N431 Care Plan #1

Lakeview College of Nursing

Kylie Cox

Demographics (3 points)

Date of Admission 9/17/2019	**Patient Initials** GW	**Age** 90	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** NKDA
Code Status DNR	**Height** 154 cm	**Weight** 63.1 kg	

Medical History (5 Points)

Past Medical History:

- CKD stage II
- CAD
- Hyperlipidemia
- Neuropathy
- Chronic hypertension
- Arthritis
- GERD

Past Surgical History:

- Hysterectomy
- Appendectomy
- Cataract removal
- Tonsillectomy
- Right heart catherization
- PTCA stent placement

Family History:

- Heart disease

Social History (tobacco/alcohol/drugs):

Patient is a retired factory worker who resides at home with her husband of 70 years. Patient denies use of alcohol, tobacco or drug use. Patient does use glasses but does not use a walker, wheelchair, or a cane. She is an avid churchgoer and is of the Pentecostal religion. She resides at home with her husband.

Assistive Devices:

- Glasses
- Patient denies use of walker, wheelchair or cane

Living Situation:

- Patient resides at home with her husband

Education Level:

- High school diploma

Admission Assessment

Chief Complaint (2 points):

- Heaviness in chest

History of present Illness (10 points):

- Patient is a 90-year-old female who was brought to the ED (9/17/2019) by her husband. Patient complained of chest discomfort, heaviness, mild dizziness, and SOB. Her pain started in the morning when she finally agreed to come to the hospital. She rated her pain 8/10 when she arrived. Patient was on telemetry and it showed she had sinus arrhythmia. Her cardiologist was contacted and she was admitted. Tests were performed to further evaluate the patient's condition. A 2 view X-ray was completed to find the patient had SOB but also her heart is normal and lungs are clear. An EKG was also done that

determined the patient was in sinus rhythm, had a bundle branch block and inferior infarct.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Chest Pain

Secondary Diagnosis (if applicable): Coronary Artery Disease

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

Coronary Artery Disease develops as a result of a damaged or injured endothelium, lining of the artery (Mandal, 2019). Cholesterol, fats, lipoproteins, and numerous other forms of debris, begin to gather in the wall of the artery (Mandal, 2019) Oxidation, which is the chemical process in which the highly concentrated low density lipoprotein (LDL) invade the endothelium. Therefore, causing white blood cells to travel towards the wall of the vessel where macrophages appear and the lipoproteins are engulfed. After this, a fatty streak occurs which attracts smooth muscle cells that reproduce to form a type of collagen. Fatty streak then turns into a fibrous plaque which causes stenosis of the luminal space when it bulges. Signs and symptoms associated with Coronary Artery disease are angina, shortness of breath, weakness, sweating, dizziness, rapid heartbeat, and palpitations. Diagnostic testing used to identify whether or not a patient has CAD are blood tests specifically a lipid profile and lipoproteins, an ECG, looking at the heart's electrical activity and dysrhythmias, echocardiogram that monitors for heart perfusion and the ability to keep up with stress, a stress test, and lastly, a coronary arteriogram that views any build-up of plaque causing a clogged artery. This test also is used to confirm CAD when all the other noninvasive tests have been inclusive. Lifestyle changes such as

physical activity, a heart-healthy diet, a healthy weight, and avoiding tobacco is one type of treatment for patients. Others include treating hypertension, and the use of medications like ACE inhibitors, beta blockers, ARBS, and calcium channel blockers. The patient came into the ER for chest pain, SOB and dizziness which are all symptoms of Coronary Artery Disease.

