N321 Care Plan #2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
10/16/21	K.C	53	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Petro fueling station	Married	Penicillin
Code Status	**Height**	**Weight**	
Full	160.02 cm	132.4 kg	

Medical History (5 Points)

Past Medical History:

Allergic rhinitis, anxiety, arthritis of right hip, chronic headaches, chronic lower back pain, CKD stage III, diabetes mellitus, flat feet bilaterally, hypercholesteremia, hypertension, insomnia, knee pain, major depressive disorder, numbness of the tongue, osteoarthritis, planter fasciitis, post operative anemia, reactive airway disease, trigger fingers on both left and right ring fingers, urinary incontinence, hyponatremia.

Past Surgical History:

C-section x2, arthroplasty of knee, tubal litigation, wound vac to left lower extremity, cataract surgery, arthroplasty of both left and right hip, incision and drainage debridement of left hip x2, arthroplasty revision, gynecological ablation.

Family History:

Mother- anxiety, arthritis, asthma, diabetes mellitus, glaucoma, heart attack, HTN, psychiatry, thyroid disorder

Grandma, moms side- Diabetes mellitus

Father- CHF, heart attack, HTN, Parkinson’s disease, stroke

Social History (tobacco/alcohol/drugs):

No prior tobacco, alcohol, or recreational drug use noted by the patient.

Assistive Devices:

The patient wears corrective lenses, no contacts.

Living Situation:

The patient lives at home with her husband.

Education Level:

High school. No learning barriers.

Admission Assessment

Chief Complaint (2 points):

Chest pain

History of present Illness (10 points):

In the early morning hours of October 16th, the patient was at work when she started developing chest pain. The chest pain was localized in the left anterior side of the chest. It lasted approximately 15 to 30 minutes before it went away. The patient described the pain as a tightness followed by a racing heart, and shortness of breath. The patient didn't note any diaphoresis or nausea. The patient claimed that the pain worsened upon excretion and at the time nothing made it better. Shortly after this episode the patient called a friend to pick her up and take her home. When the patient arrived at home, her heat rate was in the 140's so she took propranolol which did decrease her heart rate. My patient stated that her pain was "very bad" at this time. After this episode the patient proceeded to the emergency room.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):

Chest pain

Secondary Diagnosis (if applicable):

Hypertension

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

Angina pectoris is defined by a squeezing pain felt in the chest and occurs when there is a lack of blood flow to the myocardium (Capriotti, 2020). Stable angina is chronic chest pain that the patient has experienced before and feels similar to past episodes of chest pain and has a predictable pattern. Unstable angina is cardiac chest pain occurring for the first time and is considered a medical emergency (Capriotti, 2020). Stable angina is often triggered by stress or physical exertion and doesn't worsen over time, whereas unstable angina strikes for no apparent reason and gets worse as time continues (Capriotti, 2020).

The etiology of angina pectoris is commonly caused by myocardial ischemia due to coronary artery atherosclerosis (Capriotti, 2020). Atherosclerotic plaques accumulate in the coronary arteries, showing hyperlipidemia and endothelial injury (Capriotti, 2020). Most angina pain is experienced with exertion, which increases the need for the heart to circulate more oxygen to the cells. In those with atherosclerotic plaques in their arteries, the heart can not supply enough oxygenated blood to the cardiac muscle, which can cause ischemia (Capriotti, 2020). Adenosine is the primary chemical mediator of anginal pain, and lactic acid is also known to be noxious to muscle cells (Capriotti, 2020).

Many pathophysiological reasons contribute to ischemia and lack of sufficient oxygen, the first of which is a coronary artery blocked by a thrombus (Capriotti, 2020). If the coronary artery diameter is blocked by 50% to 70%, this can result in ischemia (Capriotti, 2020). Atherosclerotic plaques more commonly cause anginal pain in the coronary artery. As these plaques age, they become fragile and can break off, causing a plaque obstruction which can cause ischemia in the

distal myocardial tissue (Capriotti, 2020). Lastly, myocardial ischemia can occur by coronary artery vasospasm, which can lead to Prinzmetal's or variant angina (Capritotti, 2020). These vascular spasms obstruct blood flow through the coronary arteries causing ischemia in the surrounding myocardial tissues (Capriotti, 2020). Patients with metabolic syndrome are also at higher risk of developing coronary atherosclerosis, which my patients meet the criteria for.

