N321 Care Plan #1

Lakeview College of Nursing

Lindsey Platt

Demographics (3 points)

Date of Admission 09/14/2019	Patient Initials JS	Age 75	Gender Female
Race/Ethnicity white	Occupation Retired	Marital Status Married	Allergies Ampicillin, azithromycin, Bactrim, cefdinir, celeBREX, codeine, guaiFENesin, HYDROcodone, Keflex, nitrofuranation, traMADol
Code Status Full	Height 157 cm	Weight 70.5 kg	

Medical History (5 Points)

Past Medical History: HTN, hyperlipidemia, constipation, right flank pain, urinary incontinence, atropic vaginitis

Past Surgical History: hysterectomy in 1985, colonoscopy in 2012

Family History: Grandmothers on both sides has heart disease, mother had uterine cancer, brother had colon cancer, aunt had hypertension

Social History (tobacco/alcohol/drugs): denies any use

Assistive Devices: glasses

Living Situation: lives at home with her spouse

Education Level: some college

Admission Assessment

Chief Complaint (2 points): Chest pain radiating down neck and left arm

History of present Illness (10 points): Patient is a 75 year old female with a history of HTN and hyperlipidemia who presented to the ER via ambulance complaining of chest pain. She claims

that it lasted awhile before getting better. She states she got up to go to the bathroom in the middle of the night and fell to her knees because of the pain. She has had multiple EKGs and stress tests while in the hospital and waiting for discharge.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute chest pain

Secondary Diagnosis (if applicable):.HTN, hyperlipidemia, right flank pain

Pathophysiology of the Disease, APA format (20 points): Hypertension occurs when cardiac output and peripheral vascular resistance are altered. Most commonly, endothelial changes of peripheral arterioles cause restriction of blood flow, raising arterial pressure. Risk factors include age, heredity, ethnicity (incidence is higher in African Americans), renal disease, obesity, hyperlipidemia, smoking, and some endocrine disorders (e.g., Cushing's disease, thyroid disease, primary aldosteronism, pheochromocytoma). Complications of hypertension include increased incidence of transient ischemic attack/stroke, retinopathy, cardiovascular disease, heart failure, aortic aneurysm, and renal failure. Prehypertension: SBP 120-139 mm Hg or DBP 80-89 mm Hg. Hypertension stage 1: SBP 140-159 mm Hg or DBP 90-99 mm Hg. Stage 2: SBP 160 mm Hg or greater or DBP 100 mm Hg or greater. Treatment goals of hypertension in persons 60 yr of age and older is to achieve blood pressure of less than 150/90. In persons less than 60 yr of age, or those with chronic kidney disease or diabetes, the treatment goal is less than 140/90. Patients with severe hypertension may require acute hospitalization.

Pathophysiology References (2) (APA):

Swearingen, P. L. (2018). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Place of publication not identified: MOSBY.

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	**4.0-5.2**	**4.01**	**N/A**	
Hgb	**F:12-15 M: 14-16**	**12.1**	**N/A**	
Hct	**F:42-52**	**36.1**	**N/A**	**She could have internal bleeding or**

	M:35-47			**an enlarged spleen from the fall**
Platelets	**140-440**	**244**	**N/A**	
WBC	**4.0-11.0**	**7.6**	**N/A**	
Neutrophils	**45-75%**	**49.3**	**N/A**	
Lymphocytes	**20-40%**	**39.8**	**N/A**	
Monocytes	**4-6%**	**8.0**	**N/A**	**She has a blood disorder (HTN)**
Eosinophils	**<7%**	**2.2**	**N/A**	
Bands	**<3%**	**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**	**139**	**N/A**	
K+	**3.5-5.0**	**3.9**	**N/A**	
Cl-	**98-107**	**107**	**N/A**	
CO2	**35-45**	**25**	**N/A**	**She has kidney stones**
Glucose	**70-100**	**96**	**N/A**	
BUN	**6-20**	**14**	**N/A**	
Creatinine	**0.6-1.3**	**0.81**	**N/A**	
Albumin	**3.4-5.4**	**3.8**	**N/A**	
Calcium	**8.5-10.5**	**N/A**	**8.9**	
Mag	**1.7-3.4**	**N/A**	**N/A**	
Phosphate	**2.5-4.5**	**N/A**	**N/A**	

