

N321 Care Plan #1

Lakeview College of Nursing

Alyssa Brooks

Demographics (3 points)

Date of Admission 3-17-2020	Client Initials R.O.	Age 54 years old	Gender Male
Race/Ethnicity Caucasian	Occupation Gas Station Attendant	Marital Status Divorced	Allergies Penicillin
Code Status Full	Height Five feet ten inches	Weight 220 pounds	

Medical History (5 Points)

Past Medical History: Hypertension, hypercholesterolemia, obesity (BMI: 31.6)

Past Surgical History: Appendectomy (2007)

Family History:

Mother: diabetes

Father: myocardial infarction, status post stent placement

Sister: obesity

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

Smokes one pack a day for thirty years, Client states he drinks "A few beers on the weekends."

Client denies history of drug use.

Assistive Devices: N/A

Living Situation: Lives at home alone.

Education Level: High school diploma with no other education noted.

Admission Assessment

Chief Complaint (2 points): Substernal chest pain and nausea.

History of Present Illness – OLD CARTS (10 points): The client is a 54-year-old male who presents to the Emergency Department for substernal chest pain and nausea for the past hour. An electrocardiogram was performed upon arrival. The electrocardiogram indicates an ST-elevation.

The client was taken to the cardiac catheterization lab where his right coronary artery had a ninety-five percent blockage. A stent was placed by Dr. Whapham, and he was admitted to the cardiac unit at the hospital.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): The client's primary diagnosis is ST elevation myocardial infarction.

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): A myocardial infarction is another word for heart attack. A myocardial infarction is a blockage of blood flow to the heart muscle where those cells start to die. A ST elevation myocardial infarction is called a STEMI. A STEMI often means there is a total blockage of one of the heart's main supply arteries (Cleveland clinic, 2021). Some causes of a STEMI include coronary artery disease, blood clots, and coronary artery spasm (Mayo Foundation for Medical Education and Research, 2021). Risk factors for a STEMI can include tobacco use, diabetes, hypertension, hypercholesterolemia, elevated triglycerides, obesity. Increased waist circumference, and a lack of physical activity (Mayo Foundation for Medical Education and Research, 2021). Signs and symptoms of a STEMI are different for men and women. Men typically have symptoms including chest pain, shortness of breath, heart palpitations, sweating, dizziness, anxiety, or nausea (Cleveland clinic, 2021). Women show symptoms of insomnia, fatigue, shortness of breath, pain that radiates to their back, shoulders, or jaw, and nausea (Cleveland clinic, 2021). An electrocardiogram, echocardiography, and blood tests are the best ways to understand if a STEMI occurred (Cleveland clinic, 2021). The electrocardiogram looks at the heart's electrical system to detect if there is a ST elevation. An echocardiography uses sound waves to create an image of a client's heart to see how the blood is

flowing throughout the heart (Cleveland clinic, 2021). Blood test can reveal cardiac enzymes such as CKMB, CK, and troponin. All of these cardiac enzymes can reveal if there is heart damage. Troponin is the best indicator for heart damage as it is the most accurate. The treatment for a STEMI is time sensitive and must happen as fast as possible to avoid further damage of the heart. One treatment option that the client did partake in is a cardiac catheterization. During this procedure, a stent was placed in the artery that had a blockage. This blockage was causing ischemia and causing the heart muscle to die due to lack of oxygen. The stent placement opened up the artery to allow more blood flow. Medications that can treat a STEMI include beta blockers that can relax the heart muscle, calcium channel blockers that relax and widen the blood vessels (Mayo Foundation for Medical Education and Research, 2021). Daily aspirin can reduce the risk of blood clots forming (Mayo Foundation for Medical Education and Research, 2021). Angiotensin converting enzyme inhibitors may be prescribed to lower blood pressure and decrease the workload of the heart (Mayo Foundation for Medical Education and Research, 2021). The patient is at an increased risk for a STEMI because of the risk factors of tobacco use, hypertension, hypercholesterolemia, and obesity. The patient has the symptoms of substernal chest pain and nausea which can be associated with STEMI symptoms. The patient had an electrocardiogram to diagnose the STEMI. The patient was treated with cardiac catheterization with a stent placement in the right coronary artery.

Pathophysiology References (2) (APA):

Cleveland Clinic. (2021). *What is a stemi heart attack?* Cleveland Clinic. Retrieved February 25, 2022, from <https://my.clevelandclinic.org/health/diseases/22068-stemi-heart-attack#symptoms-and-causes>

Mayo Foundation for Medical Education and Research. (2021, May 5). *Myocardial ischemia*.

