N431 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 1/30/2022	**Client Initials** M.R.	**Age** 73	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Divorced	**Allergies** Macrobid Wellbutrin
Code Status Full code	**Height** 167 cm	**Weight** 94.800 kg	

Medical History (5 Points)

Past Medical History: Arthritis, Chronic obstructive pulmonary disease, Hyperlipidemia, and hypertension.

Past Surgical History: Phacoemulsification cataract with intraocular lens implants (1/23/2019 and 1/30/2019), hysterectomy (1995), colonoscopy, CTR-carpal tunnel.

Family History: Father had Addison and liver disease, mother had breast cancer and osteoporosis, and sister had asthma and breast cancer.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient been smoking tobacco a pack a day for 50 years. The patient denies drinking alcohol or and other drugs.

Assistive Devices: The patient denies using any assistive devices.

Living Situation: The patient lives at home with her boyfriend.

Education Level: The patient only has her high school diploma.

Admission Assessment

Chief Complaint (2 points): Chest pain that radiated to her shoulder

History of Present Illness – OLD CARTS (10 points): The patient is a 73-year-old female that came to the hospital on 1/30/2022 complaining of chest pain that radiated to her shoulder. The patient stated that it started the morning of 1/30/2022, and the pain was in her chest and radiated to her shoulder. The patient stated, "I originally thought it was indigestion pain, but it would not go away." The patient said that the pain was consistent until her boyfriend finally made her go to the hospital. The patient described the pain as a sharp pain, like how indigestion feels. The patient said there was nothing that made the pain worse or better. The patient tried to take Pepto-Bismol, but nothing worked for her consistent pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Chest pain; angina

Secondary Diagnosis (if applicable): Hypokalemia

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

Chest pain is discomfort in the chest, including a dull ache, a crushing or burning feeling, a sharp stabbing pain, and pain that radiates to the neck or shoulder (Capriotti, 2020). Chest pain can also be referred to as angina pectoris. This specific term can be described as squeezing pain in the chest when there is a lack of blood flow to the myocardium (Capriotti, 2020). The patient described her pain that started in her chest described as indigestion pain but eventually radiated to her shoulder. There are two types of anginas which include stable angina and unstable angina. When a patient experiences stable angina, their chest pain is chronic, and they have experienced it before, which is the opposite of unstable angina. In contrast, cardiac chest pain occurs first (Hinkle & Cheever, 2018). The patient was experiencing unstable angina, so she was admitted to the hospital because it was more of an emergency. Angina is myocardial ischemia resulting from

ischemia as a result of coronary artery atherosclerosis (Hinkle & Cheever, 2018). Atherosclerosis builds plaque in the arteries that can seclude the blood and stop the flow to the heart. When there is a buildup in the arteries, it can be because of hyperlipidemia. The patient has a past medical history of hyperlipidemia, increasing her risk of cardiac events. In angina, cardiac muscles also suffer from a lack of oxygen (Capriotti, 2020). A coronary thrombosis can also be formed and can block blood flow by 50% to 70%, which then causes ischemia. Some signs and symptoms of angina are pale, dyspneic, diaphoretic (Capriotti, 2020). Although my patient was experiencing angina, I did not see any changes in her appearance.

Angina also affects a person's vital signs, such as weak pulses, heart rate can be regular, bradycardic, or tachycardiac, and there may be extra beats or irregular rhythm (Capriotti, 2020). The patient had typical vital signs, but her heartbeat was irregular. Some tests for angina are blood pressure measurement, total blood cholesterol, LDL, HDL, and triglycerides (Capriotti, 2020). The patient levels were measured, and all were in the expected range—some additional tests were her chest x-ray, ECG, stress test (Capriotti, 2020). The patient chest x-ray came back normal, but the ECG saw some irregular rhythm. The patient stress test also came back normal. The major treatment for preventing angina is educating the patient. Patients mainly need the education to reduce modifiable risks such as smoking cessation, stress, diet, and weight (Capriotti, 2020). I was able to educate the patient on recognizing cardiac events and ways to prevent them. Another way to treat angina is to administer aspirins and nitrates (Capriotti, 2020). The patient was given aspirin to help with her angina hopefully. The patient eventually was discharged home with no signs of any additional cardiac events besides angina.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology* (2nd ed.). F. A. Davis

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed). Wolters Kluwer.

