N321 Care Plan #1

Lakeview College of Nursing

Alexis Wormsley

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
9/14/19	JS	75	female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Married	Bactrim, celeBREX, hydrocodone, Kefelx, ampicillin, azithromycin, cefdinir, codeine, guaiFENesin, nitrofurantoin, TramADOL.
Code Status	**Height**	**Weight**	
Full code	5”2	71.4 kg	

Medical History (5 Points)

Past Medical History: Atrophic vaginitis, chronic venous hypertension, dyslipidemia, GERD, hypertension, Lichen planopilaris, lower left extremity pain, aortic regurgitation, obesity, osteoarthritis, osteopenia, restless leg syndrome, somnoilence, urinary incontinence, venous insufficiency, varicose veins bilaterally LE, chest discomfort, chronic fatigue, environmental allergies.

Past Surgical History: Colonoscopy, mole removal, varicose vein, right wrist, left shoulder, carpal tunnel release, right shoulder, hysterectomy.

Family History: Mother: uterine cancer

Aunt: hypertension

Brother: colon cancer

Cousin: Diabetes Mellitus

Social History (tobacco/alcohol/drugs): Alcohol: denies use. Tobacco: never. Drugs: never.

Assistive Devices: None

Living Situation: Lives with spouse, independent living.

Education Level: Retired, some college.

Admission Assessment

Chief Complaint (2 points): "Chest pain"

History of present Illness (10 points): Patient is a 75 year old female who presented to the emergency department complaining of chest pain and shortness of breath. Patient said the chest pain occurred early Saturday morning 9/14/19. Patient states it was a stabbing pain on the left side of her chest. Patient has SOB associated with the chest pain. Patients husband gave her one of his nitroglycerin tablets and she felt relief. Since admitted patient had a nuclear stress test, results are still pending. Patient also had an EKG that came back normal along with a chest X-ray that came back normal. Patient will be getting discharged if nuclear stress test results come back normal.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute angina.

Secondary Diagnosis (if applicable): Hypertension.

Pathophysiology of the Disease, APA format (20 points): Angina pectoris is the squeezing pain in the chest that occurs when there is lack of blood flow to the myocardium. Unstable angina is chest pain that is occurring for the first time by a patient. Approximately 9 million people suffer from angina in the United States. The prevalence of angina rises with age. Angina is more prevalent in women than men. "The most common cause of unstable angina is due to coronary artery narrowing due to a thrombus that develops on a disrupted atherosclerotic plaque and is nonocclusive" (Goyal, Zelster, 2019, p.1). Risk factors include obesity, diabetes, hypertension, high cholesterol, smoking history, cocaine or amphetamine

use, family history, chronic kidney disease, HIV, autoimmune disorders, and anemia. Patients with unstable angina with often present with chest pain and shortness of breath. Patients might describe the pain as tightness, burning, or sharp. The pain can radiate to the jaw or both arms. Symptoms of angina include nausea, vomiting, diaphoresis, dizziness, and palpitations. Nitroglycerin and aspirin administration may improve the pain. To diagnose the patient the patient should have an EKG performed, a chest X-ray and a stress test. Patient should also have a CBC to evaluate for anemia and platelet count. Patient should also have a BMP to look for electrolyte imbalances.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. (2016). ***Pathophysiology: Introductory Concepts and Clinical Perspectives.*** **Philadelphia: PA. Davis Company.**

Goyal, A., Zelster, R. (2019). ***Unstable Angina.*** **Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK442000/.**

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	3.8-5.41	4.01	NA	
Hgb	11.3-155.2	12.1	NA	
Hct	33.2-45.3 %	36.1	NA	
Platelets	149-393	244	NA	
WBC	4.0-11.7	7.6	NA	
Neutrophils	45.3-79.0	49.3	NA	
Lymphocytes	11.8-45.9	39.8	NA	
Monocytes	4.4-12.0	8.0	NA	

