

**N311 Care Plan 4**

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Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Merriweather

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### Demographics

<b>Date of Admission</b> 10/01/2025	<b>Client Initials</b> T.M	<b>Age</b> 58	<b>Biological Gender</b> Male
<b>Race/Ethnicity</b> White	<b>Occupation</b> On Disability Leave	<b>Marital Status</b> Divorced	<b>Allergies</b> Fluoxetine
<b>Code Status</b> Full (no ACP docs)	<b>Height</b> 5'7" (170.2 cm)	<b>Weight</b> 74.3 kg (163 lb. 12.8oz)	

### Medical History

**Past Medical History:** Patient has a medical history of a Heart Attack and Seizures.

**Past Surgical History:** Patient has had 2 Cardiac Clean-outs and a Bypass.

**Family History:** Patient is unaware of his family's medical history because he was adopted.

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

Patient has never smoked, does not drink, and no history of doing drugs.

**Education:** Patient's highest level of education was junior year of college.

**Living Situation:** Patient lives in a house with his children.

**Assistive devices:** Patient does not use any assistive devices.

### Admission Assessment

**Chief Complaint:** Shortness of breath

**History of Present Illness (HPI) – OLD CARTS:**

Patient's symptoms of shortness of breath started two days ago, and he decided to check himself into the ER. His shortness of breath leads to him experiencing chest pain that is in his upper chest with pain gravitating more towards the left side. The pain typically only lasts around a day and a half. What makes the pain worse is when he has to sit straight-up, to relieve the pain laying down flat makes the pain more tolerable. To treat his symptoms the doctors have tried

giving him medications, and keeping him comfortable lying flat most of the day. When asked to rate his pain on a scale from 1 – 10, he rated it a 1.

**Primary Diagnosis**

**Primary Diagnosis on Admission:** Chest pain/shortness of breath

**Secondary Diagnosis (if applicable):**

## Pathophysiology

### Pathophysiology of the Disease, APA format:

“Classic cardiac chest pain is a crushing sensation felt on the left side of the chest, radiating into the left shoulder down the left arm.” (Capriotti and Frizzell 2016). Cardiac chest pain commonly is also described as feeling as though something is sitting on the chest; a heavy feeling weighing the chest down. Chest pain can also gravitate into the epigastric region, right arm, back, or up to the jaw. (Capriotti and Frizzell 2016).

According to Capriotti and Frizzell, “Chest pain most commonly occurs with exertion and is accompanied by dyspnea, diaphoresis, and pallor.”. Dyspnea is defined as the sensation of shortness of breath, and is also a symptom commonly of cardiovascular or pulmonary disease. The patient was also showing signs of orthopnea. Orthopnea is shortness of breath when lying flat (which is a good signal of heart failure as well). Diaphoresis in a simple term means excessive sweating. The sweating normally is more of a “cold sweat”, which is due to the body having reduce blood flow. (Capriotti and Frizzell 2016). Pallor is pale skin, which can be resulted due to anemia or in this case reduced blood flow.

The patient also had previously suffered from a heart attack (myocardial infarction, MI). A heart attack happens when myocardial ischemia (not enough blood flow and oxygen getting to the heart), is prolonged. (Capriotti and Frizzell 2016). In the patient’s vital signs, the systolic number in their blood pressure reading was abnormally high. The systolic number represents how hard the heart is contracting/beating to pump the blood out.

To diagnose MI, an ECG is performed; although alone it cannot confirm the MI, blood tests are a necessary step to solidify the MI as well. In this patient’s case there is no reason for

the ECG and blood test since, the heart attack did happen and he showed all the symptoms of a heart attack.

Lastly, although a heart attack does not necessarily cause chest pain or shortness of breath it is obvious after reading to know that his reasoning for coming into the hospital was due to his previous medical history of a heart attack and the seizures that followed.

### **Pathophysiology References (2) (APA):**

Capriotti, T., & Frizzell, J. P. (2016a). *Pathophysiology: Introductory concepts and clinical perspectives* (3rd ed.). F.A. Davis Company.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's Diagnostic & Laboratory Test Reference* (17th ed.). Elsevier.

