N441 Care Plan

Lakeview College of Nursing

Kaity Taylor

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/10/2020	MB	49	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Truck Driver	Single	Lisinopril, Morphine
Code Status	**Height**	**Weight**	
Full	195cm	142.6 kg	

Medical History (5 Points)

Past Medical History: Anxiety, dyspnea, obesity, history of malignant melanoma, BPH, hypertension, depression

Past Surgical History: Colonoscopy, inguinal/umbilical hernia repair, cystoscopy

Family History: Pt reported his father died of a stroke in 2011. In addition, the patient's father had hypertension, hyperlipidemia, and was a smoker. Mother was a smoker and had breast cancer.

Social History (tobacco/alcohol/drugs): Former smoker as of 43 days ago, denies alcohol/illicit drug use

Assistive Devices: glasses

Living Situation: pt lives at home with his children. Pt has a girlfriend who does not live in the home.

Education Level: Some college credits, no degree obtained

Admission Assessment

Chief Complaint (2 points): “chest pressure”, 60-pound weight gain in a 2-week period, “extreme headache”.

History of present Illness (10 points):. A 49-year-old male presented to the ER for complaints of severe headache accompanied by increased blood pressure. Pt reported he had cardiac workup done in October but had been feeling ill and noticed he had gained 60 pounds in two weeks. The patient drives a semi-truck and is on the road long hours with no exercise and dismissed his weight gain to fast food. The patient and his family were planning a vacation out of state but wanted to stop in to get his "heart checked out" before the trip. The patient was immediately transferred to the critical care unit upon admission to the hospital. The primary goal was to be treated for hypertensive crisis and to rule out myocardial infarction (MI) or cerebral vascular accident (CVA). Upon assessment, the patient's abdomen was fluid-filled and was causing some discomfort. The patient also reported his bouts of hypertension caused a severe headache. The patient is scheduled for a 2-day stress test, echocardiogram, and ultrasound of the abdomen later this afternoon.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):. Hypertensive crisis

Secondary Diagnosis (if applicable):. chest pain/pressure

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

Hypertensive crisis is when the blood pressure is extremely elevated and requires immediate intervention to avoid possible organ damage (Swearington, 2016). If extreme hypertension is left untreated, it can lead to increased pressure and possible rupture within the blood vessels. In this patient's case, he presents with a carotid aneurysm, so careful monitoring of blood pressure is crucial. Typically, hypertension is referred to as a blood pressure reading of 140/90 or higher (Cheever & Hinkle, 2017). Occasionally, a hypertensive crisis can be secondary to a disease process such as an "acute MI, dissecting aortic aneurysm, or intracranial hemorrhage" (Swearington, 2016, p.897). The patient was admitted to the CCU to rule out MI or CVA. Clinical manifestations of hypertensive crisis can be asymptomatic, which means the patient experiences no symptoms or abnormalities other than high blood pressure readings (Cheever & Hinkle, 2017). Hypertensive crisis can also be accompanied by symptoms such as headache, syncopal episodes, dizziness, facial weakness, or arm tingling sensations. In MB's case, he was experiencing occasional shortness of breath, fatigue, and an excruciating headache. MB states he can always tell when his blood pressure is high due to the sudden onset of a headache. Diagnostic testing, such as physical assessments and laboratory studies, can be done to identify hypertensive crises. MB had an ultrasound of the abdomen and echocardiogram early this morning, and results for those tests are pending. Also, MB completed a stress test where he walked on a treadmill while being carefully monitored. The speed and inclination of the treadmill both increased at specific intervals to monitor cardiac output and stress to the heart. Due to MB's BMI and overall size, the stress test was split into two separate sessions. MB was given Labetalol with his morning medications, which kept his heart rate below 100; therefore, the results of the stress test were inconclusive and will have to be repeated. MB had an ultrasound of the abdomen to identify the potential cause of the fluid buildup and increased weight gain. MB had routine chemistry blood panels sent to the lab, all of which were deemed unremarkable. Typically, the main goal for treating hypertensive crisis is to stabilize the blood pressure, monitor the patient, and identify potential causes

(Swearington, 2016). Treatments for a hypertensive crisis can be the administration of beta-blockers or antihypertensive medications and IV vasodilators to expand the vessels (Cheever & Hinkle, 2017). MB was prescribed a variety of medications during his hospitalization and was instructed to continue at home.