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	3.90-5.41	4.71	n/a	n/a
Hgb	11.0-15.2	14.5	n/a	n/a
Hct	33.2-45.3	42.6	n/a	n/a
Platelets	140-400	300	n/a	n/a
WBC	4.0-11.7	8.2	n/a	n/a
Neutrophils	45.3-79.0	57.4	n/a	n/a
Lymphocytes	11.8-45.9	30.6	n/a	n/a
Monocytes	4.4 - 12.0	8.6	n/a	n/a
Eosinophils	0.0-6.3	2.8	n/a	n/a
Bands	0.2-1.6	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-	136-145	145	n/a	n/a
K+	3.5-5.1	3.3	n/a	The patient potassium was possibly low due to taking the diuretic, hydrochlorothiazide, which could of loss potassium through eliminating fluids (Pagana et al., 2021).
Cl-	98-107	102	n/a	n/a

CO2	21-31	36	n/a	The patient CO2 level can be high due to the patient having a history of COPD and retaining to much CO2 because the functioning of lungs (Pagana et al., 2021).
Glucose	74-109	98	n/a	n/a
BUN	7-25	15	n/a	n/a
Creatinine	0.6-1.2	.74	n/a	n/a
Albumin	3.5-5.2	4.0	n/a	n/a
Calcium	8.6-10.3	.94	n/a	n/a
Mag	1.6-2.1	n/a	n/a	n/a
Phosphate	45-117	n/a	n/a	n/a
Bilirubin	0.3-1.0	.4	n/a	n/a
Alk Phos	7-52	43	n/a	n/a
AST	0.3-1.0	.6	n/a	n/a
ALT	13-39	19	n/a	n/a
Amylase	30-110	n/a	n/a	n/a
Lipase	11-82	n/a	n/a	n/a
Lactic Acid	0.5-1.0	n/a	n/a	n/a
Troponin	0-0.04	<0.010	n/a	n/a
CK-MB	3-5%	n/a	n/a	n/a
Total CK	22-198	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	Normal: 1 Therapeutic: 2-3	n/a	n/a	n/a
PT	10-12 seconds	n/a	n/a	n/a
PTT	30-45 seconds	n/a	n/a	n/a
D-Dimer	< 200	n/a	n/a	n/a
BNP	0-100	n/a	n/a	n/a
HDL	23-92	n/a	n/a	n/a
LDL	< 100	n/a	n/a	n/a
Cholesterol	< 199	n/a	n/a	n/a
Triglycerides	0-149	n/a	n/a	n/a
Hgb A1c	< 6.4	n/a	n/a	n/a
TSH	0.45-5.33	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	Pale yellow/ clear	n/a	n/a	n/a
pH	5-8	n/a	n/a	n/a
Specific Gravity	1.005-1.030	n/a	n/a	n/a
Glucose	Negative	n/a	n/a	n/a
Protein	Negative	n/a	n/a	n/a
Ketones	Negative	n/a	n/a	n/a

WBC	Negative	n/a	n/a	n/a
RBC	Negative	n/a	n/a	n/a
Leukoesterase	Negative	n/a	n/a	n/a

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	n/a	n/a	n/a
PaO2	80-100	n/a	n/a	n/a
PaCO2	35-45	n/a	n/a	n/a
HCO3	22-26	n/a	n/a	n/a
SaO2	92-100	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	Negative	n/a	n/a	n/a
Blood Culture	Negative	n/a	n/a	n/a
Sputum Culture	Negative	n/a	n/a	n/a
Stool Culture	Negative	n/a	n/a	n/a

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). Mosby’s diagnostic & laboratory test reference (14th ed.) Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1.) **Chest x ray (01/30/2022)-** Heart size was normal according to age. The patient had streaky bibasilar scarring persists. No developing infiltration and visualized pneumothorax pleural effusion.

2.) **Electrocardiogram (ECG) (01/30/2022)-**Normal sinus rhythm and nonspecific ST and T wave abnormity, abnormal ECG.