### **Laboratory/Diagnostic Data**

<b>Lab Name</b>	<b>Admission Value</b>	<b>Today's Value</b>	<b>Normal Range</b>	<b>Reasons for Abnormal</b>
CBC with Diff (WBC)	13.66 10(3)/mcL	10.82 10(3)/mcL	4.00 – 12.00 10(3)/mcL	Could be due to Heparin, or chest pain
Immature Granulocyte	0.5 %	0.5 %	0.0 – 0.4 %	The pulmonary edema
Absolute Neutrophils	8.19 10(3)/mcL	8.45 10(3)/mcL	1.40 – 5.30 10(3)/mcL	Ischemia

Absolute Lymphocytes	3.31 10(3)/mcL	1.21 10(3)/mcL	0.90 – 3.30 10(3)/mcL	Chest pain
Absolute Monocytes	1.49 10(3)/mcL	1.01 10(3)/mcL	0.10 – 0.90 10(3)/mcL	Tissue repair
Absolute Eosinophil	0.56 10(3)/mcL	0.09 10(3)/mcL	0.00 – 0.50 10(3)/mcL	New medications
Absolute Immature	0.07 10(3)/mcL	0.05 10(3)/mcL	0.00 – 0.03 10(3)/mcL	Tissue damage
CMP (Sodium)	129 mmol/L	131 mmol/L	136 – 145 mmol/L	Heart failure
CMP (Potassium)	3.4 mmol/L	3.7 mmol/L	3.5 – 5.1 mmol/L	Certain medications
CMP (Chloride)	94 mmol/L	98 mmol/L	98 – 107 mmol/L	Certain medications
CMP (Glucose)	103 mmol/L	111 mmol/L	70 – 99 mmol/L	Acute chest pain
CMP (BUN)	7 mmol/L	6 mmol/L	8 – 26 mmol/L	Malnutrition
CMP (BUN/Creatine Ratio)	8 ratio	8 ratio	12 – 20 ratio	Low protein intake
UR CANNABINOID	Detected	Detected	Non-detected	Cannabinoid

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
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Chest X-Ray	Chest pain with difficulty breathing	Pulmonary Edema
CT Angio Chest w/wo Contrast with Post Processing	Pulmonary Embolism suspected	Negative CTA of chest for pulmonary embolism, interstitial edema with trace bilateral pleura effusions. Subtle patchy ground glass opacities at upper lobes likely of similar etiology. 4 cm ectasia of the ascending thoracis aorta.
Adult CV Stress Pharmacologic w/NUC MED		*Reason for not being allowed to eat after 10/03 midnight
NM Card Multi Spect with Wall Motion and Ejection Fraction		*Reason for not being allowed to eat after 10/03 midnight

**Diagnostic Test Reference (1) (APA):**

### **Current Medications**

<b>Brand/ Generic</b>	Aspirin EC tablet	Atorvastatin (Lipitor) tablet	Carvedilol (COREG) tablet	Clonazepam (Klonopin) tablet	Ezetimibe (ZETIA) tablet
<b>Dosage, Route, Frequency given</b>	81 mg, oral, daily	80 mg, oral, daily	6.25 mg, oral, daily	1 mg, oral, nightly	10 mg, oral, nightly
<b>Reason Client Taking</b>	Manage chest pain, prevent blood clot formation	Secondary heart attack prevention, lowers LDL cholesterol	Reduce heart workload	Sleep helper	Reduce MI risk
Tamsulosin (FLOMAX) capsule	Gabapentinin (NEURONTIN ) capsule	Heparin (Porcine) injection	Losartan (COZAAC ) tablet	Oxcarbazepin (TRILEPTAL ) tablet	Pantoprazole (PROTONIX ) tablet
0.4 mg, oral, daily	400 mg, oral, 3x daily (every 8 hrs.)	5,000 units, subcutaneous , 3x daily (every 8 hrs.)	100 mg, oral, daily	300 mg, oral, 2x daily	40 mg, oral, every morning before breakfast
Used for urinary reasoning	Seizure control	Prevent blood clot	Protects heart after a heart attack	Seizure control	Managing acid reflux

### Assessment

**Physical Exam – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS**

General, Psychosocial/Cultural, and TWO focused assessment specific to the client is required.

The student and instructor may complete these assessments together.

<p><b>GENERAL:</b></p> <p><b>Alertness:</b> Alert</p> <p><b>Orientation:</b> Orientated</p> <p><b>Distress:</b> No signs</p> <p><b>Overall appearance:</b> Well groomed</p>	<p>Patient is A&amp;O x4 well groomed, no signs of distress.</p>
<p><b>INTEGUMENTARY:</b></p> <p><b>Skin color:</b></p> <p><b>Character:</b></p> <p><b>Temperature:</b></p> <p><b>Turgor:</b></p> <p><b>Rashes:</b></p> <p><b>Bruises:</b></p> <p><b>Wounds:</b> .</p> <p><b>Braden Score:</b></p> <p><b>Drains present:</b> Y <input type="checkbox"/>      N <input type="checkbox"/></p> <p><b>Type:</b></p>	
<p><b>HEENT:</b></p> <p><b>Head/Neck:</b></p> <p><b>Ears:</b></p> <p><b>Eyes:</b></p> <p><b>Nose:</b></p> <p><b>Teeth:</b></p>	
<p><b>CARDIOVASCULAR:</b></p> <p><b>Heart sounds:</b> Normal</p> <p><b>S1, S2, S3, S4, murmur etc.</b> Normal</p>	<p>Heart sounds were normal and steady. All pulses were palpable. Capillary refill was less than 3 seconds, and no edema was detected.</p>