Pathophysiology References (2) (APA):

Cheever, K., & Hinkle, J. (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins

Swearingen, P. L. (2016). *All-in-One Nursing Care Planning 4th Edition.* St. Louis, Missouri: Elsevier

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	Today's Values	Reasons for abnormal
RBC	4.2-6.1	4.44	4.41	
Hgb	12-18	14.5	14.4	
Hct	37-52	41.3	41.1	
Platelets	150-400	208	222	
WBC	5-10	7.1	6.1	
Neutrophils	45-75%	50.7%	53.6%	
Lymphocytes	20-40%	40.3%	38.2%	
Monocytes	4-6%	8.3%	6.7%	

Eosinophils	**Less than 10%**	**0.2**	**0.2**	
Bands	**<3%**	**-**	**-**	

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**	**3.4**	**3.6**	
Cl-	**96-106**	**101**	**106**	
CO2	**20-29**	**26**	**26**	
Glucose	**70-110**	**88**	**93**	
BUN	**6-20**	**8**	**9**	
Creatinine	**0.8-1.2**	**0.89**	**0.96**	
Albumin	**3.5-5.5**	**4.1**	**4.3**	
Calcium	**8.5-10.2**	**8.8**	**8.6**	
Mag	**1.3-2.1**	**-**	**-**	

Phosphate	3.0-4.5	-	-	
Bilirubin	0.3-1	0.4	-	
Alk Phos	30-120	35	-	
AST	10-40	23	-	
ALT	44-147	35	-	
Amylase	30-220	-	-	
Lipase	0-160	-	-	
Lactic Acid	0.5-1	-	-	
Troponin	Less than 0.04	<0.010	-	
CK-MB	3-5%	3.23	-	
Total CK	5-25	5.25	-	

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 Warfarin 2-3	-	-	

PT	11-12.5	-	-	
PTT	30-40	-	-	
D-Dimer	Less than 0.4	-	-	
BNP	Less than 100	77	-	
HDL	Greater than 40	-	25	Patient reports being a driver and not adhering to regular diet.
LDL	Less than 100	-	102	Unhealthy diet leads to low HDL and high LDL (Cheever & Hinkle, 2017).
Cholesterol	Less than 200	-	198	
Triglycerides	Less than 150	-	375	Unhealthy diet with vast amounts of unhealthy food choices increases triglycerides (Cheever & Hinkle, 2017).
Hgb A1c	4-5.6% (if diabetic less than 7)	-	5.4%	
TSH	0.4-4	-	1.20	

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 and yellow	Clear and yellow	Clear and yellow	

pH	6.0	-	-	
Specific Gravity	1.005-1.035	-	-	
Glucose	0	-	-	
Protein	0	-	-	
Ketones	0	-	-	
WBC	Less than 5	-	-	
RBC	0	-	-	
Leukoesterase	0	-	-	

***** - Indicates was not listed in patient's chart**

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	-	-	
PaO2	75-100	-	-	
PaCO2	35-45	-	-	

HCO3	**22-26**	**-**	**-**	
SaO2	**95-100%**	**-**	**-**	

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	**0**	**-**	**-**	
Blood Culture	**0**	**-**	**-**	
Sputum Culture	**0**	**-**	**-**	
Stool Culture	**0**	**-**	**-**	

Lab Correlations Reference (APA): ATI Nursing Education. (2016). *Content Mastery Series: RN Adult Medical Surgical Nursing Edition 10.0.* Assessment Technologies Institute, LLC.

Van Leeuwen, A. M., & Bladh, M. L. (2017). *Davis's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7 ed.). Philadelphia, PA: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Past CT of the head showed nonspecific patchy cerebral white matter. The patient had an ultrasound of the abdomen and an echocardiogram, which results are pending. EKG showed a normal sinus rhythm of 77 beats per minute. The patient reports a resting heart rate typically in the upper 50s as being typical for him, and cardiologist agreed on no sign of concern.

Diagnostic Test Correlation (5 points): Pt diagnostic testing procedures were marked within normal limits and absent of any abnormalities. Diagnostic procedures such as blood work and EKG were completed to rule out possible concerns of CVA or MI.