Eosinophils	**0- 6.3**	**2.2**	**NA**	
Bands	**<1**	**0.8**	**NA**	

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**	**NA**	
K+	**3.5-5.0**	**3.9**	**NA**	
Cl-	**97-107**	**107**	**NA**	
CO2	**22-29**	**25**	**NA**	
Glucose	**70-99**	**100**	**NA**	
BUN	**10-20**	**14**	**NA**	
Creatinine	**0.7-1.2**	**0.81**	**NA**	
Albumin	**3.5-5.2**	**3.8**	**NA**	
Calcium	**8.6-10.4**	**8.9**	**NA**	
Mag	**1.6-2.4**	**NA**	**NA**	
Phosphate	**3.0-4.5**	**NA**	**NA**	
Bilirubin	**0-1.2**	**0.3**	**NA**	
Alk Phos	**40-130**	**85**	**NA**	
AST	**0-40**	**16**	**NA**	
ALT	**0-41**	**15**	**NA**	

Amylase	**56-90**	**NA**	**NA**	
Lipase	**0-110**	**NA**	**NA**	
Lactic Acid	**6-16**	**NA**	**NA**	

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		**NA**	**NA**	
PT		**NA**	**NA**	
PTT		**NA**	**NA**	
D-Dimer		**NA**	**NA**	
BNP		**NA**	**NA**	
HDL	**40-59**	**58**	**NA**	
LDL	**100-120**	**122**	**NA**	**Patient has a history of dyslipidemia.**
Cholesterol	**200-239**	**196**	**NA**	
Triglycerides	**<150**	**83**	**NA**	
Hgb A1c		**NA**	**NA**	
TSH		**NA**	**NA**	

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		**Clear**	**Clear**	

pH	**4.5-8.0**	**6.0**	**NA**	
Specific Gravity	**1.002-1.030**	**1.006**	**NA**	
Glucose	**negative**	**normal**	**NA**	
Protein	**negative**	**negative**	**NA**	
Ketones	**negative**	**negative**	**NA**	
WBC	**0-5**	**4**	**NA**	
RBC	**<4**	**1**	**NA**	
Leukoesterase	**negative**	**2+**	**NA**	**Can result in a patient having a UTI.**

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		**NA**	**NA**	
Blood Culture		**NA**	**NA**	
Sputum Culture		**NA**	**NA**	
Stool Culture		**NA**	**NA**	

Lab Correlations Reference (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Nuclear stress test, EKG, chest x-ray.

Diagnostic Test Correlation (5 points): Patient received a nuclear stress test, EKG, and a chest X-ray because of her diagnosis of acute angina. An EKG, stress test, and chest X-ray

are often performed in patients with angina to diagnose the cause. The EKG can show ST depression or elevation. The patient's EKG and chest X-ray came back normal. Patients nuclear stress test results are still pending.

Diagnostic Test Reference (APA):

Capriotti, T., & Frizzell, J. (2016). ***Pathophysiology: Introductory Concepts and Clinical Perspectives.*** **Philadelphia: PA. Davis Company.**

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

Home Medications (5 required)

Brand/ Generic	**Estradiol topical**	**Omeprazole**	**Pravastatin**	**Montelukast**	**Dilatiazem**
Dose	**1 g**	**20 mg**	**40 mg**	**10 mg**	**120 mg**
Frequency	**HS**	**PRN**	**HS**	**QPM**	**daily**
Route	**Vaginal**	**PO**	**PO**	**PO**	**PO**

Classification	**Estrogen derivative, antineoplastic.**	**Antiulcer**	**Antihyperlipidemic.**	**Antiallergin**	**Antianginal.**
Mechanism of Action	**Increases the rate of DNA and RNA synthesis in cells of female reproductive organs, pituitary gland, hypothalamus, and other target organs.**	**Interferes with gastric acid secretion by inhibiting the hydrogen potassium Adenosine triphosphatase enzyme system, or proton pump, in gatric parietal cells.**	**Inhibits cholesterol synthesis in liver by blocking the enzyme needed to convert HMG-CoA to mevalonate, a cholesterol precursor.**	**Works by blocking the action of leukotriene D4 in the lungs resulting in decreased inflammation and relexation of smooth muscle.**	**Blocks voltage sensitive calcium channels in blood vessels, by inhibiting the ion-control gating mechanisms.**
Reason Client Taking	**Atrophic vaginitis**	**Heartburn**	**High cholesterol**	**Allergies**	**High blood pressure**
Contraindications (2)	**Active deep vein thrombosis, pulmonary embolism.**	**Hypersensitivity to omeprazole. Hypersensitivity to proton pump inhibitors.**	**Active hepatic disease, elevated liver enzymes.**	**Depression, pregnancy.**	**Acute MI, cardiogenic shock.**
Side Effects/Adverse Reactions (2)	**Deep venous thrombosis, abdominal cramps or pain.**	**Agitation, Dizziness.**	**Anxiety, asthenia.**	**Anxiousness, abdominal pain.**	**Abnormal gait, amnesia.**
Nursing Considerations (2)	**Use cautiously in patients with asthma, chorea, diabetes, epilepsy**	**Give before meals. Know that this drug can interfere with absorption of vitamin B12.**	**Use cautiously in patients with hepatic or renal impairment. Monitor liver enzymes.**	**Know that it is not for acute asthma attacks. Monitor patients for**	**Use cautiously in patients with impaired hepatic or renal function.**