Mayo Clinic. Retrieved February 25, 2022, from <https://www.mayoclinic.org/diseases-conditions/myocardial-ischemia/diagnosis-treatment/drc-20375422>

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.0-5.8 x10 ⁶ /mcL	N/A	N/A	
Hgb	12.0-15.8g/dL	13.1 g/dL	N/A	
Hct	36.0-47.0%	N/A	N/A	
Platelets	140-440 K/mcL	N/A	N/A	
WBC	4.0-12.0 K/mcL	6.3 K/mcL	N/A	
Neutrophils	40-60%	N/A	N/A	
Lymphocytes	19-49%	N/A	N/A	
Monocytes	3.0-13.0%	N/A	N/A	
Eosinophils	0.0-8.0%	N/A	N/A	
Bands	0.0-10.0%	N/A	N/A	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145 mmol/L	135 mmol/ L	N/A	

K+	3.5-5 mmol/L	3.6 mmol/L	N/A	
Cl-	98-107 mmol/L	N/A	N/A	
CO2	21-31 mmol/L	N/A	N/A	
Glucose	70-99 mg/dL	171	N/A	An elevated glucose level can result from the substernal chest pain. The stress of a myocardial infarction can cause elevated glucose levels. A BMI of 31.6 can contribute to the elevated glucose levels (Writers, 2021).
BUN	7-25 mg/dL	10	N/A	
Creatinine	0.50-1.20 mg/dL	1.53	N/A	A myocardial infarction can cause creatinine levels to increase due to the reduced blood flow to the kidneys (Writers, 2021).
Albumin	3.5-5.7 g/dL	N/A	N/A	
Calcium	8.6-10.3 mg/dL	N/A	N/A	
Mag	1.6-2.6 mg/dL	N/A	N/A	
Phosphate	2.4-4.5 units/L	N/A	N/A	
Bilirubin	0.3-1.0 mg/dL	N/A	N/A	
Alk Phos	34-104 units/L	N/A	N/A	
AST	5-30 U/L	N/A	N/A	
ALT	5-30 U/L	N/A	N/A	
Amylase	30-125 U/L	N/A	N/A	
Lipase	10-150 U/L	N/A	N/A	
Lactic Acid	4.5-19.8 mg/dL	N/A	N/A	

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.9-1.2	N/A	N/A	
PT	11-14 sec	N/A	N/A	
PTT	20-40 sec	N/A	N/A	
D-Dimer	< 500 ng/mL	N/A	N/A	
BNP	< 100 pg/mL	N/A	N/A	
HDL	40-80 mg/dL	N/A	N/A	
LDL	85-125 mg/dL	N/A	N/A	
Cholesterol	3-5.5 mmol/L	N/A	N/A	
Triglycerides	50-150 mg/dL	N/A	N/A	
Hgb A1c	4%-6%	N/A	N/A	
TSH	0.5-5 mIU/L	N/A	N/A	
Troponin	0-0.4 ng/mL	0.98 ng/mL	N/A	Troponin levels are elevated when there is heart damage after a myocardial infarction (Writers 2021).
CKMB	0-4 ng/mL	42 ng/mL	N/A	CKMB levels are elevated three to ten hours after myocardial damage. The client had a myocardial infarction that caused the CKMB levels to be elevated (Writers, 2021).

Urinalysis **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	yellow, clear	N/A	N/A	

pH	5.0-9.0	N/A	N/A	
Specific Gravity	1.003-1.013	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0.0-0.5	N/A	N/A	
RBC	0.0-3.0	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	N/A	N/A	
Blood Culture	negative	N/A	N/A	
Sputum Culture	negative	N/A	N/A	
Stool Culture	negative	N/A	N/A	

Lab Correlations Reference (1) (APA):

Writers, R. N. S. (2021, July 28). *Laboratory values: NCLEX-RN*. RegisteredNursing.org.

Retrieved October 18, 2021, from <https://www.registerednursing.org/nclex/laboratory-values/>.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

The client received a chest x-radiation related to the chief complaint of substernal chest pain. The chest x-radiation indicated negative for any acute abnormalities. The cardiac silhouette is within

normal limits. The client received an electrocardiogram due to the chief complaint of substernal chest pain. The electrocardiogram revealed sinus tachycardia with ST elevation in I, II, and AVF leads. The client had a cardiac catheterization where one stent was placed in the right coronary artery. The blood flow resumed as noted by a fluoroscopy.