Diagnostic Test Reference (APA): Cheever, K., & Hinkle, J. (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins

Current Medications (10 points, 1 point per completed med)

10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Carvedilol (Coreg)	Tamsulosin (Flomax)	Trazodone (Oleptro)	(Norvasc) Amlodipine	Doxazosin (Cardura)
Dose	6.25 mg	0.4 mg	50 mg	5 mg	8 mg
Frequency	BID	Daily	HS, PRN	Daily	4 mg
Route	PO	PO	PO	PO	PO

Classification	Beta blocker	Alpha-adrenergic blocker in prostate	Antidepressant	Calcium channel blocker	Alpha-adrenergic blocker
Mechanism of Action	Vasodilation of blood vessels	Relaxation of smooth muscle in prostate to improve flow of urine	Inhibit reuptake of serotonin and histamine blocker	Inhibit movement of calcium ions into vascular smooth muscle and cardiac muscle cells	Relaxes blood vessels so blood flows more easily
Reason Client Taking	To control hypertension	Diagnosis of BPH	Treatment of depression	Control hypertensio n	Anti Hypertensi on and BPH
Contraindicatio ns (2)	Cardiogenic shock and 2nd/3rd heart block	Prostate cancer and allergies to quinazolines	Alcohol use and MAOI medications	Renal impairment and T2DM	Renal impairment and seizure disorders
Side Effects/Adverse Reactions (2)	Angina, blurred vision	Atrial fibrillation and decreased libido	Abnormal dreams and ejaculation disorders	Dry mouth and impotence	Palpitation s and priapism
Nursing Considerations (2)	Do not abruptly stop and assess for increased angina	Rule out prostate cancer, give 30 mins after same meal each day	Use cautiously in pt with heart disease d/t dysrhythmia potential and monitor for	Use cautiously in heart block patients and monitor BP	Do not give to hypotensiv e patients and monitor for orthostatic

			suicidal ideations		hypotension
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Blood glucose levels, HR/BP	I&O, prostate cancer screening	Cardiac workup	Liver function tests and cardiac workup	Monitor BP
Client Teaching needs (2)	Drug may cause dizziness and notify PCP if weight gain >5 lbs in 2 days	Change positions slowly and notify eye doctor is scheduled for surgery	Do not take NSAIDS and report unusual thinking patterns	Take missed dose with 24 hours and take with food	May become faint and take with meals

Hospital Medications (5 required)

Brand/Generic	Furosemide (Lasix)	(Labetalol) Trandate	Losartan (Cozaar)	Enoxaparin (Lovenox)	Hydrochlorothiazide (Oretic)
Dose	40 mg	400 mg	25 mg	40 mg	25 mg
Frequency	daily	TID	BID	Daily	Daily
Route	PO	PO	PO	SubQ	PO
Classification	Loop diuretic	Beta blocker	Angiotensin receptor blocker (ARB)	Low molecular weight heparin	Diuretic

Mechanism of Action	Inhibit sodium and chloride reabsorption	Blocks receptors in smooth muscle in heart to reduce BP and resistance	Blocks the vasoconstrictor effects of angiotensin II	Accelerates the activity of antithrombin	Reduces blood volume to reduce sodium
Reason Client Taking	Reduce edema, manage hypertension	Control hypertension	Control hypertension	DVT prevention	Fluid retention and hypertension
Contraindications (2)	Anuria and cirrhosis	Severe bradycardia and cardiogenic shock	Renal impairments and diabetes	Active bleeds and thrombocytopenia	Anuria and renal failure
Side Effects/Adverse Reactions (2)	Tachycardia and muscle spasms	Anxiety, ejaculation failure	Nasal congestion and hypotension	Confusion and bruising at site	Dry mouth and nausea
Nursing Considerations (2)	Monitor BP and discontinue if oliguria	Can mask common signs of shock, do not abruptly stop	Monitor serum potassium levels and evaluate drug effectiveness	Use cautiously in patients with HIT and administer 1-2 inches from umbilicus	Give in the morning to avoid nocturia and monitor for hypokalemia
Key Nursing Assessment(s)/Lab(s) Prior to	Daily weights	Monitor BP	GFR Blood glucose	Monitor bleeding/clotting times	Daily weights I&O

Administration	I&O BUN				Blood glucose
Client Teaching needs (2)	Control weight and do not take prior to bed	May cause scalp tingling and report SOB	Avoid exercising in hot weather and avoid potassium rich salt substitutes	Notify healthcare team if bleeding occurs and do not rub the site after administration	Take in the morning or day time to avoid nocturia and report decreased urination

Medications Reference (APA): Jones & Bartlett Learning. (2018). *Nurse's Drug Handbook 17th Edition.* Burlington, MA: Jones & Bartlett Learning.