Most anginal chest pain is brought on by exertion or stress (Capriotti, 2020). Patients often report retrosternal pain followed by pressure, choking, squeezing, or heaviness on the chest (Capriotti 2020). This pain can radiate to the left shoulder, arm, and jaw and can also be felt on the right side of the body (Capriotti, 2020). In women, the symptoms can present as episodic dyspnea, dizziness, lightheadedness, epigastric pain (Capriotti, 2020). When nurses perform a physical exam, they should note a pale, dyspeptic, diaphoretic patient (Capriotti, 2020). Pulses might be weak, and the patient may show hyperlipidemia signs, including xanthomas and xanthelasmas (Capriotti, 2020). Vital signs will show an increased respiratory rate, slow heart rate, and low blood pressure (Capriotti, 2020). Patients also exhibit a Levine's sign when they bring their fist to their chest (Capriotti, 2020).

Several diagnostic tests can help aid in the diagnosis of stable and unstable angina. When ECGs are performed with unstable angina, they will show an ST depression, ST elevation, or T wave inversions (Capriotti, 2020). Cardiac catheterization with a coronary angiogram will show areas of occlusions brought on by atherosclerosis (Capriotti, 2020). CTs are performed to evaluate the arteries for any narrowing (Capriotti, 2020). Lipid profiles will show high levels of LDL, low levels of HDL, and high levels of triglycerides (M. & Bladh, 2021). Stress tests are often ordered as well as cardiac enzyme tests to rule out MIs. If the troponin level is increased,

this can indicate an MI or unstable angina (M. & Bladh, 2021). cTn is used to rule out an MI (M. & Bladh, 2021).

There are many treatment options for angina pectoris, including diet, lifestyle, and pharmaceuticals. Some lifestyle factors the patient can change are diet and exercise. A low-fat diet and daily exercise can help reduce the risk of angina pectoris and treat it (Capriotti, 2020). Medications include nitroglycerin, aspirin, anticoagulants, Ca ++ antagonists, beta-adrenergic blockers, dual antiplatelet therapy, ranolazine, and PCI procedures (Capriotti, 2020). My patient is currently taking beta blockers, aspirin, calcium channel blockers, and an anticoagulant. I believe that my patient would benefit from having nitro prescribed to her.

As previously stated, having metabolic syndrome can lead to angina pectoris, which my patient meets the criteria given a past history of diabetes mellitus, hypertension, and hyperlipidemia. I think my patient would greatly benefit from diet and lifestyle education. An EKG was performed on my patient, which showed premature atrial complexes. The patient had also gone down for a stress test during my clinical but wasn't finished with it by the time our rotation was over. A troponin lab was also drawn in the emergency room, which ruled out an MI.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis.

M., V. L. A., & Bladh, M. L. (2021). *Davis's comprehensive manual of laboratory and diagnostic tests with nursing implications*. F.A. Davis.

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	3.90-4.98	4.80	N/A	
Hgb	12.0-15.5	14.6	N/A	
Hct	35-45	42.7	N/A	
Platelets	140-400	239	N/A	
WBC	4.0-9.0	8.0	N/A	
Neutrophils	40-70	59.6	N/A	
Lymphocytes	10-20	29.7	N/A	**This abnormal value could be due to my patient having an some sort of sinus infection upon admission considering she has a hx of allergic rhinitis.**
Monocytes	4.4-12.0	5.9	N/A	
Eosinophils	0.0-6.3	2.6	N/A	
Bands	0-700	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-	135-145	141	N/A	
K+	3.5-5.1	4.1	N/A	
Cl-	98-107	104	N/A	
CO2	22-29	28	N/A	
Glucose	70-99	88	N/A	
BUN	6-20	9	N/A	
Creatinine	0.50-1.00	0.80	N/A	

Albumin	3.5-5.2	4.2	N/A	
Calcium	8.4-10.5	9.0	N/A	
Mag	1.6-2.6	2.0	N/A	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0.0-1.2	0.7	N/A	
Alk Phos	35-105	101	N/A	
AST	0-32	17	N/A	
ALT	0-33	13	N/A	
Amylase	30-110	N/A	N/A	
Lipase	10-140	N/A	N/A	
Lactic Acid	4.5-19.8	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	2-3	N/A	N/A	
PT	9.6-11.8 sec	N/A	N/A	
PTT	30-40 sec	N/A	N/A	
D-Dimer	≤250	N/A	N/A	
BNP	<125	N/A	N/A	
HDL	>60	N/A	N/A	
LDL	<130	N/A	N/A	