Diagnostic Test Correlation (5 points): The chest x-radiation correlated to the client's chief complaint of substernal chest pain. The electrocardiogram is used to detect the presence of ST elevation during a myocardial infarction (Akbar et al., 2021). The cardiac catheterization was indicated from the ST elevation of the electrocardiogram.

Diagnostic Test Reference (1) (APA):

Akbar, H., Mountfort, S., Foth, C., & Kahloon, R. (2021, August 9). *Acute ST elevation myocardial infarction*. StatPearls [Internet]. Retrieved February 25, 2022, from <https://www.ncbi.nlm.nih.gov/books/NBK532281/>

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

Home Medications (5 required)

Brand/Generic	Zestril/lisinopril	Lipitor/atorvastatin	N/A	N/A	N/A
Dose	10mg	20mg	N/A	N/A	N/A
Frequency	Twice a day	Once daily	N/A	N/A	N/A
Route	By mouth	By mouth	N/A	N/A	N/A
Classification	Pharmacologic: angiotensin- converting enzyme inhibitor Therapeutic: Antihypertensive (Jones & Bartlett, 2020).	Pharmacologic: HMG CoA reductase inhibitor Therapeutic: Antihyperlipidemia (Jones & Bartlett, 2020).	N/A	N/A	N/A
Mechanism of Action	Inhibits the conversion of angiotensin I to angiotensin II resulting in a reduced blood pressure (Jones & Bartlett, 2020).	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG CoA reductase and cholesterol synthesis in the liver by increasing the number of LDL receptors on liver cells (Jones & Bartlett, 2020).	N/A	N/A	N/A
Reason Client Taking	Hypertension	hypercholesterolemia	N/A	N/A	N/A
Contraindications (2)	Concurrent aliskiren use in patients with diabetes and angioedema related to previous treatment with an ACE inhibitor (Jones & Bartlett,	Unexplained persistent rise in serum transaminase and active hepatic disease (Jones & Bartlett, 2020).	N/A	N/A	N/A

	2020).				
Side Effects/Adverse Reactions (2)	Dry cough and acute renal failure (Jones & Bartlett, 2020).	Hepatic failure and thrombocytopenia (Jones & Bartlett, 2020).	N/A	N/A	N/A
Nursing Considerations (2)	Do not give after a client has a myocardial infarction and monitor blood pressure often (Jones & Bartlett, 2020).	Know that atorvastatin may be used with colestipol or cholestyramine (Jones & Bartlett, 2020). Expect to be used in patients without obvious coronary artery disease (Jones & Bartlett, 2020).	N/A	N/A	N/A

Hospital Medications (5 required)

Brand/Generic	Heparin Sodium Injection/ heparin	Nitro-Bid/ nitroglycerin	Zofran/ ondansetron	Tylenol/ acetaminophen	Kadian/ morphine
Dose	5,000 units	0.4 mg	4mg	650 mg	1 mg
Frequency	Twice a day	PRN	Every six hours	Every six hours PRN	Every two hours
Route	subcutaneously	sublingual	sublingual	By mouth	Intravenously
Classification	Pharmacological and therapeutic: Anticoagulant (Jones & Bartlett, 2020).	Pharmacological: nitrate Therapeutic: vasodilator (Jones & Bartlett, 2020).	Pharmacological: selective serotonin receptor antagonist Therapeutic: antiemetic (Jones & Bartlett, 2020).	Pharmacological: nonsalicylate, para-aminophenol derivative Therapeutic: antipyretic, nonopioid analgesic (Jones & Bartlett, 2020).	Pharmacological: Opioid Therapeutic: Opioid analgesic (Jones & Bartlett, 2020).
Mechanism of Action	Binds with antithrombin III, enhancing antithrombin III's inactivation of the coagulation enzymes thrombin and factors Xa and Xia (Jones & Bartlett, 2020).	Reduces to cGMP causing vasodilation. Vasodilation reduced the myocardial workload and oxygen demand (Jones & Bartlett, 2020).	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at the vagal nerve (Jones & Bartlett, 2020).	Blocks prostaglandin production and interfering with pain impulse (Jones & Bartlett, 2020).	Binds with and activates opioid receptors to produce analgesia and euphoria (Jones & Bartlett, 2020).
Reason Client	Prevent blood clots	Chest pain	nausea	Pain/fever	Severe pain