Janice L. Hinkle PhD, R.C. (2017). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing.* New York, New York: Wolters Kluwer.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient was pleasant and cooperative during all interactions. Alert and oriented x4. Patient was able to have developmentally appropriate conversations with all healthcare team members.

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 22** **Drains present: Y☐ N ☐** **Type:**	Upon assessment, the patient's skin was pink, warm, and dry with no evidence of abnormal rashes, bruises, or wounds. Patient's Braden score was 22. Patient did not have any drains. Patient has scars on his chest where he had malignant melanoma removed.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's eyes and ears were equally symmetrical with no evidence of abnormalities. Patient's nose was midline with no NG placement present. Patient's hair was evenly dispersed and brown in nature. Patient wears glasses on occasion to assist in visual impairment. Patient's teeth were white and there was no evidence of abnormalities.

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: Abdomen**	Patient is currently on cardiac monitors to watch for any abnormalities. Heart sounds were assessed at the aortic, pulmonic, tricuspid, and mitral valves and all appeared within normal limits. Pulses were felt at the radial and pedal locations and deemed within normal limits upon assessment. Capillary refill was approximately 2-3 seconds. No signs of neck vein distention was noted. Patient had accumulated abdominal distention. EKG showed normal sinus rhythm at 77 beats per minute.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	No accessory muscle use was observed during assessment. Patient did not report any shortness of breath or difficulty breathing during assessment but stated he was experiencing excess fatigue and shortness of breath overnight. Lung sounds were present and clear bilaterally in all 5 lobes. Patient denies using oxygen at home. Patient did not have an ET tube.

GASTROINTESTINAL (2 points): **Diet at home: normal** **Current Diet: heart healthy** **Height: 195 cm** **Weight: 144.2 kg** **Auscultation Bowel sounds:** **Last BM: 2/10/20** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Patient is currently on a low-sodium, heart healthy diet. Patient reports while at home, he eats whatever is available. Patient is a truck driver and spends the majority of his time in his truck and consumes drive-thru food several times a day. Bowel sounds were assessed and heard in all 4 quadrants and deemed within normal limits. Patient is currently NPO as testing will take place today. No ostomy, NG, drains, or feeding tubes were present. Patient was experiencing abdominal distention and reported a weight gain of 60 pounds in 2 weeks. Upon palpation to the abdomen, the patient reports slight discomfort and it is firm to the touch.

GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	Patient is independent with voiding and does not have a catheter. Patient did not report urgency, burning, or pain upon urination. Pt's urine is clear and yellow in nature. Pt was not on strict I&O so no amount was collected or noted.
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**	Morse fall risk score of 45. Patient is independent for all activities of daily living but was instructed to call for help if he is feeling weak or fatigued upon ambulation. During his stay in CCU, the patient is mostly in his bed. Patient was wheeled down for the stress test. Pt has a full range of motion in all extremities.

Needs support to stand and walk	
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation: A&O x4** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient was alert and oriented x 4 during the duration of shift. Patient was pleasant and answered all the questions appropriately. Patient spoke English and his speech was within normal limits. Strength was equal bilaterally in all extremities. No signs of any neurological impairments during assessment.
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):**	Patient is an overall positive guy who likes to tell jokes and make people laugh. Patient lives at home with his children who he reported to love very dearly. Patient stated wanting to find a good diet so that he is able to be around to watch his children grow up and become adults. Patient reported having some college credits, but no degree was obtained. Patient has a girlfriend who lives in her own home and he is planning a proposal in the future.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	77	141/94	26	36.7 C	100%
1200	65	149/88	20	36.6 C	99%