Cholesterol	<200	N/A	N/A	
Triglycerides	<150	N/A	N/A	
Hgb A1c	4%-5.5%	N/A	N/A	
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 and clear**	N/A	**N/A**	
pH	**5.0-8.0**	N/A	**N/A**	
Specific Gravity	1.005-1.034	N/A	N/A	
Glucose	Normal	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	< = 5	N/A	N/A	
RBC	0-3	N/A	N/A	
Leukoesterase	Negative	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 growth	N/A	N/A	
Blood Culture	Negative growth	N/A	N/A	

Sputum Culture	Negative Growth	N/A	N/A	
Stool Culture	Negative growth	N/A	N/A	

Lab Correlations Reference (1) (APA):

M., V. L. A., & Bladh, M. L. (2021). *Davis's comprehensive manual of Laboratory and diagnostic tests with nursing implications*. F.A. Davis.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

10/16- Troponin was draw reading <0.010 ng/mL which is within normal range

10/16- A 12 lead EKG was preformed which showed normal sinus rhythm with premature atrial complexes.

10/16- A 2 view chest x-ray was taken which showed the heart size was normal, lungs were clear, no signs of a pneumothorax or pleural effusion, osseous structures intact, and degrative changes in the spine.

10/17- An echocardiogram with out contrast was taken which showed normal LV chamber size and systolic function. Ejection fraction was 55-65%. Normal LV wall thickness with grade I diastolic function. Normal RV size and function. Trileaflet aortic valve without stenosis or regurgitation. Normal structure and function of mitral and tricuspid valves. No pericardial effusion.

10/18- Stress test was conducted (Unable to get results as clinical ended before I could).

Diagnostic Test Correlation (5 points):

The Troponin is a cardiac marker that can help diagnosis an MI, which my patient did not have.

The chest x-ray was preformed to view the heart and lungs structure.

The EKG was preformed because of the complaints of chest pain and to rule out an MI.

The echo was also preformed to rule out any cardiac dysfunction since the patient was complaining of chest pain.

The stress test was preformed to evaluate for and assist in diagnosing CAD and MI.

Diagnostic Test Reference (1) (APA):

M., V. L. A., & Bladh, M. L. (2021). *Davis's comprehensive manual of Laboratory and diagnostic tests with nursing implications*. F.A. Davis.

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

Home Medications (5 required)

Brand/ Generic	AccuNeb/albuterol	Tylenol/ acetaminophen	Atarax/hydroxyzine	Almora/magnesium gluconate	Apo-Verap/ verapamil
Dose	2.5 mg/ 3 mL	650 mg	10 mg	500 mg	40 mg
Frequency	Q6, PRN	BID	TID	BID	Once daily
Route	Inhalation solution	P.O.	P.O.	P.O.	P.O.
Classification	Pharmacological: Adrenergic Therapeutic: Bronchodilator	Pharmacological: Nonsalicylate, Para- aminophenol derivative Therapeutic: Antipyretic, nonopioid analgesic	Pharmacological: Piperazine derivative Therapeutic: Anxiolytic, Antiemetic, antihistamine, sedative-hypnotic	Pharmacological: Mineral Therapeutic: Electrolyte replacement	Pharmacological: Calcium channel blocker Therapeutic: Antianginal, antiarrhythmic, antihypertensive