3.) **Stress test (01/31/2022)-** There was no abnormal findings of the patient stress test.

Diagnostic Test Correlation (5 points):

1.) A chest x ray is a film that produces images of your heart, lungs, blood vessels, airways, and the bones of your chest and spine (Hinkle & Cheever, 2018). The patient was getting a chest x ray to see images of her heart. The patient was given this test to rule cardiac events such a heart attack due to her coming for chest pain

2.) Electrocardiogram is a graph that shows electric activity of the heart. An electrocardiogram is used to measure time and velocity (Hinkle & Cheever, 2018). The patient will have electrodes that placed throughout the body specific parts to measure the heart. The patient was given this test to rule cardiac events such a heart attack due to her coming for chest pain.

3.) A stress test usually involves waling on a treadmill or riding a stationary bike while your heart rhythm, blood pressure and breathing are being monitored (Hinkle & Cheever,

2018). The patient performed this test is her results were in expected range. The stress test can diagnose cardiac events such as CAD and arrhythmias (Hinkle & Cheever, 2018).

Diagnostic Test Reference (1) (APA):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed). Wolters Kluwer.

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

Home Medications (5 required)

Brand/Generic	Albuterol/ ProAir HFA	Hydrochlorothiazide/ Microzide	Latanoprost/ Xalatan 0.0059%	Meloxicam/ Mobic	Simvastin/ Zocor
Dose	90mcg	25mg	1 drop	15mg	40mg
Frequency	Three times a day(TID)	Daily	Every night	Daily	HS
Route	Oral	Oral	Ophthalmic	Oral	Oral
Classification	Inhaled beta 2 agonist	Thiazide diuretic and diuretic	Prostaglandin analog	NSAID	HMG-CoA reductase and antilipemic
Mechanism of Action	Albuterol acts on beta 2 adrenergic	The medication promotes movement of sodium,	The medication reduces intraocular	Blocks cyclooxygenase, the enzyme	This medication reduces the formation

	receptors to relax the bronchial smooth muscles (Jones, 2021).	chloride, and water from the blood in the peritubular capillaries into nephron's distal convoluted tube to lower blood pressure (Jones, 2021).	pressure by increasing the outflow of aqueous humor (Jones, 2021).	needed to synthesize prostaglandins, which mediate the inflammatory response and cause local pain, swelling, and vasodilation (Jones, 2021).	of mevalonic acid, cholesterol level declines in hepatic cells, LDLs are consumed which turn reduces the levels of circulating total cholesterol and serum triglycerides (Jones, 2021).
Reason Client Taking	The patient has a history of COPD.	The patient is taking this medication to help control her hypertension.	The patient is taking this medication due to maintain low pressure in her eyes after her phacoemulsification surgery.	The patient has a history of arthritis.	The patient is taking this medication due to her history of hyperlipidemia.
Contraindications (2)	Diabetes, high blood pressure (Jones, 2021).	Hypersensitivity to sulfonamide derivates, other thiazides (Jones, 2021).	Pink eye, maculopathy (Jones, 2021).	History of angioedema, asthma (Jones, 2021).	Active hepatic disease, breastfeeding (Jones, 2021).
Side Effects/Adverse Reactions (2)	Nervousness, tachycardia (Jones, 2021).	Hypotension, renal failure (Jones, 2021).	Change in eye color, eye infection (Jones, 2021).	Heart failure, MI (Jones, 2021).	Atrial fibrillation, hepatic failure (Jones, 2021).
Nursing Considerations (2)	The nurse should monitor respiration and	The nurse should give to the patient early morning to avoid nocturia	Contact physician immediately if any ocular reactions, note	This medication should be avoided if the patient	Use cautiously in elderly with hepatic or