Taking					
Contraindications (2)	History of heparin-induced thrombocytopenia and a hypersensitivity to pork (Jones & Bartlett, 2020).	Acute myocardial infarction and cerebral edema (Jones & Bartlett, 2020).	Concomitant use of apomorphine and a hypersensitivity to ondansetron (Jones & Bartlett, 2020).	Severe hepatic impairment and severe active liver disease (Jones & Bartlett, 2020).	Acute or severe bronchial asthma and gastrointestinal obstruction (Jones & Bartlett, 2020).
Side Effects/Adverse Reactions (2)	Hemorrhage and thrombosis (Jones & Bartlett, 2020).	Arrhythmias and hypotension (Jones & Bartlett, 2020).	Serotonin syndrome and prolonged QT interval (Jones & Bartlett, 2020).	Hypokalemia and hepatotoxicity (Jones & Bartlett, 2020).	Constipation and bradycardia (Jones & Bartlett, 2020).
Nursing Considerations (2)	Use heparin cautiously in women that are menstruating (Jones & Bartlett, 2020). Alternate injection sites (Jones & Bartlett, 2020).	Store premixed containers in the dark and teach the patients the signs and symptoms of angina (Jones & Bartlett, 2020).	Monitor the patient for decreased bowel activity and monitor the patient's electrocardiogram (Jones & Bartlett, 2020).	Monitor renal function and monitor the end of a parenteral infusion to prevent possible air embolism (Jones & Bartlett, 2020).	Use cautiously with those who may be at risk for carbon dioxide retention (Jones & Bartlett, 2020). Monitor circulatory and respiratory status (Jones & Bartlett, 2020).

Medications Reference (1) (APA):

Jones & Bartlett. (2020). *Nurse's Drug Handbook* (12th ed.). Jones & Bartlett Learning.

Assessment

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

<p>GENERAL: Alertness: Alert Orientation: oriented times four Distress: not distressed Overall appearance: well groomed</p>	<p>The client is alert and oriented times four and does not show any signs of distressed. The client is well groomed.</p>
<p>INTEGUMENTARY: Skin color: appropriate for ethnicity Character: dry, intact Temperature: warm Turgor: elastic Rashes: N/A Bruises: N/A Wounds: left femoral Braden Score: N/A Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A</p>	<p>The client’s skin appropriate for ethnicity, pink, warm, dry, and intact. The clients skin turgor is elastic with no rashes, bruises noted. The client has a left femoral wound from a cardiac catheterization. The site has gauze and tegaderm in place. No bleeding is noted, and the dressing is clean, dry, and intact. The Braden score was not identified. No drains are present.</p>
<p>HEENT: Head/Neck: normocephalic, neck supple, no masses noted Ears: symmetrical, no signs of drainage Eyes: pupils are equal and reactive to light, PERLA, and EOM intact Nose: nares patent with no signs of deviated septum Teeth: gums are pink and moist, teeth show no signs of carries, no masses or lesions noted.</p>	<p>The client’s head is normocephalic, the neck is supple, and no masses noted. The ears are symmetrical with no signs of drainage present. The pupils are equal and reactive to light. PERLA and EOM intact. The nares are patent with no signs of deviated septum. He gums are pink, moist, and intact. The teeth show no signs of dental carries. No masses or lesions noted.</p>
<p>CARDIOVASCULAR: Heart sounds: auscultated, no murmurs present S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): S1, S2, S4 present Peripheral Pulses: radial +2 Capillary refill: less than 3 seconds Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema: N/A</p>	<p>The heart sounds auscultated with no murmurs present. S1, S2, and S4 heart sound present. +2 radial pulses noted bilaterally. The capillary refill less than three seconds noted in all extremities. No signs of neck vein distention or edema.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character Anterior and posterior auscultated clear and</p>	<p>The client showed no signs of accessory muscle being used. Anterior and posterior breath sounds auscultated clear and equal bilaterally.</p>