Pathophysiology References (2) (APA):

Mandal, A. (2019). *Coronary Artery Disease Pathophysiology*. News-Medical.net. https://www.news-medical.net/health/Coronary-Artery-Disease-Pathophysiology.aspx

Sorenson, M., Quinn, L., & Klein, D. (2017). *Pathophysiology*. Hoboken: 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	4.2-6 million	4.35	4.39	
Hgb	11.6-15	13.4	13.0	
Hct	33.2%-45.3%	40	40.8	
Platelets	150,000-400,00	214	218	
WBC	4,000-11,000	7.6	6.1	
Neutrophils	50-70	69.3	65.3	
Lymphocytes	11.8-45.9	14.6	18.3	
Monocytes	0.0-15.0	10.5	11.5	
Eosinophils	0.0-6.0	3.2	4.2	
Bands	0.0-2.0	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	141	143	
K+	3.5-5.0	3.5	4.2	
Cl-	98-107	106	107	
CO2	22-29	24	28	
Glucose	70-110	104	102	
BUN	8-25	22	20	
Creatinine	0.6-1.3	1.30	1.19	
Albumin	3.5-5.2	4.3	N/A	
Calcium	8.6-10	10.0	9.9	
Mag	1.5-2	2.0	N/A	
Phosphate	0.8-1.5	N/A	N/A	
Bilirubin	<1.5	0.6	N/A	
Alk Phos	50-100	96	N/A	
AST	10-30	20	N/A	
ALT	10-40	10	N/A	
Amylase	30-125	N/A	N/A	

Lipase	10-150	N/A	N/A	
Lactic Acid	0.5-2.4	N/A	N/A	
Troponin	<0.05	0.010	0.010	
CK-MB	5-25	5.19	N/A	
Total CK	90-140	93	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	<250	N/A	N/A	
BNP	0.5-30	N/A	N/A	
HDL	>60	N/A	N/A	
LDL	<100	N/A	N/A	
Cholesterol	3-5.5	N/A	N/A	
Triglycerides	<150	N/A	N/A	
Hgb A1c	<5.6	N/A	N/A	
TSH	0.4-5	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 Admissio	Today's Value	Reason for Abnormal

		n		
Color & Clarity	Yellow, clear	N/A	N/A	
pH	5.0-8	N/A	N/A	
Specific Gravity	1.005-1.024	N/A	N/A	
Glucose	Normal	N/A	N/A	
Protein	Negative-normal	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	<5	N/A	N/A	
RBC	0-3	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

Arterial Blood Gas 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
pH	7.35-7.45	N/A	N/A	
PaO2	>80	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	95-100%	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 (APA):

Sorenson, M., Quinn, L., & Klein, D. (2017). *Pathophysiology*. Hoboken, New Jersey: Pearson.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

An X-ray is an electromagnetic wave of high energy and very short wavelength, which is able to pass through many materials. A 2 view Xray was performed on this patient to view her chest. The findings founds that she was SOB, her heart is normal and her lungs were clear.

X-ray 2 views showed SOB, heart is normal, and lungs are clear. A measurement of cardiac activity, an EKG, found this patient has sinus rhythm, bundle branch block, and inferior infarct. Irregularities on an EKG can indicate abnormalities in the heart. These tests correlate with the patient because she experienced shortness of breath which was found on the X-ray and is a sign and symptom of CAD.

Diagnostic Test Reference (APA):

Sorenson, M., Quinn, L., & Klein, D. (2017). *Pathophysiology*. Hoboken: Pearson.

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

Home Medications (5 required)

Brand/Generic	Acetaminop	Amlodipine	Losartan	atorvastatin	Ibandronic

	hen (Tylenol)	(Norvasc)	(Cozaar)	(Lipitor)	acid (Boniva)
Dose	500 mg	5 mg	25 mg	10 mg	150 mg
Frequency	Daily	Daily	Daily	Daily	Daily
Route	PO	PO	PO	PO	PO
Classification	antipyretic	Antianginal, antihypertensive	antihypertensive	Antihyperlipidemic	Bisphosphonate derivative
Mechanism of Action	Inhibits the enzyme cylcooygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system	Inhibits the influx of extracellular calcium into vascular smooth muscle and myocardial cells	Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver	Based on its affinity for hydroxyapatite which is part of the mineral matrix of bone
Reason Client Taking	For her pain	For her HTN and chest pain	Hypertension	High cholesterol	To prevent osteoporosis
Contraindications (2)	Severe hepatic impairment hypersensitivity	Hypersensitivity Aliskiren therapy	Hypersensitivity Aliskiren threrapy	Hypersensitivity Active hepatic disease	Hypersensitivity Hypocalcemia
Side Effects/Adverse Reactions (2)	Anaphylaxis nausea	Anxiety Hot flashes	Dizziness Muscle spasms	Amnesia Dry mouth	Depression Abdominal pain
Nursing Considerations (2)	Use cautiously in patients	Monitor BP while adjusting	Losartan is more effective	Be aware that atorvastatin may be used	Use cautiously in patients with