	oxygen saturation (Jones, 2021).	and monitor blood pressure and daily weights (Jones, 2021).	increases pigmentation of the iris and eyelid (Jones, 2021).	had a recent MI and risk for heart failure increases (Jones, 2021).	renal impairment and monitor serum lipoprotein levels to see therapeutic effect (Jones, 2021).
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	The nurse should measure the client blood pressure and heart prior and during the administration of this medication (Jones, 2021).	The patient should get their serum level monitor and blood glucose checked (Jones, 2021).	The nurse should monitor changes in overall eyes and monitor for allergies (Jones, 2021).	A pregnancy test should taken and renal functioning should also be taken before administration (Jones, 2021).	The labs that should be monitor are the renal and liver prior to given medication to patient.
Client Teaching Needs (2)	The patient should follow the directions on prescription label carefully and know that the medication can cause tachycardia and jittery feeling so do not be alarmed	The patient should take drug with food to avoid GI upset and eat a diet high in potassium (Jones, 2021).	The patient should not breastfeed while using this drug and monitor changes in the eye (Jones, 2021).	Take medication with food and refrain from alcohol use (Jones, 2021).	The patient should take drug in the evening and follow low fat cholesterol diet (Jones, 2021).

	(Jones, 2021).				

Hospital Medications (5 required)

Brand/Generic	Acetaminophen/ Tylenol	Aspirin/ Ancasal	Enoxaparin/ Lovenox	Ondansetron /Zofran	Morphine/ Arymo ER
Dose	650mg	81mg	40mg	40mg	1mg
Frequency	OH6 PRN	Daily	Daily	QH6 PRN	QH4 PRN
Route	Oral	Oral	Subcutaneous	IV push	IV push
Classification	Analgesics and antipyretics	Salicylate and NSAID	Low molecular weight and Anticoagulant	Selective serotonin Antiemetic	Opioid and opioid analgesic
Mechanism of Action	Block prostaglandin production and interferes with pain impulse generation in the peripheral nervous system (Jones, 2021).	Blocks cyclooxygenase which inhibits inflammatory symptom subside (Jones, 2021).	Potentiates the action of antithrombin and without thrombin, fibrinogen cant convert to fibrin and clots cant form (Jones, 2021).	Blocks serotonin receptors centrally in chemoreceptors trigger zone and peripherally at vagal nerve terminals in the intestine (Jones, 2021).	Bind with and activates opioid receptor in brain and spinal cord to produce analgesia and euphoria (Jones, 2021).
Reason Client Taking	The patient take this medication for her arthritis.	The patient is taking the medication for because she came to	The patient is taking this medication due the hospital	The patient is only taking this medication for	The patient is only taking this medication

		hospital for chest pain and it reduces risk of death with patients with history of MI.	policy which indicates it should be taken as precautions to avoid blood clots.	precaution purposes if they ever start to vomit.	for precaution purposes if they ever start to have pain.
Contraindications (2)	Severe hepatic impairment, severe active liver disease (Jones, 2021).	Active bleeding, breastfeeding (Jones, 2021).	Active major bleeding, hypersensitivity to pork products or their components (Jones, 2021).	Concomitant use of apomorphine, hypersensitivity to ondansetron (Jones, 2021).	Acute or severe bronchial asthma, GI obstruction (Jones, 2021).
Side Effects/Adverse Reactions (2)	Hypotension, angioedema (Jones, 2021).	CNS depression, GI bleeding (Jones, 2021).	Pulmonary edema, hemorrhage (Jones, 2021).	Bronchospasms, laryngospasm (Jones, 2021).	Bradycardia, cardiac arrest (Jones, 2021).
Nursing Considerations (2)	Use cautiously in patients with hepatic impairment and monitor renal impairment (Jones, 2021).	Do not crush timed released capsule and ask about tinnitus (Jones, 2021).	Use cation with patient with heparin-induced thrombocytopenia and hepatic impairment (Jones, 2021).	If electrolytes are unbalances it should be fix first and watch for signs of hypersensitivity (Jones, 2021).	This medication can lead to abuse and addiction and this patients has COPD so it should be use with cautious due to decrease respiration (Jones, 2021).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	The key assessments that are renal and liver labs.	The nurse should assess for active bleeding and look at platelet's	The nurse should assess for active bleeding and look at platelet's labs.	The nurse should check serum electrolytes before administration.	The nurse should measure vital sign prior to administering the

		labs.			medication.
Client Teaching Needs (2)	The patient can crush or take whole and learn signs of hepatic toxicity (Jones, 2021).	The patient should take medication with food and should not take if the patient has a tartrazine allergy (Jones, 2021).	Teach patient how to give this medication at home and know the signs of bleeding (Jones, 2021).	Patient should report signs of hypertensive and transient blindness fixes itself	Take morphine exactly how it is and take with food to prevent GI upset (Jones, 2021).