	and migraines. Administer oral preparations with food to decrease nausea.			**adverse reactions.**	**Monitor liver and renal function.**

Hospital Medications (5 required)

Brand/Generic	**Zofran**	**Acetaminophen**	**Mylanta**	**Docusate**	**Nitroglycerin**
Dose	**4 mg or 2 ml given over 5 minutes**	**650 mg**	**30 ml**	**100 mg**	**0.4 mg**
Frequency	**Every 6 hrs PRN for nausea**	**Every 6 hrs PRN for pain**	**QID**	**BID**	**Q5M**
Route	**IV push**	**PO**	**PO**	**PO**	**SL**
Classification	**Antiemetic**	**Antipyretic**	**Antiflatulence**	**Laxative**	**Antianginal**
Mechanism of Action	**Blocks serotonin receptors centrally in the chemoreceptor trigger zone and peripherally**	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain**	**Acts in the stomach and intestines to change the surface tension of gas bubbles, enabling their**	**Acts as a surfactant that softens stool by decreasing surface tension between**	**May interact with nitrate receptors in vascular smooth-muscle cell membrane**

	at vagal nerve terminals in the intestine.	**impulse generation in the peripheral nervous system.**	**breakdown and the formation of larger bubbles.**	**oil and water in the feces.**	**s.**
Reason Client Taking	**Nausea**	**Fever/ pain**	**Heart burn**	**constipation**	**Chest pain**
Contraindications (2)	**Concomitant use of apomorphine, congenital long QT syndrome.**	**Hypersensitivity to acetaminophen. Severe hepatic impairment.**	**Breast feeding, hypersensitivity to simethicone.**	**Fecal impaction, intestinal obstruction.**	**Acute MI, cerebral hemorrhage.**
Side Effects/Adverse Reactions (2)	**Agitation, arrhythmias.**	**Hypoglycemic coma, abdominal pain.**	**Allergic reaction, dizziness.**	**Dizziness, abdominal cramping.**	**Dizziness, arrhythmias.**
Nursing Considerations (2)	**Correct electrolyte imbalances before giving. Monitor patient for adverse reactions.**	**Use cautiously in patients with hepatic impairment. Monitor renal function in patient.**	**Assess for abdominal pain. Administer after meals or at bed time.**	**Assess for laxative abuse syndrome. Advise patient to take with a full glass of water.**	**Use cautiously in older patients. Place patient in sitting position when taking medication.**

Medications Reference (APA):

Jones, & Bartlett. (2017). *Nurse's Drug Handbook* (16th ed.). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Patient is awake and A&O x3 with ability to speak. Patient is orientated to place, time and name. Patient is alert and appears well nourished. Patient shows no signs of distress.**
INTEGUMENTARY (2 points): **Skin color: Fair, pink.** **Character: Warm, dry and pink.** **Temperature: 36.9 C** **Turgor: Good** **Rashes: None** **Bruises: Right upper arm** **Wounds: None** **Braden Score: 20** **Drains present: Y☐ N ☒** **Type:**	**Patient is a Caucasian female with a fair complexion. Skin is warm, dry, and pink. Good skin turgor with no abnormal textures. Patients temperature is 36.9 degrees C. Patient has no rashes or wounds present. Patient has a bruise on her right upper arm. Braden score is a 20. No drains present.**
HEENT (1 point): **Head/Neck: Symmetrical head. Full head of hair.** **Ears: No hearing aids, grey tympanic membrane.** **Eyes: No assistive eye glasses.** **Nose: Symmetrical, normal mucous membrane.** **Teeth: No dentures.**	**Head is midline with no deviations. Patient has a full head of hair. Patient can hear well. PERLA is present. Conjunctiva and sclera are normal. Nose does not have swelling and has a normal mucous membrane. Teeth are well maintained, proper oral hygiene. Oral mucosa is moist and pink.**
CARDIOVASCULAR (2 points): **Heart sounds: S1 + S2** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses: present**	**Heart sounds were clear and equal. S1 and S2 heard. No murmur of bruit auscultated. Cardiac rhythm is normal with no unusual findings during auscultation. Peripheral pulses were palpable. Capillary refill was < 3**

