosine monophosphate (cAMP). This reaction decreases intracellular calcium levels and increases intracellular levels of cAMP. Together, these effects relax bronchial smooth-muscle cells and inhibit histamine release.
Reason Client Taking	To control lipid levels in homozygous familial hypercholesterolemia.	To control symptoms of depression.	The patient doesn't have a history of GERD or acid reflux listed, so I'm not sure why she is taking this medication.	To manage hypertension, alone or with other hypertensives.	To prevent exercise-induced bronchospasm.
Contraindications (2)	Hypersensitivity to atorvastatin or its components, unexplained persistent rise in	Hypersensitivity to clonazepam, other benzodiazepin	Concurrent therapy with rilpivirine-containing products.	Cardiogenic shock, sinus bradycardia.	Hypersensitivity to albuterol or its components, no other

	serum transaminase level.	es, or their components, hepatic disease.	Hypersensitivity to omeprazole.		contraindications listed.
Side Effects/Adverse Reactions (2)	Palpations, hyperglycemia.	Palpitations, increased appetite.	Chest pain, hypomagnesemia, bronchospasms, cough, upper respiratory infection.	Depression, diaphoresis.	Angina, hyperglycemia, hypokalemia.
Nursing Considerations (2)	-Expect atorvastatin to be used in patients without obvious coronary artery disease (CAD) but with multiple risk factors (such as hypertension, smoker). - Emphasize to the patient that atorvastatin is an adjunct to-not a substitute for- a low cholesterol diet. (Jones & Bartlett, 2020).	-Monitor drug level, CBC, and liver enzymes during long-term or high-dose therapy, as ordered. -Instruct patient to report difficulty urinating, palpitations, persistent drowsiness, seizure activity, or severe dizziness. (Jones & Bartlett, 2020).	-Monitor the patient, especially the patient on long-term therapy, for hypomagnesemia. If patient is to remain on omeprazole long term, expect to monitor the patient's serum magnesium level, as ordered, and if level becomes low, anticipate magnesium replacement therapy and omeprazole to be discontinued. -Know that proton pump inhibitors such as omeprazole should not be prescribed longer than medically necessary. (Jones & Bartlett, 2020).	-Use cautiously in patients with angina or hypertension who have congestive heart failure because beta blockers such as metoprolol can further depress myocardial contractility, worsening heart failure. -Be aware that patients with a history of severe anaphylactic reactions may be more reactive to repeated challenges of the allergen while taking beta blocker therapy, such as metoprolol, and may be unresponsive to the usual doses of epinephrine used to treat an allergic reaction.	-Use cautiously in patients with cardiac disorders, diabetes mellitus, digitalis intoxication, hypertension, hyperthyroidism, or history of seizures. Albuterol can worsen these conditions. - Monitor serum potassium level because albuterol may cause transient hypokalemia. (Jones & Bartlett, 2020).

				(Jones & Bartlett, 2020).	

Brand/Generic	Magnesium sulfate (Milk of Magnesia)	enoxaparin (Lovenox)	Venlafaxine (EFFEXOR-XR)	Potassium chloride SA (KLORCON M)	amLODIPine (NORVASC)
Dose	Premix 2g	40mg	Extended release (XR) capsule 75mg	40 mEq tablet	5mg tablet
Frequency	once	daily	daily	once	daily
Route	IV 50mL/hr	Subcutaneous injection	By mouth (PO)	PO	PO
Classification	Therapeutic: electrolyte replacement	Therapeutic: anticoagulant	Therapeutic: Antidepressant	Therapeutic: Electrolyte replacement	Therapeutic: Antianginal, antihypertensive
Mechanism of Action	Assisting all enzymes involved in phosphate transfer reactions that use ATP. Magnesium is required for normal function of ATP-dependent sodium-potassium pump in muscle membranes.	Potentiates the action of antithrombin III, a coagulation inhibitor.	Inhibits neuronal reuptake of norepinephrine and serotonin, along with its active metabolite, O-desmethylvenlafaxine. These actions raise synapses, elevating mood and reducing depression.	Acts as the major cation in intracellular fluid, activating many enzymatic reactions essential for physiologic processes, including nerve impulse transmission and cardiac and skeletal muscle contraction.	Inhibits coronary artery muscle contractions and restoring blood flow, drug may relieve Prinzmetal's angina.
Reason Client Taking	To correct magnesium deficiency caused magnesium-depleting drugs, malnutrition, or restricted	To prevent DVT in medical patients who are at risk for thromboembolic complications due to restricted	To treat and prevent relapse of major depression.	To prevent or treat hypokalemia in patients who can't ingest sufficient dietary potassium	To control hypertension