Mechanism of Action	"Attaches to beta 2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine monophosphate. This reaction decreases intracellular calcium levels. These effects smooth bronchial muscle cells and inhibit histamine release" (Jones & Bartlett, 2020).	"Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system. Acetaminophen also acts directly on temperature regulating center in the hypothalamus by inhibiting synthesis of prostaglandin E2" (Jones & Bartlett, 2020)	"Competes with histamine for histamine 1 receptors sites on surfaces if effector cells. This suppresses results of histaminic activity, including edema flare, and puritus. Sedative actions occur at subcortical level of CNS and are dose related" (Jones & Bartlett, 2020).	"Assists all enzymes involve in phosphate transfer reactions that use adenosine triphosphate. Magnesium is required for normal function of the ATP dependent sodium-potassium pump in muscle membranes. It may effectively treat digitalis glycoside-induced arrhythmias because correction of hypomagnesemia improves the sodium-potassium pumps ability to distribute potassium into intracellular spaces because magnesium decreases calcium uptake and potassium outflow through myocardial cell membranes" (Jones & Bartlett, 2020).	"Inhibits calcium movement into coronary and vascular smooth muscle cells by blocking slow calcium channels in cell membranes. Inhibits smooth muscle contractions, decreases myocardial oxygen demand by relaxing coronary and vascular smooth muscle, reducing peripheral vascular resistance, and decreasing systolic pressures, slows AV conduction time and prolongs AV nodal refractoriness, interrupts reentry circuit in AV nodal reentrant tachycardias" (Jones & Bartlett, 2020).
Reason Client Taking	For her reactive airway disease	Arthritis pain	To relieve her anxiety	Used to treat hypomagnesemia	Angina pectoris
Contraindications (2)	Hypersensitivity to albuterol or its components (The drug book provided by the college only has one listed)	1. Hypersensitivity to acetaminophen or its components 2. Severe hepatic impairment	1. Hypersensitivity to cetirizine, hydroxyzine, or their component 2. Prolonged QT interval	1. Hypersensitivity to magnesium gluconate 2. Hypermagnesemia	3. Hypersensitivity to verapamil or its components, hypotension 4. Hypotension
Side Effects/Adverse Reactions (2)	1.Angina 2. Angioedema	1. Hypoglycemic coma 2. Hypokalemia	1. Seizures 2. Hallucinations	1. Arrythmias 2. Respiratory depression	1. MI 2. CVA

Nursing Considerations (2)	1. Monitor serum potassium levels because albuterol may cause hypokalemia. 2. Use cautiously in patients with cardiac disorders, diabetes mellites, digitalis intoxication, hypertension, hyperthyroidism, or history of seizures.”	1. Liver function tests must be monitored if on this drug long term. 2. Monitor renal function if the patient is on this medication long term.	1. Don’t give this medication by subcutaneous or I.V. route because tissue necrosis may occur. 2. Use this medication cautiously in patients with risk factors for QT prolongation such as concomitant arrhythmogenic drug use, electrolyte imbalance, or preexisting heart disease.	1. Monitor serum electrolyte levels in patients with renal insufficiency because they are at risk for magnesium toxicity. 2. Frequently assess cardiac status of patients taking drugs that lower heart rate such as beta blockers because magnesium may aggravate symptoms of heart block.	1. Assess for bradycardia and hypotension and notify prescriber if blood pressure or heart rate declines significantly. 2. Institute measures to prevent constipation including a high fiber diet and a stool softener as prescribed.

Hospital Medications (5 required)

Brand/ Generic	Bayer/aspirin, acetylsalicylic acid	Lipitor/atorvastatin calcium	Lovenox/enoxaparin	Cozaar/losartan potassium	Detensol/ propranolol hydrochloride
Dose	81 mg	2- 40 mg tablets	0.4 ml	4- 100mg tablets	2- 20 mg tablets
Frequency	Once daily	Once daily	Once daily	Once daily	BID

Route	P.O.	P.O.	Subcutaneous injection	P.O.	P.O.
Classification	Pharmacological: Salicylate Therapeutic: NSAID	Pharmacological: HMG-CoA reductase inhibitor Therapeutic: Antihyperlipidemic	Pharmacological: Low-molecular weight heparin Therapeutic: Anticoagulant	Pharmacological: Angiotensin II receptor blocker Therapeutic: Antihypertensive	Pharmacological: Beta-adrenergic blocker Therapeutic: Antianginal, antiarrhythmic, antihypertensive, anti-MI, antimigraine, antitremor, hypertrophic cardiomyopathy, and pheochromocytoma therapy adjunct
Mechanism of Action	"Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis. Prostaglandins, important mediators in the inflammatory response, cause local vasodilation with swelling and pain. With blocking of cyclooxygenase and inhibition of prostaglandins, inflammatory symptoms subside. Pain is also relieved because prostaglandins play a role in pain transmission from periphery to the spinal cord. Aspirin inhibits platelet aggregation by interfering with production of thromboxane A2, a substance that stimulates platelet	"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" (Jones & Bartlett, 2020).	"Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors. Without thrombin, fibrinogen can't convert to fibrin and clots can't form" (Jones & Bartlett, 2020).	"Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle. Angiotensin II is a potent vasoconstrictor that also stimulates the adrenal cortex ti secrete aldosterone. The inhibiting effects of angiotensin II reduce blood pressure. Decreases left ventricular mass index in patients with left ventricular hypertrophy who also have hypertension. By targeting the renin-angiotensin system, a renoprotective action occurs through the lowering of the albumin excretion rate in patients	"Prevents arterial dilation and inhibits renin secretion, resulting in decreased blood pressure and relief of migraine headaches. Decreases heart rate, which helps resolve tachyarrhythmias. Improves myocardial contractility, which helps ease symptoms of hypertrophic cardiomyopathy. Decrease myocardial oxygen demand which helps prevent anginal pain and death of myocardial tissue" (Jones & Bartlett, 2020).

