

N321 Care Plan #2

Lakeview College of Nursing

Riley Doran

Demographics (3 points)

Date of Admission 3-17-20	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 Code	Height 5'10"	Weight 220 lbs/100kg	

Medical History (5 Points)

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

Past Surgical History: Appendectomy (2007)

Family History: Mother- diabetes Father- MI, stent placement, Sister- obesity

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

Tobacco, 30 years, 1 pack/day

Alcohol, "a few beers on the weekends"

Assistive Devices: None

Living Situation: At home alone

Education Level: High school diploma, no other education noted

Admission Assessment

Chief Complaint (2 points): substernal chest pain and nausea

History of Present Illness – OLD CARTS (10 points):

The patient is a 54-year-old male who presented to the Emergency Department for substernal chest pain and nausea for 1 hour. An EKG was performed to reveal ST-elevation I, I, II, and AVF. He was taken to the cardiac cath lab where his right coronary artery was noted to have a 95% 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): ST-elevation myocardial infarction

Secondary Diagnosis (if applicable): N/A

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

Acute coronary syndrome is an emergent situation characterized by an acute onset of myocardial ischemia that results in myocardial death (Sorenson, 2018). During an MI, plaque ruptures and thrombus formation results in an occlusion of an artery which leads to ischemia and necrosis of the myocardium (Sorenson, 2018). To further identify an MI, various descriptions are used, including the location on injury and the point of time within the process (Sorenson, 2018).

Clinical manifestations of a myocardial infarction include chest pain, shortness of breath, indigestion, nausea, and anxiety (Hinkle, 2018). Chest pain that occurs suddenly and continues with no alleviating factors is an indication of MI. Cool and pale skin can indicate insufficient oxygenated blood flow. Patients can also present with an increased heart rate and respiratory rate (Hinkle, 2018). These symptoms correlate with our own patient because the patient's chief complaint was substernal chest pain and nausea.

Cardiac enzymes and biomarkers, including troponin, creatine kinase and myoglobin are used to diagnose myocardial infarction (Hinkle, 2018). The protein found in myocardial cells known as troponin regulates the myocardial contractile process and can be detected anywhere from within a few hours up to two weeks post myocardial infarction (Hinkle, 2018). Creatine kinase (CK) is divided into three isoenzymes, CK-MB regarding the heart muscle and is an indicator of myocardial infarction that peaks within 24 hours. Myoglobin is a protein found in the cardiac and skeletal muscle that helps transport oxygen and peaks within 12 hours after the onset

of symptoms (Hinkle, 2018). A 12-lead electrocardiogram provides information that assists in diagnosing an acute MI and should be obtained within a 10 minute window of reporting pain or arriving to the emergency department (Hinkle, 2018). Myocardial injury causes ST segment changes on an EKG tracing. Monitoring multiple EKG changes overtime can indicate the location, evolution and resolution of an MI (Hinkle, 2018). An echocardiogram is used to evaluate ventricular function and may be used to diagnose a MI if the EKG is nondiagnostic (Hinkle, 2018).

The goal of medical management for a myocardial infarction is to minimize myocardial damage, preserve myocardial function and prevent further complications (Hinkle, 2018). Suspected MI patients should receive supplemental oxygen, aspirin, nitroglycerin and morphine to reduce pain and anxiety (Hinkle, 2018). Increasing oxygen supply and reducing oxygen demand is achieved with medications, oxygen administration and bedrest. Reducing pain will also reduce the patient's preload and afterload, overall decreasing the work of the heart. Beta blockers can be administered if dysrhythmias occur.

The patient's lab results showed an elevated troponin level, elevated creatine kinase (CK-MB) and decreased hemoglobin. These labs indicate a myocardial infarction because these proteins and enzymes are present when damage to the myocardial cells occurs. Without the evidence found in the lab results, the patient's chief complaint of nausea and substernal chest pain indicate a possible myocardial infarction. The patient's history of smoking also puts him at further risk.

Pathophysiology References (2) (APA):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-surgical Nursing*. Wolters Kluwer.

Sorenson, M., Quinn, L., & Klein, D. (2018). *Pathophysiology: Concepts of Human Disease* (1st ed.). Pearson.