Medications Reference (1) (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert and oriented to person, time, place, and situation (x4). The patient did not appear to be in any distress. The patient overall appearance seems well groomed and looked young for age.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient skin was pink and moist to appearance and touch. The patient skin was warm to touch on all extremities bilaterally. The patient had no rashes but had bruises on arms and hands bilaterally. There were no wounds present. The patient Braden score is 23.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head and neck appeared to be midline with no deviation, and her ears were intact and symmetrical. There was currently no drainage present. The client's eyes appeared to be symmetrical with no drainage. The sclera was white, and conjunctiva was pink. The patient had no missing teeth.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	. S1 and S2 heard. No murmur or gallop present when listening to the aortic, pulmonic, Erb's point, tricuspid, and mitral locations. Pulses 2+ bilaterally in the carotid arteries, radial arteries, and dorsalis pedis arteries. All locations were easily palpable. Capillary refill was less than 3 seconds in all extremities. The patient had no edema present.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	The patient lung sounds were clear. The patient was not using accessory muscles and I did not see any chest deformities.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:**	.The patient at home eats mostly a heart healthy .At the hospital the patient is also on a heart healthy diet. The patient height was 167 cm and weighed 94.800 kg. The patient bowel sounds

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:**	were active in all four quadrants. The patient last bowel movement was the night of 01/30/2022. The patient had no pain or masses preset during palpation. There appear to be no distention, wounds, incisions, or drains. The patient did not have an ostomy, nasogastric, or feeding tubes.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient urine was yellow and clear. The patient voided 400 mL of urine while I was present. The patient had no pain while urinating. The patient was not on dialysis or did not have a catheter. The genitals were pink, damp and slightly soiled
MUSCULOSKELETAL: **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☐**	Neurovascular status is intact and is in control. The patient was able to show me active ROM in the upper and lower extremities. The client does not assistive devices to get around. The patient's strength is equal and strong in upper and lower extremities, and they all were bilateral. The patient needs no assistance with activities of daily living. The patient Fall risk score was 35.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:**	The patient is alert and orientated times 4. The patient mental status is fully intact, and speech is clear and within normal vocal range. The patient sensation is intact, and the patient level of consciousness is alert.

Sensory: **LOC:**	
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient is very calm and cooperative. The patient does not appear to be concern about health. The patient appears to be younger than age. The patient is not religious and has a stable home environment with her boyfriend. The patient is looking to go back home.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	75	160/90	16	36.1	98%
1400	81	140/82	14	36.8	97%

Vital Sign Trends: The patient blood pressure is unstable but other vital signs are close in range and normal.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numerical Scale (0-10)	Overall body	4	achy	Tylenol for pain
1400	Numerical Scale (0-10)	n/a	n/a	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:**	**The patient has a 20-gauge IV in the right forearm. The IV was placed on 01/30/2022. IV site is dry, and intact. IV is patent. No Drainage, erythema, swelling,**

Signs of erythema, drainage, etc.: **IV dressing assessment:**	**inflammation, or warmth.** **IV dressing was clear and intact.** **The patient has a saline lock**

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
400 ml of water and coffee	230 ml of urine

Nursing Care

Summary of Care (2 points)

Overview of care: I was able to give the patient her medication and do a physical assessment on her. I was able to walk her downstairs to go home. The patient did not need help with ADLs at all.

Procedures/testing done: The patient did a stress test, and it came out normal with no significant signs of any cardiac events so she was able to get discharged.

Complaints/Issues: The patient had no complaints or issues.

Vital signs (stable/unstable): The patient vital signs were unstable when I first came but eventually stabilized once given medication.

Tolerating diet, activity, etc.: The patient did not need help with ADL's.