	aggregation. Aspirin acts on the heat regulating center in the hypothalamus and cause peripheral vasodilation, diaphoresis, and heat loss" (Jones & Bartlett, 2020).			with type 2 diabetes" (Jones & Bartlett, 2020).	
Reason Client Taking	To reduce the risk of MI or CVA	To reduce the risk of acute cardiovascular events such as angina, CVA, or MI	To prevent DVT	To manage hypertension	To manage hypertension and to treat chronic angina
Contraindications (2)	1. Active bleeding or coagulation disorders 2. Current or recent GI bleeds or ulcers	1. Hypersensitivity to atorvastatin 2. Active hepatic disease	1. Active major bleeding 2. History of heparin induced thrombocytopenia	1. Concurrent aliskiern therapy 2. Hypersensitivity to losartan or its components	1. Cardiogenic shock 2. Hypersensitivity to propranolol
Side Effects/Adverse Reactions (2)	1. CNS depression 2. Hepatotoxicity	1. Arrythmias 2. Hypoglycemia	1. CVA 2. Arterial fibrillation	1. Thrombocytopenia 2. Hyponatremia	3. Bronchospasm 4. Bradycardia
Nursing Considerations (2)	1. Don't crush extended-release aspirin unless otherwise directed. 2. Ask about tinnitus. This reaction usually occurs when blood aspirin level reaches or	1. Be aware that atorvastatin may be used with colestipol or cholestyramine for additive antihyperlipidemic effects. 2. Expect liver function tests to be performed before atorvastatin therapy starts and	1. Use cautiously in those with bleeding diathesis, diabetic retinopathy, hepatic or renal impairment, recent GI hemorrhage or ulceration, or uncontrolled hypertension. 2. Expect to give drug	1. Know that in some patients, losartan is more effective when given in 2 divided doses daily; it may be used with other antihypertensives. 2. Monitor blood pressure and renal	3. Monitor diabetic patient taking an antidiabetic because propranolol can prolong hypoglycemia or promote hyperglycemia. It also can mask signs of hypoglycemia, especially tachycardia, palpitations, and tremor, but

	exceeds maximum dosage for therapeutic effect.	then thereafter as clinical necessary.	with aspirin to patient with unstable angina, STEMI, and non-Q wave MI.	function studies, as ordered, to evaluate drug effectiveness.	it doesn't suppress diaphoresis or hypertensive response to hypoglycemia.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *Nurse's Drug Handbook.*

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Patient alert and responsive to verbal and painful stimuli. Patient is alert to person, place, time and situation. Patient did not appear to be in any pain or distress. Patients' appearance was appropriate for age.

	Patient appeared clean and well groomed.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin color was usual for ethnicity. No cyanosis, ecchymosis, jaundice, or erythema noted. Patient's skin was dry. Patient was warm to the touch. Skin turgor was elastic. No rashes noted. No bruises noted. No wounds noted. **Braden: 20** No drains present
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck were symmetrical No trauma to the head No tracheal deviation was presented, thyroid and lymph nodes were not palpable Eyes were symmetrical, sclera was white, no erythema, discharge, or conjunctiva. Patient does have vison problems. The patient uses glasses. Six cardinals were preformed and pupils were equal round and reactive to light and accommodation. No discharge or erythema on the nose. Nose was midline of the face. No turbinate's, polyps, deviated symptom was seen. Patient had good dental care. The mucosa membrane was pink and moist. Rise and fall of the soft palate was seen.
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:**	Sinus Rhythm, Heart sounds S1 and S2 were heard. No murmurs or gallops. S3 and S4 were not heard. Peripheral pulses: 3+ normal Capillary refill: After nail was blanched nail bed returned back to normal in less than two seconds. No neck vein distention No edema
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No use of accessory muscles. Respirations were unlabored.