Bilirubin	**<1.5**	**N/A**	**0.3**	
Alk Phos	**20-140**	**85**	**N/A**	
AST	**10-30**	**16**	**N/A**	
ALT	**10-40**	**15**	**N/A**	
Amylase	**23-85**	**N/A**	**N/A**	
Lipase	**60-160**	**N/A**	**N/A**	
Lactic Acid	**0.5-1**	**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	**0.86-1.16**	**N/A**	**N/A**	
PT	**11.9-14.9**	**N/A**	**N/A**	
PTT	**60-70 secs**	**N/A**	**N/A**	
D-Dimer	**<250**	**N/A**	**N/A**	
BNP	**<450 if under the age of 75 <125 if under the age of 74**	**N/A**	**N/A**	
HDL	**>60**	**N/A**	**58**	
LDL	**<130**	**N/A**	**122**	
Cholesterol	**<200**	**N/A**	**196**	
Triglycerides	**<150**	**N/A**	**83**	
Hgb A1c	**<7-8%**	**N/A**	**N/A**	

TSH	**0.4-4.0**	**N/A**	**N/A**	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow and clear**	**N/A**	**Clear**	
pH	**6.0**	**N/A**	**6.0**	
Specific Gravity	**1.010-1.025**	**N/A**	**1.006**	**She could have an infection**
Glucose	**0-0.8**	**N/A**	**Normal**	
Protein	**0-20**	**N/A**	**Negative**	
Ketones	**Negative**	**N/A**	**Negative**	
WBC	**4.5-11**	**N/A**	**4**	
RBC	**4**	**N/A**	**1**	**Kidney stones**
Leukoesterase	**2-5**	**N/A**	**2+**	

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		**Labs not drawn**	**Labs not drawn**	
Blood Culture		**Labs not drawn**	**Labs not drawn**	
Sputum Culture		**Labs not drawn**	**Labs not drawn**	
Stool Culture		**Labs not drawn**	**Labs not drawn**	

Lab Correlations Reference (APA):

Fareed, K. (n.d.). Urinalysis (Urine) Test: Types, Drugs, Alcohol, Results and Interpretation.

Retrieved from https://www.medicinenet.com/urinalysis/article.htm

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT of abdomen for abdominal pain. It showed 2 nonobstructing 4 mm left renal pelvis stone. Chest XR for chest pain. There were no noted abnormalities. Stress tests showed normal sinus rhythm.

Diagnostic Test Correlation (5 points): She has a history of right flank pain which is explained by the kidney stones.

Diagnostic Test Reference (APA):

Villines, Z. (n.d.). 6 causes of left and right flank pain. Retrieved from https://www.medicalnewstoday.com/articles/324592.php

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

Home Medications (5 required)

Brand/Generic	**aspirin**	**montelukast**	**Bifidobacterium-lactobacillus**	**omeprazole**	**pravastatin**
Dose	**81 mg**	**10 mg**	**1 cap**	**20 mg**	**4 mg**
Frequency	**daily**	**QPM**	**PRN**	**PRN**	**daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**antiplatelet**	**Anti-inflammatory**	**herbals**	**antiulcer**	**HMG-CoA reductase inhibitor**
Mechanism of Action	**Causes local vasodilation**	**Increase endothelial membrane permeability**	**probiotic**	**Suppresses basal and stimulated acid secretion**	**Prevents MI or stroke in patients with DM**
Reason Client Taking	**Pain relief**	**Exercise induced bronchoconstriction (EIB)**	**She only takes this if she is on an antibiotic**	**heartburn**	**hyperlipidemia**
Contraindications (2)	**Active bleeding**	**Pregnancy, behavioral changes**	**None**	**Other proton pump**	**Hepatotoxicity, myopathy**

	(PUD) or asthma			**inhibitors, substitiutued benzimidazoles**	
Side Effects/Adverse Reactions (2)	**GI irritation and confusion**	**Aggression, muscle cramps**	**None**	**Headache, Abdominal pain**	**Rhabdomyolysis, headache**
Nursing Considerations (2)	**Prevent bleeding**	**Not for acute asthma attacks, watch for suicidal tendencies**	**Helps people with IBS and also supports vaginal health**	**Give before meals in the morning, if needed, mix with yogurt or applesauce**	**To be take with evening meals, don't take with NSAIDS**

Hospital Medications (5 required)

Brand/Generic	**dilTAZem**	**Docusate (Colace)**	**melatonin**	**Acetaminophen (Tylenol)**	**Nitroglycerin (Nitro)**
Dose	**120 mg**	**100 mg**	**1.5 mg**	**650 mg**	**0.4 mg**
Frequency	**Daily**	**PRN**	**PRN**	**PRN**	**PRN**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**antianginal**	**laxative**	**herbal**	**analgesics**	**antianginal**
Mechanism of Action	**Controls HTN**	**Softens stool**	**Promotes sleep**	**Pain reliver**	**Decreases myocardial workload and oxygen demand**
Reason Client Taking	**Angina, HTN**	**constipation**	**insomnia**	**pain**	**Chest pain**
Contraindications (2)	**Acute MI, pulmonary edema**	**Fecal impaction, nausea/vomiting**	**Caffeine, nicotine**	**Alcohol, oral contraceptives**	**Acute MI, stroke**
Side Effects/Adverse Reactions (2)	**Headache, edema**	**Dizziness, abdominal cramps**	**Abdominal cramps, decreased alertness**	**Dizziness,**	**Headache, hypotension**