	diet.	mobility during acute illness.		or who are losing potassium because of a drug (such as a potassium-wasting diuretic or certain antibiotics).	
Contraindications (2)	Heart block, hypersensitivity to magnesium salts or any components of magnesium-containing preparations.	Pork products or their components, hypersensitivity to enoxaparin or its components.	Hypersensitivity to desvenlafaxine, venlafaxine, or their components; use of a MAO inhibitor within 14 days.	Acute dehydration, peptic ulcer disease.	Hypersensitivity to amlodipine or its components, no other contraindications listed.
Side Effects/Adverse Reactions (2)	Diaphoresis, magnesium toxicity.	Hyperlipidemia, elevated liver enzymes.	Tachycardia, Elevated liver enzymes.	Cardiac arrest, ulcers.	Pancreatitis, arrhythmias.
Nursing Considerations (2)	-Frequently assess cardiac status of patient taking drugs that lower heart rate, such as beta blockers because magnesium may aggravate symptoms of heart block. -Inform patient that magnesium supplements used to replace electrolytes can cause diarrhea. (Jones & Bartlett, 2020).	-Be aware that drug isn't recommended for patients with prosthetic heart valves, because of risk of prosthetic valve thrombosis. -Don't give drug by intramuscular injection. (Jones & Bartlett, 2020).	**-DO NOT CRUSH** -Use cautiously in patients who have medical conditions that might be made worse by an increased heart rate, as in heart failure, hyperthyroidism, or recent myocardial infarction. (Jones & Bartlett, 2020).	**DO NOT CRUSH** - Dissolve packet in at least 120mL of cold water (may need to get creative if patient doesn't like the way it tastes). If GI upset occurs, increase the dilution. (Jones & Bartlett, 2020).	-Use amlodipine cautiously in patients with heart block, heart failure, impaired renal function, hepatic disorder, or severe aortic stenosis. -Assess patient frequently for chest pain when starting or increasing the dose of amlodipine, because worsening of angina or an acute myocardial infarction can occur, especially in

					patients with severe obstructive coronary artery disease. (Jones & Bartlett, 2020).

Hospital Medications (5 required)

Medications Reference (1) (APA):

Jones and Bartlett Learning. (2020). *Nurse's drug handbook* (19th ed). Jones and Bartlett Publishers.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient was alert and oriented to person, place, and time. She was well-groomed and did not appear to have any acute distress.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 22** **Drains present: Y☐ N ☒** **Type:**	The patient's skin was normal for her ethnicity and was warm and dry to the touch. Her skin turgor has normal mobility. She did not have any rashes, lesions, or wounds, but there was slight bruising on her right arm in the median basilic area from a blood draw. There was no pallor, no erythema, no cyanosis, or pitting edema. Patient has a Braden score of 22 which puts her at low risk for pressure ulc
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical. Trachea is midline with no deviation. Thyroid is nonpalpable, no nodules were noted. Bilateral carotid pulses were palpable. No lymphadenopathy noted. Bilateral auricles moist and pink without lesions. Bilateral canals clear and pearly gray membrane. Bilateral lids were moist and pink without lesions or discharge. Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Pupils equal, round, and reactive bilaterally. Extraocular movements bilaterally intact. Turbinates appear a little dry, but there is no bleeding or polyps noted bilaterally. Septum is midline and frontal sinuses are non-tender to palpation. Oral mucosa is pink, moist, clear, and without any lesions. Soft palate rises and falls symmetrically, hard palate is intact. Uvula is midline. Teeth look normal.
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:**	Patient denies any current chest pains. Upon auscultation the rate and rhythm sounded normal with no murmur, friction rub, or gallop noted. No chest tenderness upon palpation. Peripheral pulses were 2+ bilaterally on upper and lower extremities. Capillary refills were less than 3 seconds bilaterally on upper extremities but were not able to be determined on lower extremities due to nail polish.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒**	Patient showed no signs of a cough or shortness of breath. She did not appear to be in any