	Respiration patter was normal. Breath sounds were clear Lung sounds equal bilaterally in all lobes, including the right middle lobe, anterior and posterior
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:**	 Regular Consistent carb 160.02 cm 132.4 kg Bowel sound active in all four quadrants. Last bowel movement was 10/16. No masses or tenderness was felt upon palpitation No distention No incision No scars No drains No wounds No nasogastric, feeding, or PEG tubes
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	 Patients urine appeared light yellow. Patients urine was clear. Patient urinated 250 ml during my shift. No pain noted during urination. No dialysis. Genitals appeared clean with no odors noted.
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) ☒**	 All extremities are warm to the touch with no edema noted. Nail beds are intact and appear pink with <3 second cap refill. Patient has active range of motion. Patient can move all extremities well The patient does not use any supporting devices like canes or walkers Patient does wear glasses though Patients strength is a 5 with active motion against

Needs assistance with equipment ☐ **Needs support to stand and walk** ☐	full force resistance No ADL Assistance **Fall Risk Score: 45** Patient is independent and up ad lib Patient does not need any assistance with equipment. Patient did have a IV saline lock, but no fluids running Patient does not need support to stand or walk
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient moves all extremities well without assistance. Patients' pupils are equal, round, reactive to light and accommodation. Patients strength is a 5 in all extremities. Patient is alert to person, place, situation and time. Cognition is normal and appropriate for age. Speech is clear and easy to understand. Sensory: Patient could feel when I assessed all of her pulses as well as when I palpated her abdomen. Patient was alert, awake, and able to answer all questions.
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):**	Patients states that watch movies and relaxing help her cope when she is going through stressful times. Patients' development is appropriate for age and education level. She has no problem reading or writing. Patient doesn't have a great support system. Patient states that her husband is a truck driver and is away from home a lot and 1 of her 2 daughters is estranged.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0753	91 beats per minute	139/90 mmHg	16 breaths per minute	37.1 degrees Celsius	97% on room air

0857	93 beats per minute	140/92 mmHg	18 breaths per minute	37.2 C degrees Celsius	99% on room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0753	Numerical	N/A	0/10	N/A	N/A
0857	Numerical	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Left peripheral forearm
Date on IV:	Placed on 10/17
Patency of IV:	IV is patent and flushes easily
Signs of erythema, drainage, etc.:	No signs of erythema or drainage
IV dressing assessment:	Tegaderm over IV site was clean and intact IV is saline locked

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
300 ml of water at breakfast time	**250** ml of urine

Nursing Care

Summary of Care (2 points)

Overview of care:

The patient was on a caffeine restriction this morning because she was going down for a stress test later that day. She was very pleasant and enjoyed talking to me as I was gathering information for my care plan as well as preforming my head-to-toe assessment. I did assist her in changing into street clothes and walking shoes for her stress test.

Procedures/testing done:

The patient went down late morning for a stress test. I was off the floor before the results came back,

Complaints/Issues:

At the time of my clinical rotation the patient wasn't experiencing any chest pain. The patient did voice frustrations over her chronic headaches which she thought was due to her hypertension.

Vital signs (stable/unstable):

The patients' blood pressure was slightly elevated during my clinical rotation but nothing that was critical.

Tolerating diet, activity, etc.:

The patient was on a consistent carb diet with a caffeine restriction due to her stress test. She tolerated her diet and morning activities well. I was not able to assess how she tolerated the stress test as I was off the floor before she came back.

Physician notifications:

The patients doctor came up to the floor to talk with the nurse about future for the patient. She put in orders for PRN Hydralazine.

Future plans for patient:

Future plans for the patient include diet and lifestyle modification to manage her chest pain and hypertension.

Discharge Planning (2 points)

Discharge location:

Patient will be discharging back to her home in Mattoon.

Home health needs (if applicable):

No home health needed at this time.

Equipment needs (if applicable):

No equipment needs at this time.

Follow up plan:

Patient should continue to monitor her blood pressure with her at home blood pressure cuff, pick up her Hydralazine at her pharmacy, as well as attend her scheduled appointments as needed.