	with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment Monitor for renal function in patient on long term therapy	dosage Assess frequently for chest pain when administering medication	when given in two divided doses daily in some patients Monitor patients for muscle pain	with colestipol or cholestryramine for additive antihyperlipidemic effects Obtain diet history, especially in regards to fat consumption	active upper gastrointestinal problems Administer drug as soon as possible after missed appointment
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess renal function including liver function test	Monitor VS such as BP and assess for pain	Blood pressure and renal function studies	Liver function test before atorvastatin therapy	Obtain serum creatinine
Client Teaching needs (2)	Stop to use if pain gets worse or lasts more than 10 days Stop medication if redness or swelling is present	Take missed dose as soon as remember Take amlodipine with food to reduce GI upset	Can be taken with or without food Keep taking medication even if feeling better	Take drug at the same time each day to maintain its effects Take misdose as soon as possible	Take at least one hour before first food or drink of the day Take supplemental calcium and vitamin D on daily basis

Hospital Medications (5 required)

Brand/Generic	Aluminum-magnesium hydroxide (Mylanta)	clopidogrel bisulfate (Plavix)	enoxaparin (Lovenox)	famotidine (Pepcid)	ondansetron (Zofran)
Dose	30 mL	75 mg	30 mg	20 mg	4 mg
Frequency	QID/PRN	Daily	Daily	BID	Q6 hours
Route	PO	PO	SUBQ	PO	PO
Classification	antacid	Platelet aggregation	antithrombotic	H-2 receptor antagonist	Antiemetic
Mechanism of Action	Mag-hydroxide fast-acting antacid & aluminum hydroxide is slow-acting antacid working together to neutralize gastric acid	Inhibitor of platelet aggregation that is used to decrease the risk of myocardial infarction and stroke	Binds to antithrombin III and accelerates activity, inhibiting thrombin and factor Xa	Blocks histamine H2 receptor on parietal cells	Antiemetic may result of peripheral & or central serotonin receptor blockers 5HT3 receptors are found peripherally on vagal nerve terminals and centrally within chemoreceptor trigger zone
Reason Client Taking	Heartburn	Prevent MI	Prevention of DVT	Excessive gas excretion	nausea
Contraindications (2)	Aluminum allergy hypersensitivity	Hypersensitivity Active pathologic bleeding	Hypersensitivity to pork products Circulating antiplatelet antibodies	Hypersensitivity QT prolongation	Congenital long QT syndrome Concomitant use of apomorphine
Side Effects/Adverse Reactions (2)	Constipation Pruritis	Upper respiratory tract infection headache	Hemorrhage Anemia	Diarrhea headache	Agitation Arrhythmias
Nursing Considerations (2)	Don't give within one to two hours with other oral drugs Make sure patient does	Expect to give aspirin with colpidogrel in patient with acute coronary syndrome Monitor	Do not give by IM injection Keep protamine sulfate nearby in case of accidental	Shake famotidine oral suspension vigorously for five to ten seconds before administration	monitor pt for serotonin syndrome monitor patient closesly for

	not consume alcohol while taking this medication	patient who takes aspirin closely because risk of bleeding is increased	overdose	Be aware for patients who have phenylketonuria as this contains aspartame	signs of hypersensitivity
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Serum levels of sodium, phosphate	Monitor/ report for signs and symptoms of GI bleeding when administered with NSAIDS, aspirin, heparin, or warfarin Labs: Periodic platelet count and lipid profile	Monitor for any signs of bleeding	Assess heart rate EKG and heart sounds	Monitor electrocardiogram
Client Teaching needs (2)	Can be mixed with water or milk Drink a full glass of water after taking tablet	Avoid chronic aspirin or NSAID use unless approved by physician Report promptly any unusual bleeding	Notify prescriber about adverse reactions, especially bleeding Do not rub site after giving injection to minimize bleeding	Do not take more than 2 tablets within 24 hours Do not lie flat or bend over soon after eating	Report signs of hypersensitivity such as rash Notify provider if pain develops, trouble swallowing or bloody vomit