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	F: 4.5-5 M: 4.5-6	N/A	N/A	N/A
Hgb	F: 12-15 M: 14-16	13.1	N/A	Related to patient's inbalance of oxygen supply and demand of the myocardium (Van & Mickey Lynn Bladh, 2017).
Hct	F: 42-52 M: 35-47	N/A	N/A	N/A
Platelets	150,000-400,00	N/A	N/A	N/A
WBC	4,500-11,000	6.3	N/A	N/A
Neutrophils	45-75%	N/A	N/A	N/A
Lymphocytes	20-40%	N/A	N/A	N/A
Monocytes	1-10%	N/A	N/A	N/A
Eosinophils	<7%	N/A	N/A	N/A
Bands	<1%	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-	135-145	135	N/A	N/A

K+	3.5-5.0	3.6	N/A	N/A
Cl-	97-107	N/A	N/A	N/A
CO2	20-30	N/A	N/A	N/A
Glucose	70-110	171	N/A	Elevated glucose level due to patient's insufficient fluid intake due to patient's nausea or infection (Van & Mickey Lynn Bladh, 2017)
BUN	10-20	10	N/A	N/A
Creatinine	0.7-1.4	1.53	N/A	Elevated creatinine signifies possible impaired kidney function.
Albumin	3.5-5	N/A	N/A	N/A
Calcium	8.6-10.2	N/A	N/A	N/A
Mag	1.3-2.1	N/A	N/A	N/A
Phosphate	2.5-4.5	N/A	N/A	N/A
Bilirubin	0.3-1	N/A	N/A	N/A
Alk Phos	30-120	N/A	N/A	N/A
AST	0-35	N/A	N/A	N/A
ALT	4-36	N/A	N/A	N/A
Amylase	30-220	N/A	N/A	N/A
Lipase	0-160	N/A	N/A	N/A
Lactic Acid	0.5-1	N/A	N/A	N/A
Troponin	0-0.04	0.98	N/A	Elevated troponin indicates injury to the myocardial. Increase can be detected within a few hours of acute MI (Hinkle, 2018).
CK-MB	5-25	42	N/A	Elevated CK-MB indicates acute MI. This lab peaks within 24 hours

				of an infarct (Hinkle, 2018).
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	0.8-1.1	N/A	N/A	N/A
PT	11-12.5	N/A	N/A	N/A
PTT	30-40	N/A	N/A	N/A
D-Dimer	<0.4	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A
HDL	>60	N/A	N/A	N/A
LDL	<130	N/A	N/A	N/A
Cholesterol	<200	N/A	N/A	N/A
Triglycerides	<150	N/A	N/A	N/A
Hgb A1c	4-5.9%	N/A	N/A	N/A
TSH	0.4-4.0	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	Yellow and Clear	N/A	N/A	N/A
pH	5.0-8.0	N/A	N/A	N/A
Specific Gravity	1.005-1.035	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	<5	N/A	N/A	N/A
RBC	0-3	N/A	N/A	N/A
Leukoesterase	Negative	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):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-surgical Nursing*. Wolters Kluwer.

Van, A. M., & Mickey Lynn Bladh. (2017). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implications*. F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-ray – negative for any acute abnormalities. Cardiac silhouette within norm limits

EKG- ST with ST-elevation in I,II, and AVF leads

Cardiac Catheterization- 1 stent placed in the right coronary artery (RCA), blood flow resumed to RCA, patient tolerated procedure well, given 50mcg Fentanyl and 2.5mg Versed during procedure

Diagnostic Test Correlation (5 points):

A chest x-ray was performed for the patient's initial complaint of substernal chest pain. Chest radiography, commonly called chest x-ray, is one of the most frequently performed diagnostic imaging studies. This study yields information about the pulmonary, cardiac, and skeletal systems. The lungs are easily penetrated by x-rays and appear black on chest images. A routine chest x-ray includes a posteroanterior projection, in which x-rays pass from the posterior to the anterior, and a left lateral projection. (Van & Mickey Lynn Bladh, 2017) The patient's chest x-ray was negative for any acute abnormalities and the cardiac silhouette is within normal limits.