Education needs:

Patient needs to be educated on her new prescription medication.

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 decreased oxygen supply to the myocardium as evidence by	This nursing diagnosis was chosen because the patient sought medical attention due to her anginal	**1.** Instruct patient to avoid activities and factors that are known to cause stress.	The patient responded well to both of these recommendations and was confident in her ability to perform each intervention.

diagnosis of chest pain.	pain.	**2.** Discuss relaxation techniques which may help reduce stress and anxiety, which may make anginal pain worse.	The desired outcome is within 30 minutes each of these interventions the patients pain level will decrease as will their anxiety. These goals can be measured by reassessing the patients pain level.
3. Knowledge deficit related to unfamiliarity with relaxation techniques effective for stress reduction as evidence by exacerbation of angina pectoris	This nursing diagnosis was chosen because stress and emotional triggers are known to exacerbate angina pectoris.	**1.** Assess the patients level of stress and discuss the importance of relaxation techniques. **2.** Introduce methods of relaxation such as music, guided imagery, massage, art, and biofeedback.	The patient didn't know that stress and emotions can trigger angina pectoris. The patient works many night shifts as her job which she thinks can contribute to her stress. I discussed several of these techniques with the patient and she said that listening to music was something she could do at her job to promote a more relaxing environment since she works night shift. This outcome can be evaluated by subjective relief of stress after using these techniques. After doing some guided imagery the patient reported feeling "more calm".
2. Intolerance to activity related to angina pectoris as evidence by chest pain and shortness of breath with activity.	This diagnosis was chosen because my patients anginal pain was brought on while doing physical activity at her job.	1. Assist the patient with recognizing and limiting factors that increase O2 demands, such as exercise and anxiety. 2. Have the patient	The patient understood after some education that stress contributes a lot to her anginal pain, as well as physical excretion. I explained that doing bed bound or chair exercises will help keep her from developing pressure ulcers, as well as keep

		preform ROM exercises, depending on tolerance and activity limitations.	her joints loosened up. She agreed that these would be good options for her. The outcome of this intervention is to keep heart rate, and respirations at 20 breaths per minute or less, and the heart rate at 120 beats or less while doing these exercises.

Other References (APA):

Concept Map (20 Points):

Patient stated they had “chest pain that radiated to my left arm”. Patient also stated that she experienced “chest tightness, shortness of breath, and a racing heart”. During my assessments on the floor patient stated she was in “no pain” either of the times I rounded on her. Patient stated “pain was very bad” before coming to the hospital.

Subjective Data

te pain related to decreased oxygen supply to the myocardium as evidence by diagnosis of chest pain.
Patient should verbally score 0/10 on the pain scale within 30 minutes of the nursing interventions provided
Lack of knowledge related to unfamiliarity with relaxation techniques effective for stress reduction as evidence by exacerbation of angina pectoris
Patient should be able to complete relaxation techniques on their own to reduce anxiety. This can be observed by the nurse and evaluated by asking “Are you feeling less anxious now?”
Intolerance to activity related to angina pectoris as evidence by chest pain and shortness of breath with activity.
The patients should be able to identify which activities exacerbate their anginal pain and avoid those activities. If activity cannot be avoided the patient will schedule breaks within their work. This will be elevated by a reduction of pain when taking a break during their work day.

Nursing Diagnosis/Outcomes

Providing education on relaxation techniques to reduce anginal pain
Providing education on the importance of taking breaks during the workday
Provide education on a diet and lifestyle change to cut down on anginal pain
Giving medications such as atorvastatin, losartan, and propranolol to help manage their hypertension and anginal pain
Assessing vitals, including level of pain
Providing education on the new medication the doctor put the patient on.

Nursing Interventions

Objective Data

Height: 160.02 cm
Weight: 132.4 kg
Blood pressures: 139/90, 140/92
Respirations: 16, 18
Temperature: 37.1 degrees Celsius, 37. 2 degrees Celsius
Oxygen: 97% on room air, 99% on room air
Pulses: 91 bpm, 93 bpm
Stress test was ordered
12 lead EKG showed sinus rhythm w/ premature atrial complexes
Echo w/o contrast showed 55-65% ejection fraction

Patient Information

A 53-year-old female patient with a history of HTN, and anxiety was admitted for chest pain.