Nursing Considerations (2)	**Use cautiously in patients with renal or hepatic dysfunction, Pills must be swallowed whole**	**Assess for laxative abuse syndrome; long-term use can cause electrolyte imbalances and more**	**Do not give if you need to function**	**Long term use can lead to liver disease**	**Patient should not receive ergotamine, use cautiously in elderly patients**

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2018 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**A+Ox4** **Patient does not show emotional or respiratory distress** **Appears well-nourished**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Skin appeared pink, warm and dry** **Varicose veins on lower extremities** **Temperature was 36.8** **No rashes, bruises, or wounds** **Skin turgor was normal, capillary refill less than 3 seconds** **Braden score of 23**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head appeared normocephalic** **Normal hearing to voice** **TMs are clear bilaterally** **Patient wears glasses** **Nasal passages are clear and moist** **Stated she has some false teeth**

CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**No murmurs. Peripheral pulses were normal. Capillary refill less than 3 seconds. No evidence of edema.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Lungs clear to auscultation bilaterally**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Regular diet at home, she is now on a caffeine-free diet.** **157 cm tall, 70.5 kg** **Bowel sounds active in all four quadrants** **No pain upon palpation** **No distention, incisions, scars, drains, or wounds**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Color of urine was clear** **Output was not monitored this day** **States she has occasional incontinence**
MUSCULOSKELETAL (2 points):	**Active ROM**

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**☐	**Fall risk of 20** **She can get up and ambulate independently**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**A+Ox4** **No headache, lightheadedness, or focal weakness** **No slurred speech or sensory deficits**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Has support from husband and 3 daughters. Christian and goes to church. Highest level of education completed is some college.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	**66**	**129/57**	**18**	**36.4**	**99**
1000	**73**	**137/48**	**18**	**36.8**	**98**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

0900	**1**	**Lower back**	**low**	**ache**	**Warm blanket**
1015 (after stress test)	**8**	**Lower left side**	**severe**	**sharp**	**Told the nurse she was in pain**

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:**	IV in brachial artery on left arm date 9/14 from the ambulance. No signs of erythema or infection.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
480	**600**

Nursing Care

Summary of Care (2 points)

Overview of care: This is her third day in the hospital. I administered aspirin in the morning**.** EKG and stress tests came back normal. She is now waiting for discharge where she will be back home with her husband.

Procedures/testing done: stress test, EKG

Complaints/Issues: she had sharp left side pain after her stress test

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: patient is compliant and can walk on her own

Physician notifications: discharge

Future plans for patient: discharge in the stress test comes back with no abnormalities

Discharge Planning (2 points)

Discharge location: home

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: call physician if any problems occur