Breath Sounds: Location, character	respiratory distress. Her breath sounds were normal. No wheezing or rhonchi noted.
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:**	Patient states her diet at home is "a mess." She states her current diet is "decent" and that she is "not really hungry, but ate a bagel, some fruit, and eggs." The patient has a height of 5'5" and weighs 136 kg. She has a body mass index (BMI) of 49.91 kg/m2, scoring her as morbidly obese. Bowel sounds were normoactive in all four quadrants. Her last bowel movement was yesterday (she was unsure of time). Patient denies any abdominal pain, and nausea, vomiting, or diarrhea. There was no distention, incisions, scars, drains, or wounds noted. No tenderness upon palpation. No guarding or rebound tenderness noted.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient was able to go to the bathroom independently and urine was not noted. Patient denies any pain with urination and genitals were not inspected.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 15** **Activity/Mobility Status:** **Independent (up ad lib) ☒** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Abduction, adduction, flexion extension, external rotation, internal rotation on all extremities had full range of motion. Patient has a balanced and smooth gait. Patient has a low fall risk. Patient can ambulate independently without any assistance or equipment. Hand and pedal pushes and pedal pulls demonstrate normal and equal strength on all extremities. Cranial nerves 2, 9, 10, and 12 are all intact. Olfactory and Snellen were not performed.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐**	Patient can move all extremities well. Pupils equal, round, and reactive bilaterally. All extremities of equal strength. The patient is alert and oriented x 3, with no mental delays, speech is clear and spontaneous,

Orientation: **Mental Status:** **Speech:** **Sensory:** **LOC:**	no sensory deficit, and the patient denies 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):**	Patient states that she is a "foodie" and uses eating to cope with her emotions. No developmental delays noted. Patient claims to be a Christian and used to attend the Church of Christ before the pandemic. She states that her family support isn't great because most of her family lives out of state and she prefers "not to tell them, so they don't stress."

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0725	88	128/69	18	97.9 degrees Fahrenheit	100%
1106	81	126/60	18	97.3 degrees Fahrenheit	100%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0725	0-10	Left side of chest	4	Constant pressure	Relaxation techniques and quiet environment.
1106	0-10	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:**	Size 20g IV saline lock in the left hand. The date on the IV is 06/14/21. IV is patent and flushed without difficulty. No erythema or drainage noted at the IV site. The IV dressing was clean, dry, and intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
480 mL	900 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Monitor and manage chest pain.

Procedures/testing done: Echocardiogram in progress and no results at this time.

Complaints/Issues: Chest pain.

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

Tolerating diet, activity, etc.: Yes, the patient is currently on a cardiac diet. She had no difficulty swallowing. She is not allowed to have any coffee (even decaf) or chocolate in preparation for her stress test tomorrow. Patient is at risk of activity intolerance due to morbid obesity.

Physician notifications: There was no notification to the physician during the shift.

Future plans for patient: Dependent on results from stress test tomorrow.

Discharge Planning (2 points)

Discharge location: Patient will be going home after discharge.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Follow up with primary care provider and cardiologist.

Education needs: Patient needs education on smoking cessation and monitoring risk factors for present illnesses.

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation

• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute chest pain may be related to decreased myocardial blood flow as evidenced by reports of pain varying in frequency, duration and intensity worsened with diaphoresis.	Patient with unstable angina have an acute risk of acute life-threatening dysrhythmias, which occur in response to ischemic changes or stress.	1. Monitor heart rate and rhythm 2. Maintain a quiet and comfortable environment.	Family was not present, but the patient responded well to the interventions and was very appreciative of the care she was receiving. The status is ongoing, and modifications are dependent on results from stress test tomorrow.
2. Activity intolerance may be related to sedentary lifestyle as evidenced by body mass index of 49.91 kg/m2 indicating morbid obesity.	Gradual activity progression prevents a sudden increase in cardiac workload. Aiding only as needed encourages independence in performing activities.	**1.** Encourage progressive activity and self-care when tolerated. Help as needed. **2.** Assess the patient's response to activity, noting pulse rate more than 20 beats per minute faster than resting rate; marked increased in blood pressure during and after activity (systolic pressure increase of 40mm Hg or diastolic pressure increase of 20mm Hg); dyspnea or chest pain; excessive fatigue and weakness; diaphoresis; dizziness or syncope.	Family was not present, but the patient agreed to participating in a stress test tomorrow and trying to increase her tolerance to activity. The status is ongoing, and modifications are dependent on results from stress test tomorrow.
3. Imbalanced nutrition: more than body requirements may be related to food intake that exceeds the body's needs as evidenced by Weight of 20% or more over optimum body	Provides the opportunity for the individual to focus on a realistic picture of the amount of food ingested and corresponding eating habits and feelings. Identifies patterns requiring change or a base on which to tailor the dietary	**1.** Carry out and review daily food diary (caloric intake, types and amounts of food, eating habits). **2.** Explore and discuss emotions and events associated with eating.	Family was not present, but the patient stated that it was "hard to eat healthy" because her daughter "is a very picky eater" and she "has to keep her in mind when preparing meals." Patient does admit to emotional eating and is willing to hear more information on how to break habits. She states that right now it's hard because "she