Medications Reference (APA):

JONES & BARTLETT LEARNING. (2018). *Nurses's Drug Handbook* (17th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is A&Ox4. Patient knows where she is, what year it is, and what she is in for. Overall patient is content.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:** 21 **Drains present: Y☐ N ☒** **Type:**	Patient is a Caucasian female with normal elasticity, pink, dry and warm touch to the skin. Patient's skin turgor was normal, less than 2 seconds with no rashes or bruises. Braden scale: 21
HEENT (1 point): **Head/Neck:** round, normocephalic, midline with no deviations **Ears:** symmetrical, same color as face, no abnormal drainage **Eyes:** sclera is white **Nose:** no deviated septum, turbinates equal and bilateral **Teeth:** white and yellow in color	Patient's head is midline with no deviations and hair is white. She has no abnormal drainage from her ears. PERLA is present. No deviated septum, turbinates equal and bilateral. Pink and moist oral mucosa with no noted abnormalities. Patient's teeth were white and yellow in color
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** No known murmurs **Cardiac rhythm (if applicable):** Sinus rhythm **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Patient is currently being monitored by telemetry due to sinus arrhythmia. Heart sounds auscultated x5. Radial and pedal pulses 2+ and present bilaterally. Capillary refill average at <2 second. Patient does not have any edema or neck vein distention.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Patient has no accessory muscle use when breathing. Lungs were auscultated and clear bilaterally.
GASTROINTESTINAL (2 points): **Diet at home:** regular	Patient is not on a special diet at home and is on a regular diet in the hospital. Patient has active

Current Diet: regular diet **Height:** 154 cm **Weight:** 63.1 kg **Auscultation Bowel sounds:** **Last BM:** 9/17/2019 **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	bowel sounds in all four quadrants. Abdomen is soft, non-distended, and non-tender. Patient has non hepatomegaly. Patient does not have an ostomy, NG tube, or feeding tube.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient has ability to ambulate to the restroom by herself. Her urine is yellow with no abnormal odor. She had an output of 300mL. She has no catheter, was not on dialysis and did not have pain upon urination.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** 45 **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Patient does not experience any pain. She is a fall risk and is one assist. Patient does have glasses she wears consistently.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐**	Patient is awake in bed. She speaks English at a normal pace. Patient is MAEW and PERLA intact. Her strength is equal in both arm and legs. Patient does not show signs of neurological damage. Patient is AOX4.

Orientation: **Mental Status:** **Speech:** **Sensory:** **LOC:**	
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** appropriate **Religion & what it means to pt.:** Pentecostal **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient denies use of drugs or alcohol, current or past. Patient finished high school and worked at a factory in Charleston for many years. She is of the Pentecostal religion. Patient has been with her husband for 70 years and they reside at home in Charleston.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0759	61	122/72	18	36.2	98
1028	67	137/73	20	36	95

Vital Sign Trends: Everything is normal for this patient, will continue to monitor

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0755	0/10	Patient denies pain	Pt denied pain	Pt denies pain	Pt denies pain, no interventions needed at this time
1030	0/10	Patient denies pain	Patient denies pain	Patient denies pain	Pt denies pain, no interventions needed at this time

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock

Size of IV: 20 gauge **Location of IV:** left AC **Date on IV:** 9/17/19 **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** dry and intact	Saline Locked

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
100 mL - oral intake	300 mL - urine

Nursing Care

Summary of Care (2 points)

Overview of care: Patient will continue to be monitored

Procedures/testing done: The patient received an additional EKG at bedside during clinical hours, in addition to the EKG and X-rays done prior to her being admitted

Complaints/Issues: The patient had no complaints during her hospital stay.