<p><b>Cardiac rhythm (if applicable):</b> Normal</p> <p><b>Peripheral Pulses:</b> All palpable (31x2)</p> <p><b>Capillary refill:</b> &lt; 3 seconds</p> <p><b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> <b>Edema</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Location of Edema:</b></p> <p>No edema</p>	
<p><b>RESPIRATORY:</b></p> <p><b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p><b>Breath Sounds: Location, character</b></p>	.
<p><b>GASTROINTESTINAL:</b></p> <p><b>Diet at home:</b></p> <p><b>Current Diet</b></p> <p><b>Height:</b></p> <p><b>Weight:</b></p> <p><b>Auscultation Bowel sounds:</b></p> <p><b>Last BM:</b></p> <p><b>Palpation: Pain, Mass etc.:</b></p> <p><b>Inspection:</b></p> <p><b>Distention:</b></p> <p><b>Incisions:</b></p> <p><b>Scars:</b></p> <p><b>Drains:</b></p> <p><b>Wounds:</b></p> <p><b>Ostomy:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Nasogastric:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Size:</b></p> <p><b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Type:</b></p>	.

<p><b>GENITOURINARY:</b></p> <p><b>Color:</b></p> <p><b>Character:</b></p> <p><b>Quantity of urine:</b></p> <p><b>Pain with urination:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Dialysis:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Inspection of genitals:</b></p> <p><b>Catheter:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Type:</b></p> <p><b>Size:</b></p>	
<p><b>MUSCULOSKELETAL:</b></p> <p><b>Neurovascular status:</b></p> <p><b>ROM:</b></p> <p><b>Supportive devices:</b></p> <p><b>Strength:</b></p> <p><b>ADL Assistance:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Risk:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Score:</b></p> <p><b>Activity/Mobility Status:</b></p> <p><b>Independent (up ad lib)</b> <input type="checkbox"/></p> <p><b>Needs assistance with equipment</b> <input type="checkbox"/></p> <p><b>Needs support to stand and walk</b> <input type="checkbox"/></p>	.
<p><b>NEUROLOGICAL:</b></p> <p><b>MAEW:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>PERLA:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Strength Equal:</b> Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/></p> <p>Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p><b>Orientation:</b></p>	.

<b>Mental Status:</b> <b>Speech:</b> <b>Sensory:</b> <b>LOC:</b>	
<b>PSYCHOSOCIAL/CULTURAL:</b> <b>Coping method(s):</b> <b>Developmental level:</b> <b>Religion &amp; what it means to pt.:</b> <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b>	

**Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1:13pm	66 bpm	178/76	20	97.4 F	94% on room air

**Pain Assessment, 1 set**

Time	Scale	Location	Severity	Characteristics	Interventions
1:20 pm	1 out of 10	Upper chest	Not severe	Tight and heavy	Gave patient a fan and sat him up-right

**Intake and Output**

Intake (in mL)	Output (in mL)
120 mL	725 mL

Diet type 10/02: Cardiac general. Diet type 10/03: NPO after midnight

**Nursing Diagnosis**  
**\*Must be NANDA approved nursing diagnosis\***

<p style="text-align: center;"><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> <li>• Listed in order by priority – highest priority to lowest priority pertinent to this client</li> </ul>	<p style="text-align: center;"><b>Rationale</b></p> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<p style="text-align: center;"><b>Interventions (2 per dx)</b></p>	<p style="text-align: center;"><b>Outcome Goal (1 per dx)</b></p>	<p style="text-align: center;"><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• How did the client/family respond to the nurse’s actions?               <ul style="list-style-type: none"> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul> </li> </ul>
<p>1. Ineffective breathing pattern related to admitting diagnosis of shortness of breath as evidenced by patient not being able to lay flat</p>	<p>The chest X-Ray’s showed the pulmonary edema</p>	<p>1. Food restriction 2. Elevating head of bed</p>	<p>1. Lifestyle change</p>	<p>Patient verbalized importance of healthy lifestyle changes</p>
<p>2. Risk for bleeding related to Heparin use</p>	<p>He takes 3x a day Heparin so it puts him at a high risk for bleeding</p>	<p>1. Make him possibly a fall risk 2. Educate him on importance of signs and</p>	<p>1. Stable Hemoglobin</p>	<p>Patient verbalized importance of monitoring hemoglobin and being on fall risk precaution</p>

		symptoms of bleeding		
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**Other References (APA):**

Phelps, L. L. (2023). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.