Capillary refill: < 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	**seconds on patient's right index finger. No presence of neck vein distention. No present edema.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Patients lung sounds were clear and equal bilaterally upon auscultation.**
GASTROINTESTINAL (2 points): **Diet at home: Normal** **Current Diet Normal** **Height: 5"2** **Weight: 71.4 kg** **Auscultation Bowel sounds: Present** **Last BM: 1:00 pm** **Palpation: Pain, Mass etc.: None** **Inspection:** **Distention: None** **Incisions: None** **Scars: None** **Drains: None** **Wounds: None** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Current diet at hospital and at home is normal. Before the patient's stress test she was on a no caffeine diet. Patients height is 5"2 and her weight is 71.4 kg. Patient's bowel sounds are active and within normal limits in all four quadrants. Patient experienced no pain upon palpation. Patient has no masses, distension, incisions, scars, drains or wounds.**
GENITOURINARY (2 Points): **Color: Clear** **Character: No cloudiness, sediment, or unusual odor.** **Quantity of urine: NA** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals: Not performed** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Patient can void normally with no pain. Patients urine was clear with no cloudiness, sediment, or unusual odor. Quantity of urine was NA. Inspection of genitals was not performed per the patients request.**
MUSCULOSKELETAL (2 points): **Neurovascular status: Able to ambulate.** **ROM: Normal** **Supportive devices: None** **Strength: Equal bilaterally on lower extremities.**	**Patient is alert and aware of surroundings. Patients ROM is normal. Patient does not use any supportive devices or ADL assistance. Patient can ambulate on her own. Patients strength was good and equal bilaterally on her lower extremities. Patients fall score is a 10.**

ADL Assistance: Y☐ N ☒ **Fall Risk: Y ☐ N☒** **Fall Score: 10** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Patient can get out of bed with no assistance needed.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation: A&O X3** **Mental Status: Normal for age.** **Speech: Clear.** **Sensory: Sensory responses are normal.** **LOC: Alert.**	**Patient is alert and awake. Patient is A&O X3 to place, name, and time. Patient can move all extremities well. Patients PERLA is standard. Patients strength is equal bilaterally in lower extremities. Patients mental status is normal for her age. Patients speech is clear. Patients sensory's are intact. Patient is conscious and alert.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s): Talking to husband.** **Developmental level: Normal for age.** **Religion & what it means to pt.: Christian.** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient is married and living independently with her husband. Patients coping methods include talking to her husband about her problems. Patient's developmental level is normal for her age. Patient is a Christian. Patient stated that she feels safe at home and is supported by her husband and kids.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:23 am	**73**	**137/148**	**16**	**36.8 C**	**98%**
2:00 pm	**68**	**115/50**	**17**	**36.9 C**	**95%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
12:30 pm	**0-10**	**Abdominal**	**2/10**	**Dull**	**No interventions needed, patient states it is a tolerable pain.**
2:00 pm	**0-10**	**Abdominal**	**2/10**	**Dull**	**No**

					interventions needed, patient states it is a tolerable pain.

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: 20 gauge **Location of IV: peripheral AC** **Date on IV: 9/16/19, 10:31 am** **Patency of IV: dry, intact, flushes easily.** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: good**	None

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
No intake recorded	**No output recorded**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient has been receiving care since 9/14/19. Patient came in for acute angina. While at clinical I took the patients vital signs twice throughout the day. I did a head to toe assessment on the patient as well as an HPI. Patient has an IV placed incase Zofran IV push is needed for nausea. It has not been administered yet. Patient got an EKG, chest X-ray, and nuclear stress test. Patient is doing well and is expected to be discharged after nuclear stress test results come back.