<p>equal bilaterally</p>	
<p>GASTROINTESTINAL: Diet at home: regular Current Diet: regular Height: five foot ten inches Weight: 220 pounds Auscultation Bowel sounds: active in all four quadrants Last BM: N/A Palpation: Pain, Mass etc.: Soft, nontender, no masses noted Inspection: Distention: N/A Incisions: N/A Scars: N/A Drains: N/A Wounds: N/A Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: N/A Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A</p>	<p>The client's diet at home and the current diet is regular. The client is five foot ten inches and weighs 220 pounds. The client has active bowel sounds in all four quadrants and the last bowel movement has not been noted. The client's abdomen is soft and nontender with no masses noted. There are no signs of distention, incisions, scars, or wounds in the abdominal area. No ostomy is present. Nasogastric tube is not present. No feeding or PEG tubes are present.</p>
<p>GENITOURINARY: Color: pale yellow Character: clear Quantity of urine: N/A Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: clean, dry, intact Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: N/A Size: N/A</p>	<p>The client's urine is pale yellow and clear. The quantity of urine is not noted. The client reports no pain with urination. The client is not receiving dialysis. The genitalia are clean, dry, and intact. No catheter is present.</p>
<p>MUSCULOSKELETAL: Neurovascular status: intact ROM: Active and passive intact Supportive devices: N/A Strength: 5/5 in all extremities ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: N/A Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>The neurovascular status is intact. The range of motion is intact active and passively. The client does not use supportive devices and has strength 5/5 in all extremities. The client does not need activities of daily living assistance and is not a fall risk. The fall score is not noted, and the client is independent.</p>

<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: times four Mental Status: Alert Speech: Clear Sensory: N/A LOC: N/A</p>	<p>The client can move all extremities well and PERLA is intact. The strength is equal in arms and legs. The client is alert and oriented times four. The client’s speech is clear with no sensory or LOC.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): N/A Developmental level: High school diploma, no other education noted Religion & what it means to pt.: N/A Personal/Family Data (Think about home environment, family structure, and available family support): client lives at home alone</p>	<p>The client did not express any coping methods. The client has a high school diploma with no other schooling noted. The client does not partake in any religion. The client lives at home alone.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	76 beats per minute	162/76 mmHg	16 breaths per minute	37 °C	98% room air
1100	69 beats per minute	124/64 mmHg	18 breaths per minute	36.9 °C	97% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	Catheterization site	4/10	Generalized	Tylenol administered
1100	Numeric	All over	1/10	Generalized	No intervention at this time

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	18G
Location of IV:	Right antecubital, left antecubital
Date on IV:	3-16-20
Patency of IV:	No complications
Signs of erythema, drainage, etc.:	No complications
IV dressing assessment:	Patient's dressing is clean/dry/intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
920 mL	800 mL

Nursing Care**Summary of Care (2 points)**

Overview of care: No discharge needs or case management concerns at this time. Patient will be discharged home with new medication orders including Aspirin 81 mg daily by mouth. The client is being referred to Dr. Nallamotheu for cardiology services. The client will make an appointment for 1 week from the day of discharge.

Procedures/testing done: The client received a chest x-radiation, electrocardiogram, and a cardiac catheterization on 3-17-20.

Complaints/Issues: The client's chief complaint is substernal chest pain and nausea.

Vital signs (stable/unstable): The client's vital signs revealed a high blood pressure that became stable after Tylenol administration.

Tolerating diet, activity, etc.: The client is tolerating diet well.

Physician notifications: Cardiac Catheterization Note, one stent placed in the right coronary artery (RCA), blood flow resumed to RCA as noted under fluoroscopy, patient tolerated procedure well, 50 mcq Fentanyl, 2.5 mg Versed given during procedure.

Future plans for client: Monitor vital signs, monitor for signs of bleeding, educate patient on bleeding precautions. The client needs additional education regarding the importance of taking this medication related to the stent placement. The client needs to be educated on starting a low-fat diet and smoking cessation.

Discharge Planning (2 points)

Discharge location: The client will be discharged at home.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: The client is being referred to Dr. Nallamotheu for cardia services one week from the day of discharge.