Physician notifications: The physician notify the nurse that the results were clear, and she was able to go home that afternoon**.**

Future plans for client: The patient will follow up in with her primary doctor on February 15th to get a checkup and to see if there were any other complications.

Discharge Planning (2 points)

Discharge location: The patient was discharged home with her boyfriend on 01/31/2022.

Home health needs (if applicable): n/a

Equipment needs (if applicable): n/a

Follow up plan: The patient will just follow up I with her primary doctor for a checkup.

Education needs: The patient will need to be educated on the signs of cardiac events specific for her age.

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 • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for electrolyte imbalance related to secondary diagnosis of hypokalemia as evidenced by potassium levels being 3.3.	Correcting the patient potassium level is a priority because it can lead to a cardiac arrhythmias and cardiac arrest.	1.The patient was given IV potassium on 01/30/2022. 2.The patient serum levels are being monitored to correct hypokalemia.	1. The patient potassium levels will be between 3.5 and 5.1 before she is discharged.	• The patient was surprised that her levels were low which could explain her chest pain. • The patient was compliant to the administration of potassium.
2. Risk for unstable blood	If the patient blood pressure gets	1. The patient blood pressure could have been	1. The goal is to lower her	• The patient was compliant to

pressure related to medical history of hypertension evidenced by high blood pressure readings.	too high, it can lead to heart attack, stroke or other complications.	because she was in mild pain, so we gave her Tylenol. 2.The patient blood pressure could have been high because she didn't take her blood pressure medications yet, so we gave her hydrochlorothiazide	blood pressure to at least near 120/80.	the interventions that help her lower her blood pressure. • The patient blood pressure was lowered when I check it again.
3. Impaired comfort related to history of arthritis as evidenced by pain level being at a level 4.	I choose this nursing diagnosis because pain causes distress and suffering to the patient.	1. The patient was given Tylenol to help with pain. 2. The patient was also offered a massage but denied it.	1. The goal is to lower patient level to zero.	• The patient felt uncomfortable getting a massage and just preferred the medication. • The patient pain level went down to 1.
4. Readiness for enhanced health literacy related to the patient wanted to learn more evidenced by being alert and oriented time 4.	I choose this nursing diagnosis because education is key to recognizing the signs of cardiac events in elder people.	1. I talk out loud with the client to educate her on how signs and systems can be different for elder patients. 2. I also provided her with pamphlet for her to take home and read as well.	1. The goal was to help the patient better understand the signs and symptoms of cardiac events.	• The patient really appreciated the talk we had, and she learned so much. • The patient was no more educated on this topic.

Other References (APA):

Concept Map (20 Points):

Subjective Data

"I originally thought it was indigestion pain, but it would not go away"
"The pain started in my chest and went to my shoulder, and it was very consistent".

Nursing Diagnosis/Outcomes

Risk for electrolyte imbalance related to secondary diagnosis of hypokalemia as evidenced by potassium levels being 3.3.
The patient potassium levels will be between 3.5 and 5.1 before she is discharged.
Risk for unstable blood pressure related to medical history of hypertension evidenced by high blood pressure readings.
The goal is to lower her blood pressure to at least near 120/80.
Impaired comfort related to history of arthritis as evidenced by pain level being at a level 4.
The goal is to lower patient level to zero.
Readiness for enhanced health literacy related to the patient wanted to learn more evidenced by being alert and oriented time.
. I also provided her with pamphlet for her to take home and read as well.

Objective Data

The patient potassium levels were 3.2.
The patient stress test came out to be normal and her cardiac labs.

Client Information

The patient is a 73 year old female who was admitted to the hospital on 01/30/2022, due to having chest pain. The patient has a history of Arthritis, Chronic obstructive pulmonary disease, Hyperlipidemia, and hypertension.

Nursing Interventions

The patient was given IV potassium on 01/30/2022.
The patient serum levels are being monitored to correct hypokalemia
The patient blood pressure could have been because she was n mild pain, so we gave her Tylenol.
The patient blood pressure could have been high because she idn't take her blood pressure medications yet, so we gave her ydrochlorothiazide.
talk out loud with the client to educate her on how signs and systems can be different for elder patients.
I also provided her with pamphlet for her to take home and read as well.