Vital signs (stable/unstable): Patient's vital signs were stable for this patient who has hypertension

Tolerating diet, activity, etc.: Patient is on a regular diet

Physician notifications: The patient's vital signs were stable and not complications so the physician was not notified.

Future plans for patient: The patient will follow-up cardiologist and will call physician's office with any concerns or signs of pain.

Discharge Planning (2 points)

Discharge location: Patient will be discharged home with her husband.

Home health needs (if applicable): Patient does have any home health needs

Equipment needs (if applicable): Patient does not need any equipment at this time.

Follow up plan: The patient will continue to follow-up with cardiologist and follow his plan of care.

Education needs: The patient needs to make lifestyle changes if not already done so. She needs to incorporate more fruits and vegetables, with lots of fiber. Also, the patient should be walking or using some type of physical activity.

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. Ineffective airway clearance related to cardiac disease as evidenced by decreased blood flow	Patient has CAD which can cause a decrease in the amount of blood flow due to the build up of plaque in the arteries.	**1.** teach pt the proper ways of coughing and deep breathing **2.** consider verbalization of feelings	Patient understands nurse's actions in order to maintain and improve health. Patient's goals is to continue to stay on room air and keep O2 within range
2. Decreased cardiac output related to irregular heart rhythm as evidenced by sinus arrhythmias on telemetry	Patient has a history of heart problems which can have an affect but also due to her age which can also decrease output of the heart.	**1.** monitor vital signs and cardiac rhythm **2.** stress importance of avoiding straining down, especially during defecation	Patient understands protocol in order for her to get better. It is expected that patient and family are accepting of teaching.
3. Risk for falls related to dizziness as	Patient's signs and symptoms	**1.** provide wristband	Patient can easily ambulate by herself but it

evidenced by previous symptoms and signs of chest pain	she came into the ER for need to be monitor to make sure she is safely mobilizing	identification to implement fall precaution behaviors **2.** Encourage patient to don shoes or slippers with nonskid soles when walking	is best for her to have a one person assist when she is up and moving to avoid falls. Patient does understand. Patient's family will make sure to follow these rules. Patient's goals is to avoid falls
4. Acute pain related to decreased oxygen supply to myocardium as evidenced by patient reports in the ER of pain 7/10	Patient did experience pain upon arrival to ER and it continuously needs monitored	**1.** stay with patient and provide reassurance during periods of angina **2.** Assess the aspects of specific symptoms: modifying or aggravating factors, location, quality, character, timing, intensity, and/or relieving factors	Although patient is not in any pain at this time, it is very pertinent for her to report pain and patient understands this. Patient's goal is to be pain free for the remainder of the hospital stay and remain pain free at home.

Other References (APA):

Swearingen, P. (2016). *All-in-one Nursing Care Planning Resource* (4th ed). St. Louis, Missouri:

ELSELVIER.

Concept Map (20 Point

N431 Care Plan

Subjective Data

- Heaviness in chest
- Dizziness
- SOB
- Pain upon arrival 7/10

Nursing Diagnosis/Outcomes

- Ineffective airway
  - Outcome
  - Patient will continue to be on room air and not need any supplemental O2
- Decreased cardiac output
  - Outcome
  - Patient will be continuously monitored on telemetry for any signs of dysrhythmias
- Risk for falls
  - Outcome
  - Patient will remain free from falls for the remainder of time in hospital
- Acute pain
  - Outcome
  - Patient's report of pain will be within the acceptable levels

Objective Data

Xray showing SOB
EKG showing sinus rhythm, bundle branch block and inferior infarct

Patient Information

Patient is a 90 year old female with a history of CAD, neuropathy, MI, HTN, Arthritis, and GERD. She was brought into the ER on 9/17 by her husband. She has a past surgical history of hysterectomy, appendectomy, cataract removal, tonsillectomy, right heart catherization, and PTCA stent placement

Nursing Interventions

- Monitor vital signs
- Administer PRN pain medications
- Establish an honest relationship with therapeutic communication
- Allow time for rest when ambulating to restroom
- Implement fall risk precautions

N431 Care Plan

N431 Care Plan