Education needs: The client needs to be educated on the importance of taking at home medications in relation to his stent placement. The client needs educations for starting a low-fat diet and smoking cessation.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components • Listed in order by 	<p>Rationale</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Interventions (2 per dx)</p>	<p>Outcome Goal (1 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client
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<p>priority – highest priority to lowest priority pertinent to this client</p>				<p>response, status of goals and outcomes, modifications to plan.</p>
<p>1. Decreased cardiac output related to myocardial infarction as evidenced by electrocardiogram changes (Phelps, 2020).</p>	<p>This diagnosis was chosen because the client had a right coronary artery occlusion</p>	<p>1. Monitor at least every 2-4 hours for dyspnea (Phelps, 2020). 2. Monitor for irregularities in heart rate, rhythm, and blood pressure (Phelps, 2020).</p>	<p>1. Patient does not exhibit arrhythmia during monitoring or physical assessment during the shift (Phelps, 2020).</p>	<p>Goal met. Client does not report any signs of dyspnea. Client was relieved to be monitored often. Goal partially met. The clients heart rate and rhythm were within normal limits. The clients blood pressure was elevated but went to normal limits after medication intervention. Client was relieved to be monitored often.</p>
<p>2. Risk for bleeding related to treatment regimen as evidenced by anticoagulation therapy (Phelps, 2020).</p>	<p>The client is receiving heparin which is anticoagulation medication.</p>	<p>1. Monitor the patient for bleeding (Phelps, 2020). 2. Examine surgical wounds for signs of bleeding (Phelps, 2020).</p>	<p>1. Patient will experience no bleeding episodes during the shift (Phelps, 2020).</p>	<p>Goal met. Client was frequently monitored for signs of bleeding. Client was relieved to be monitored often. Goal met. Client’s surgical wounds were checked for signs of bleeding several times during shift. Client was relieved to show</p>

				no signs of bleeding.
3. Risk for metabolic imbalance syndrome related to obesity as evidenced by an elevated BMI (Phelps, 2020).	The client has a BMI of 31.6.	1. Discuss the need for weight loss with the client (Phelps, 2020). 2. Evaluate nutritional status and refer to a registered dietitian if needed (Phelps, 2020).	1. Patient walks for 30 minutes a day (Phelps, 2020).	Goal met. The client understood the need for weight loss. Goal met. The client discussed nutritional status with the nurse.

Other References (APA):

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points)

Subjective Data

Client complains of substernal chest pain and nausea. Smokes one pack a day for thirty years, Client states he drinks “A few beers on the weekends”. Client denies history of drug use. Pain at 0700 rated a 4/10 on the numeric pain scale. Characterized by Generalized pain. Pain at 1100 characterized a general pain reported a 1/10 on the numeric pain scale.

Nursing Diagnosis/Outcomes

Decreased cardiac output related to myocardial infarction as evidenced by electrocardiogram changes (Phelps, 2020). Outcome: Patient does not exhibit arrhythmia during monitoring or physical assessment during the shift (Phelps, 2020).
Risk for bleeding related to treatment regimen as evidenced by anticoagulation therapy (Phelps, 2020). Outcome: Patient will experience no bleeding episodes during the shift (Phelps, 2020).
Risk for metabolic imbalance syndrome related to obesity as evidenced by an elevated BMI (Phelps, 2020). Outcome: Patient walks for 30 minutes a day.

Objective Data

Blood pressure: 162/76, Troponin:0.98 ng/mL, CKMB: 42 ng/mL, Glucose: 171 mg/dL, Creatinine: 1.53 mg/dL, Client has a left femoral wound from cardiac catheterization. S4 sounds are heard upon auscultation.
The client received a chest x-radiation related to the chief complaint of substernal chest pain. The chest x-radiation indicated negative for any acute abnormalities. The cardiac silhouette is within normal limits. The client received an electrocardiogram due to the chief complaint of substernal chest pain. The electrocardiogram revealed sinus tachycardia with ST elevation in I, II, and AVF leads. The client had a cardiac catheterization where one stent was placed in the right coronary artery. The blood flow resumed as noted by a fluoroscopy.

Client Information

The client is a 54-year-old male who presents to the Emergency Department for substernal chest pain and nausea for the past hour. The client has a past medical history of Hypertension, hypercholesterolemia, obesity. The client has a past surgical history of an Appendectomy in 2007. Family history includes mother: diabetes, father: MI s/p stent placement, sister: obesity. The Social history includes 1 pack per day smoker for 30 years, states he drinks “a few beers on the weekends”. No known drug use. The client lives at home alone with an education level of a high school diploma.

Nursing Interventions

- 1. Monitor the patient for bleeding (Phelps, 2020).
- 2. Examine surgical wounds for signs of bleeding (Phelps, 2020).
- 1. Monitor at least every 2-4 hours for dyspnea (Phelps, 2020).
- 2. Monitor for irregularities in heart rate, rhythm, and blood pressure (Phelps, 2020).
- 1. Discuss the need for weight loss with the client (Phelps, 2020).
- 2. Evaluate nutritional status and refer to a registered dietitian if needed (Phelps, 2020).