An EKG was performed due to the patient's underlying diastolic congestive heart failure. An EKG is used to evaluate the electrical impulses generated by the heart during the cardiac cycle to assist with diagnosis of cardiac dysrhythmias, blocks, damage, infection, or enlargement. (Van & Mickey Lynn Bladh, 2017) The EKG shows ST with ST-elevation in I, II, and AVF leads.

Cardiac catheterization is a common invasive procedure used to diagnose structural and functional diseases of the heart (Hinkle, 2018). Revascularization treatment decisions come from the findings of cardiac catheterization. The procedure involves the percutaneous insertion of radiopaque catheters into a large vein and an artery, fluoroscopy is used to guide the advancement of the catheters through the right and left heart (Hinkle, 2018). During this procedure, 1 stent was placed in the right coronary artery. Blood flow resumed to the right

coronary artery as noted under fluoroscopy. Patient was given 50mcg Fentanyl and 2.5 mg Versed during the procedure and overall tolerated the procedure well.

Diagnostic Test Reference (1) (APA):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth’s Textbook of Medical-surgical Nursing*. Wolters Kluwer.

Van, A. M., & Mickey Lynn Bladh. (2017). *Davis’s comprehensive handbook of laboratory & diagnostic tests with nursing implications*. F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Lisinopril (Zestril)	Atorvastatin (Lipitor)	N/A	N/A	N/A
Dose	10mg	20mg	N/A	N/A	N/A
Frequency	BID	Daily	N/A	N/A	N/A
Route	PO	PO	N/A	N/A	N/A
Classification	Therapeutic: antihypertensive Pharm: ACE inhibitor	Therapeutic: lipid-lowering agent Pharm: HMG-CoA reductase inhibitor	N/A	N/A	N/A
Mechanism of Action	Blocks the conversion of angiotensin I to the vasoconstrictor angiotensin II	Inhibits HMG-CoA reductase from synthesizing cholesterol	N/A	N/A	N/A
Reason Client Taking	Hypertension	Hypercholesterolemia	N/A	N/A	N/A

Contraindications (2)	-history of angioedema -moderate to severe renal impairment	-active liver disease or unexplained elevations in AST and ALT - Alcoholism	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	-dizziness -hypotension	-rhabdomyolysis (life threatening) -heartburn	N/A	N/A	N/A
Nursing Considerations (2)	-excessive hypotension can occur with concurrent use of diuretics -NSAIDS may reduce hypertensive effect	-may slightly increase digoxin levels -may increase the effects of warfarin	N/A	N/A	N/A

Hospital Medications (5 required)

Brand/Generic	Aspirin (Bayer)	Heparin (Hep-Lock)	Nitroglycerin (Nitrostat)	Ondansetron (Zofran)	Acetaminophen (Tylenol)
Dose	81mg	5,000 units	0.4mg	4mg	650mg
Frequency	Daily	BID	PRN	PRN	Q6H, PRN
Route	PO	SubQ	ODT	ODT	PO
Classification	Therapeutic: antiplatelet, antipyretic Pharm: Salicylates, NSAIDS	Therapeutic: anticoagulant Pharm: antithrombotics	Therapeutic : antianginals Pharm: Nitrates	Therapeutic: antiemetic Pharm: 5-HT3 antagonists	Nonopioid analgesic

Mechanism of Action	Decreases platelet aggregation and reduction in inflammation	Prevents the conversion of prothrombin to thrombin by its effects on factor Xa. Prevents thrombus formation.	Increases coronary blood flow by dilating coronary arteries and improving collateral flow to ischemic regions.	Blocks the effects of serotonin at 5-HT ₃ receptor sites (decreased incidence and severity of nausea and vomiting)	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 E ₂ .
Reason Client Taking	Prophylaxis of transient ischemia	DVT prevention	Chest pain	Nausea	Pain management
Contraindications (2)	-thrombocytopenia -hypersensitivity to salicylates	-uncontrolled bleeding -spinal cord or brain injury	- increased intracranial pressure -pericardial tamponade	-congenital long QT syndrome -hypersensitivity	-severe hepatic impairment - severe active liver disease
Side Effects/Adverse Reactions (2)	-GI bleeding -tinnitus	-heparin induced thrombocytopenia -anemia	-hypotension -headache	-torsades de pointes -serotonin syndrome	Abdominal pain, anaphylaxis, and hypoglycemic coma.
Nursing Considerations (2)	-increased risk of bleeding with heparin -increased	-increased risk of bleeding with concurrent use of	-severe hypotension with concurrent use of ACE	-risk of severe hypotension and loss of consciousness	Use acetaminophen cautiously in patients with hepatic