Procedures/testing done: Patient received a chest X-ray, EKG, and nuclear stress test. Patients EKG and chest X-ray came back normal. Patients nuclear stress test results are still pending.

Complaints/Issues: Patient complained of abdominal pain as a 2/10. Patient said the pain was tolerable. Patient had no other complaints or issues during her stay. Patient came

in with a chief complaint of “chest pain”, but throughout her stay the chest pain has resolved.

Vital signs (stable/unstable): Patients pulse, respiration rate, temperature and oxygen saturation were all normal. Patients first set of vital signs taken at 8:23 am showed hypertension. Patients second set of vital signs taken at 2:00 pm showed her blood pressure was normal.

Tolerating diet, activity, etc.: Patients diet is normal at home and in the hospital. Before the stress test patient was on a no caffeine diet.

Physician notifications: Physician was not notified of anything while I was at clinical. Patient was stable and waiting on results from tests.

Future plans for patient: If patients nuclear stress test comes back normal patient will be discharged.

Discharge Planning (2 points)

Discharge location: Patients home.

Home health needs (if applicable): Adhere to medications prescribed by doctor.

Equipment needs (if applicable): None.

Follow up plan: Patient has a follow up appointment in two weeks to make sure her chest pain is resolved.

Education needs: Patient needs to be educated on new prescriptions. Patient needs to be educated on what to do when experiencing chest pain.

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. Acute angina related to hypertension as evidenced by chest pain, SOB, and hypertension.	**To rule out STEMI and non STEMI.**	**1. Assess location, character and severity of chest pain.** **2. Obtain EKG as prescribed.**	**Patient and patients husband responded well to the nurse's actions. Patient was compliant while assessing pain. Patient was also compliant with getting an EKG test.**
3. Acute pain related to myocardial blood flow as evidenced by hypertension, chest pain and SOB.	**Patient came in for chest pain and SOB.**	**1. Instruct patient to notify nurse immediately when chest pain occurs.** **2. Observe for associated symptoms.**	**Patient responded well to the nurse's actions. Patient was educated on telling the nurse if she is experiencing chest pain. Patient had SOB associated with her chest pain.**
4. Anxiety related situational crises as evidenced by uncertainty and restlessness.	**Patient was experiencing anxiety upon admission.**	**1. Explain purpose of tests and procedures.** **2. Promote expression of feelings and fears.**	**The patient was understanding of what was happening. Patient was informed of why she received an EKG, chest X-ray and stress test. Patient expressed fear upon admission but was feeling calm during her stay at the**

			hospital.

Other References (APA): Swearingen, P. L. (2016). ***All-in-one care planning resource: medical-surgical, pediatric, maternity & psychiatric nursing care plans*****. Philadelphia, PA: Elsevier/Mosby.**

Concept Map (20 Points):

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Subjective Data

Patient arrived at ED on 9/14/19 complaining of chest pain and SOB. Patient said the pain occurred early in the morning. Patient said her husband gave her one of his nitroglycerin tablets and it relieved the pain. During the episode patients pain was a 10/10.

Nursing Diagnosis/Outcomes

Nursing diagnosis 1: Acute angina related to hypertension as evidenced by chest pain, SOB, and hypertension.
Outcome: patient is on medication for her hypertension. Patient is following nursing interventions.

Nursing diagnosis 2: Acute pain related to myocardial blood flow as evidenced by hypertension, chest pain and SOB.
Outcome: Patient is following interventions and her chest pain is controlled.

Nursing diagnosis 3: Anxiety related situational crises as evidenced by uncertainty and restlessness.
Outcome: Patient is following interventions and her anxiety and fears are controlled. She is relaxed and feeling fine at the hospital.

Objective Data

Patient had and EKG, chest X-ray, nuclear stress test, CBC, and a BMP. Patients EKG, chest X-ray, CBC, and BMP all came back normal. Patient is still waiting on results from the nuclear stress test.

Patient Information

Patient is a 75 year old Caucasion female with a history of hypertension related to her acute angina. Patient does not use alcohol, tobacco, or drugs. Patient lives with her spouse and is retired.

Nursing Interventions

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