weight.	program.		hasn’t seen any of her family or her son in over a year.”

Other References (APA):

Concept Map (20 Points):

Subjective Data

- The patient complains of chest pain, but denies any radiating pain to the back, neck, or jaw.
- The patient denied any shortness of breath or difficulty breathing.
- The patient also denies any nausea, vomiting, or diarrhea.

Nursing Diagnosis/Outcomes

1. Acute chest pain may be related to decreased myocardial blood flow as evidenced by reports of pain varying in frequency, duration and intensity worsened with diaphoresis.
   - Patient has been maintaining a quiet environment to reduce stress.
   - Patient has been resting in bed to reduce chest pain.
2. Activity intolerance may be related to sedentary lifestyle as evidenced by body mass index of 49.91 kg/m2 indicating morbid obesity.
   - Patient will try to increase activity tolerance by utilizing physical therapy.
   - Physical therapy modification is dependent on results from stress test.
3. Imbalanced nutrition: more than body requirements may be related to food intake that exceeds the body's needs as evidenced by weight of 20% or more over optimum body weight.
   - Patient will keep a food diary to monitor caloric-intake, types and amounts of foods as well as daily eating habits.
   - Patient will try to find another outlet to cope with emotions other than eating.

Nursing Interventions

1. Monitor heart rate and rhythm
2. Maintain a quiet and comfortable environment.
3. Encourage progressive activity and self-care when tolerated. Help as needed.
4. Assess the patient's response to activity, noting pulse rate more than 20 beats per minute faster than resting rate; marked increased in blood pressure during and after activity (systolic pressure increase of 40mm Hg or diastolic pressure increase of 20mm Hg); dyspnea or chest pain; excessive fatigue and weakness; diaphoresis; dizziness or syncope.
5. Carry out and review daily food diary (caloric-intake, types and amounts of foods, and eating habits).
6. Explore and discuss emotions and events associated with eating.

Objective Data

Height: 5'5"
Weight: 136 kg
BMI: 49.91 kg/m2
Low levels of hemoglobin
Elevated levels of monocytes
Low levels of potassium
Elevated levels of glucose
Low levels of magnesium
Elevated levels of alkaline phosphate
Elevated levels of AST
Cardiac rate and rhythm sounded normal with no murmur, friction rub, or gallop noted upon auscultation. No chest tenderness upon palpation.

Patient Information

50-year-old female patient presents to the emergency room (ER) of heart palpitations and chest pain. Patient states the pain has been "coming and going for the past two weeks." Patient states the pain is "mostly in the center of the left side" of her chest and rates the feeling of "heaviness" a 4/10 using the numeric scale of 0-10. Patient states the pain has been intermittent, but patient states "they were more frequent tonight." Characteristics are short burst of chest pain. Patient claims that she has not experienced any syncope, shortness of breath (SOB), no nausea, vomiting, or diarrhea (N/V/D). Patient also denies any pain radiating to her arm, back, or jaw. The patient states that the discomfort is associated with excessively sweating and because the symptoms were more severe and frequent and lasting longer, she decided to come to be evaluated. After coming to the hospital, an electrocardiogram (EKG) was done in the ER and was negative for acute myocardial infarction (MI). Her initial troponin was also normal.

- Patient has a history of angina at rest, depression, high cholesterol, and transient ischemic attacks.
- Patient has a past surgical history of a cardiac catheter procedure.