Education needs: How to manage stress

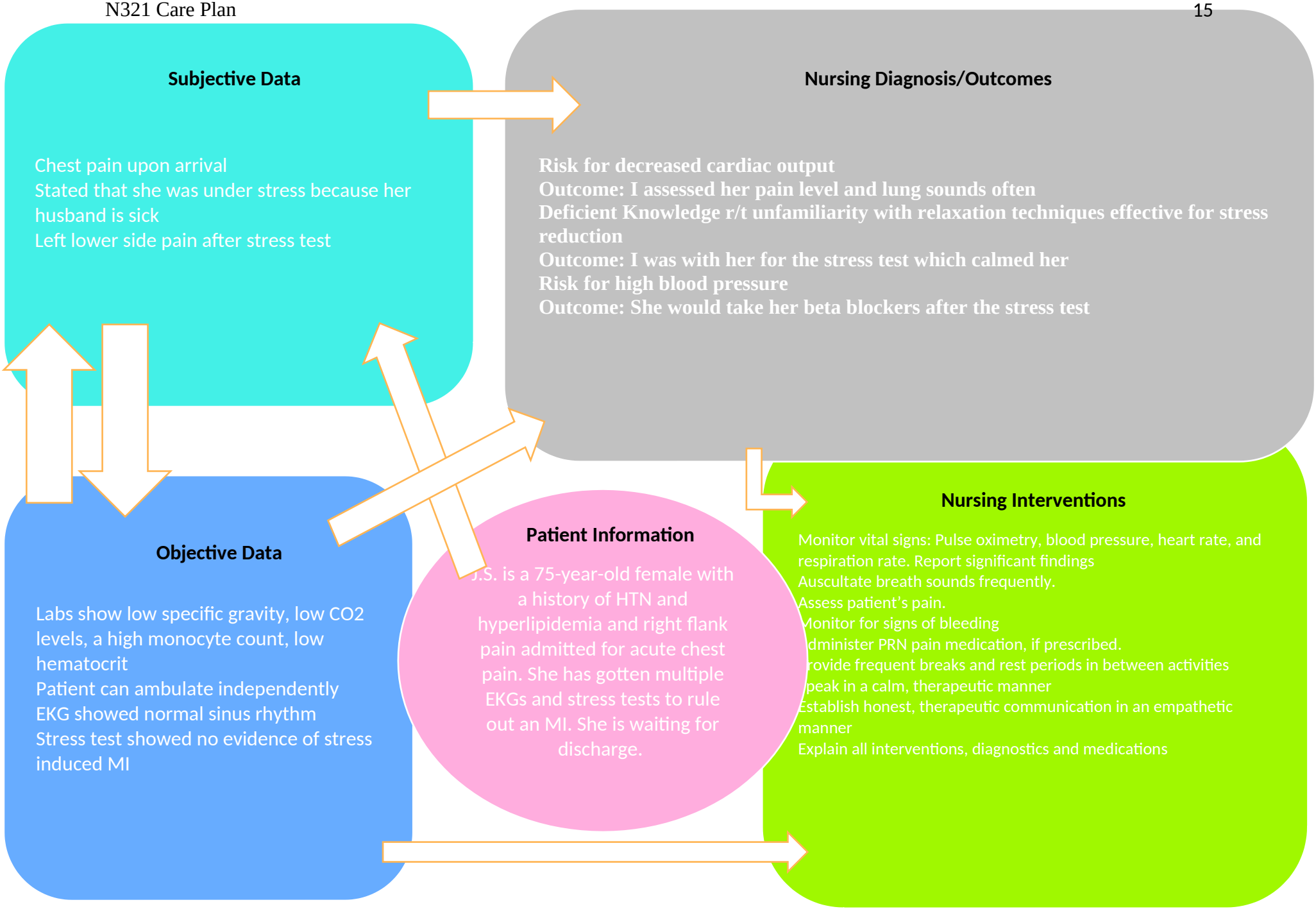
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for decreased cardiac output r/t HTN AEB acute chest pain	**HTN increases her risk for having an acute MI which could have been the reason for her admittance.**	**1. Assessed her pain level every hour** **2.Ausculted lung sounds**	**She only had a pain level of 1** **Her lung sounds showed no abnormalities**
2. Deficient Knowledge r/t unfamiliarity with relaxation techniques effective for stress reduction AEB her	**She claimed her husband was just in the hospital the week before and she was worried about him. She was also nervous before the stress test.**	**1. Helped ease her by using therapeutic communication before she went for her stress test** **2.I went with her during her stress test to ensure her if anything were to happen, I would be**	**She enjoyed having me with her and she was more relaxed going into the test.**

thinking it could have been chest pain from stress		**there. Then I brought her husband to her.**	
3. Risk for high blood pressure r/t HTN AEB holding her beta blockers	**Because she takes her blood pressure medicine every morning, we had to hold her beta blockers until after the stress test**	**1. I told the nurse she has in pain** **2. I checked he blood pressure multiple times**	**She would take an acetaminophen and her blood pressure medications when she got back to her room. Her blood pressure read 138/72 the last time I took it.**

Other References (APA):

Concept Map (20 Points)


Subjective Data
Chest pain upon arrival
Stated that she was under stress because her husband is sick
Left lower side pain after stress test
Nursing Diagnosis/Outcomes
Risk for decreased cardiac output
Outcome: I assessed her pain level and lung sounds often
Deficient Knowledge r/t unfamiliarity with relaxation techniques effective for stress reduction
Outcome: I was with her for the stress test which calmed her
Risk for high blood pressure
Outcome: She would take her beta blockers after the stress test
Objective Data
Labs show low specific gravity, low CO2 levels, a high monocyte count, low hematocrit
Patient can ambulate independently
EKG showed normal sinus rhythm
Stress test showed no evidence of stress induced MI
Patient Information
J.S. is a 75-year-old female with a history of HTN and hyperlipidemia and right flank pain admitted for acute chest pain. She has gotten multiple EKGs and stress tests to rule out an MI. She is waiting for discharge.
Nursing Interventions
Monitor vital signs: Pulse oximetry, blood pressure, heart rate, and respiration rate. Report significant findings
Auscultate breath sounds frequently.
Assess patient's pain.
Monitor for signs of bleeding
dminister PRN pain medication, if prescribed.
rovide frequent breaks and rest periods in between activities
peak in a calm, therapeutic manner
Establish honest, therapeutic communication in an empathetic manner
Explain all interventions, diagnostics and medications