	risk of GI irritation with NSAIDS	thrombolytics -decreased anticoagulant effect when used with digoxin, tetracycline, nicotine and antihistamines	inhibitors - decreased absorption when taken with anticholinergic medications	s when used with apomorphine - increased risk of serotonin syndrome when taking SSRIs, SNRIs or tramadol	impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment. Monitor renal function in patient on long term therapy.
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Medications Reference (1) (APA):

Davis’s Drug Guide Online + App | DrugGuide.com. (2022). Davis Drug Guide.

<https://www.drugguide.com/ddo/view/Davis-Drug-Guide>

Jones & Bartlett Learning. (2018). *2018 Nurse’s drug handbook* (17th ed.). Jones & Bartlett Learning.

Assessment

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

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>A&O x4 Patient alert and oriented to person, place, time and situation No acute distress Overall appearance slightly disheveled, hair messy, but hygiene good</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature:</p>	<p>Skin pink, warm and dry. Cardiac catheterization insertion site left femoral. Site has gauze and tegaderm in place. No bleeding noted. Dressing is clean, dry, and intact. Patient has a temperature</p>

<p>Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>of 36.9 degrees Celsius. Patients skin turgor is elastic. Patient has a rash or wounds indicated. Patient has a Braden score of 16. No drains present.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head is normophiliac. Trachea is midline. Eyes are equal, round, reactive and accommodate to light. Nose is midline, shows no signs of polyps. Oral mucosa is pink and moist. Patient does not have dentures or glasses/contacts.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: 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:</p>	<p>Patient's heart sounds are normal. S1 and S2 noted, no gallops or murmur noted. Pedal pulses were 2+ bilaterally. Capillary refill less than 3 seconds. No edema. Patient's EKG showing ST-elevation I, II and AVF.</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Lung sounds clear and equal bilaterally. No use of accessory muscles noted</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Patient's current diet is a low fat, heart healthy diet. Patient's diet at home is normal. Patient is 5'10" and weighs 220lbs. Bowel sounds were active and present in all 4 quadrants. Patients last bowel movement was today. There are no signs of distention, incisions, scars, drains, or wounds. Patient has no ostomy or feeding tubes.</p>

<p>Type:</p>	
<p>GENITOURINARY: Color: Character: Quantity of urine: 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: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Patient’s urine is clear and yellow with no odor. Patient has voided 800mL. There is no pain upon urination. The patient is not on dialysis. Patient’s genitals show no signs of irritation. No catheter in place.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Patient has no decrease in sensation. Does not report any numbness. Full ROM. Currently on bedrest with turns. Moderate fall risk. Fall risk score of 10. Prior to bedrest up by independently. No supportive devices used at home.</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 type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient A&O x 4 Denies numbness or tingling Able to move all extremities equally Pupils equal, round, react and accommodate light. Equal strength in all limbs. Speech is clear. No sensory impairment. No cognitive impairment.</p>
<p>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):</p>	<p>Patient’s family not active in care. Expected development level achieved. Baptist. Has 2 children. Divorced. Gas station attendant. Lives at home alone.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
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0700	76	163/76	16	37.0	98%
1100	69	124/63	18	36.9	97%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	Catheterization insertion site	4/10	At insertion site	Tylenol administered
1100	Numeric	Generalized pain	1/10	Generalized pain	No interventions

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	18G left antecubital 3/16/20 18G right antecubital 3/16/20 No complications, dressing clean, dry, and intact Normal saline 125mL/hr infusing without difficulty

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Water- 300 mL	Urine- 800mL
Orange Juice- 120 mL	
Normal Saline – 500 mL	
Total: 920 mL	Total: 800 mL

Nursing Care

Summary of Care (2 points)

Overview of care: Patient admitted 3/17/20 for substernal chest pain and nausea.

Diagnosed with ST-elevation myocardial infarction

Procedures/testing done: patient had labs drawn, chest x-ray, EKG and cardiac catheterization performed

Complaints/Issues: Patient complaining of nausea and substernal chest pain upon admission

Vital signs (stable/unstable): stable, first set of vitals showed an elevated blood pressure, second set showed a blood pressure reading within normal range.

Tolerating diet, activity, etc.: Tolerating diet, limited activity

Physician notifications: Physician monitoring the patient

Future plans for client: Plans to discharge home and schedule a follow up with Dr. Nallamotheu for cardiology services

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): Education on new medication orders and stent placement prior to discharge

Equipment needs (if applicable): N/A

Follow up plan: Follow up appointment 1 week from the day of discharge with Dr. Nallamotheu

Education needs: 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 priority – highest priority to lowest priority pertinent to this client 	<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 response, status of goals and outcomes, modifications to plan.
<p>1. Acute pain related to increased myocardial oxygen demand and decreased myocardial oxygen supply as evidenced by chest pain (Hinkle, 2018).</p>	<p>This nursing diagnosis was chosen because it relates to the patient’s chief complaint for chest pain.</p>	<p>1. Administration of supplemental oxygen</p> <p>2. Elevate patient’s head of bed to 30 degrees</p>	<p>1. Decreased in chest discomfort and increase in oxygen saturation levels</p>	<p>The client responded well to these actions, chest discomfort decreased, no modifications needed.</p>
<p>2. Risk for ineffective peripheral tissue perfusion related to decreased cardiac output as evidenced by</p>	<p>This nursing diagnosis was chosen because it relates to the patient’s laboratory findings</p>	<p>1. Assess and document hypotension, tachycardia and/or dysrhythmias or changes in activity tolerance</p> <p>2. Report cool,</p>	<p>1. Maintain adequate tissue perfusion</p>	<p>The client responded well to these actions, no noted changes in patient’s tissue perfusion, no modifications needed.</p>

<p>patient’s laboratory findings indicative of a myocardial infarction (Hinkle, 2018)</p>		<p>moist, cyanotic extremities, decreased peripheral pulses or prolonged capillary refill</p>		
<p>3. Anxiety related to cardiac event as evidenced by the patient being admitted to the hospital’s cardiac unit (Hinkle, 2018).</p>	<p>This nursing diagnoses was chosen because the patient is being admitted to the cardiac unit and monitoring patient psychological well-being is a factor of all around patient care</p>	<p>1. Assess and document the patient’s level of anxiety and coping mechanisms 2 Assess for need for social service referral or spiritual counseling</p>	<p>1. Reduction of anxiety/ possible anxiety related to the treatment plan</p>	<p>The client responded well to these actions, no reports of increased anxiety, no modifications needed.</p>

Other References (APA):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth’s Textbook of Medical-surgical Nursing*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

1. Acute pain related to increased myocardial oxygen demand and decreased myocardial oxygen supply as evidenced by chest pain (Hinkle, 2018).
 The client responded well to these actions, chest discomfort decreased, no modifications needed.
2. Risk for ineffective peripheral tissue perfusion related to decreased cardiac output as evidenced by patient's laboratory findings indicative of a myocardial infarction (Hinkle, 2018)
 The client responded well to these actions, no noted changes in patient's tissue perfusion, no modifications needed.
3. Anxiety related to cardiac event as evidenced by the patient being admitted to the hospital's cardiac unit (Hinkle, 2018).
 The client responded well to these actions, no reports of increased anxiety, no modifications needed.

Objective Data

Client Information

Nursing Interventions

1. Administration of supplemental oxygen
2. Elevate patient's head of bed to 30 degrees
1. Assess and document hypotension, tachycardia and/or dysrhythmias, or changes in activity tolerance
2. Report cool, moist, cyanotic extremities, decreased peripheral pulses or prolonged capillary refill
1. Assess and document the patient's level of anxiety and coping mechanisms
2. Assess for need for social service referral or spiritual counseling