Vital Sign Trends/Correlation: The patient's blood pressure was elevated during all vital sign rounds. The patient reports increased blood pressure during physical exertion, times of stress, and is easily fatigued. The patient presents with anxiety, and he stated having "white coat syndrome" where doctors and hospitals give him anxiety.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	Headache	3/10	Generalized headache; no relieving/aggravating factors	PO Tylenol
1000	Numeric	N/A	0/10	No pain at this time	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G **Location of IV: L hand and R upper arm**	Left hand 20 g IV is saline locked, and R upper arm was running a Cardizem drip which he is currently being weaned off. Upon flush,

Date on IV: 2/10/20 **Patency of IV: No phlebitis/infiltration, catheter patent** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	the patient's saline locked IV flushed with no signs of infiltration or draining. IV dressing was clean, dry, and dated 2/10/2020.
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:** **Date on dressing:** **CUROS caps in place: Y ☐ N ☐** **CLABSI prevention measures:**	No evidence of PICC, port, or central lines on MB.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
705 mL **IV fluids, oral hydration (water)**	**1525 mL** **Patient has not had a bowel movement this**

	shift.

Nursing Care

Summary of Care (2 points)

Overview of care: Patient was pleasant and cooperative during all interactions with the healthcare team. When professionals were not in the room for assessment, testing, or medications, the patient slept quietly. Patient reported having “the best sleep of my life” while in the hospital the night before. Patient mentioned it is not uncommon for his systolic blood pressure readings to be in the 200s. Patient and doctor were working towards a correct medication regime for the best results. Education was given regarding a heart-healthy diet and including exercise into his daily routine.

Procedures/testing done: Stress testing scheduled for this afternoon, echocardiogram done at 0900 awaiting results, ultrasound of the abdomen scheduled.

Complaints/Issues: Patient voiced having a headache that increased as the day went on despite medication. Patient rated pain 7/10 after his stress test was complete.

Vital signs (stable/unstable): Overall, patient’s vital signs remained stable with the exception of hypertension during vital sign assessments.

Tolerating diet, activity, etc.: Patient is currently NPO until a plan is in place and diagnostic testing is complete.

Physician notifications: Cardiologist suggested weaning patient off Cardizem drip and replace it with Labetalol 400 mg TID to control hypertension.

Future plans for patient: Patient was instructed to begin a heart healthy diet and incorporate exercise into his routine.

Discharge Planning (2 points)

Discharge location: Upon discharge, patient will return home with his children.

Home health needs (if applicable): Hospitalist advised keeping a daily log of random blood pressure readings and instructed pt to return to ED if symptoms worsened.

Equipment needs (if applicable): n/a

Follow up plan: Cardiologist wants to follow up as the day progresses on newly ordered medication.

Education needs: New hypertensive medications, heart healthy diet, exercise routine.

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. Activity intolerance related to generalized weakness as evidenced by voiced concern from patient	Patient reports generalized weakness and fatigue during activities.	1. Assess vital signs before and after activity 2. Administer CCB and diuretics as ordered	During medication administration and exercise stress test, the patient's VS were monitored. Patient is currently taking diuretics and CCB to reduce bouts of hypertension.
2. Imbalanced nutrition related to excessive intake of calories, sodium, or fats as evidenced by LDL/HDL results and voiced concern from pt.	Patient reports being a truck driver where healthy foods are not available, so he chooses to get fast food.	1. Encourage food diary for visual of healthy vs unhealthy choices 2. Provide education regarding meal prepping to plan for long days.	Patient voiced a need to keep track of what he eats that he can monitor while on the road. Patient suggested making food at home to take on his truck routes to avoid the temptation of driving thru for fast food.
3. Deficient knowledge related to unfamiliarity with the disease,	Patient voiced concern about the need for a sudden	1. Assess the patient's overall	Patient was educated on ways to incorporate exercise into his driving

precautions, and side effects of hypertension as evidenced by new diagnosis and prescriptions	diet modification and requested education regarding healthy food choices.	comprehension ability 2. Discuss lifestyle changes that will need to be implemented	routes and understood diet modifications. Patient was given education handouts and voiced understanding of healthy vs unhealthy foods.
4. Acute pain related to headache as evidenced by photophobia and phonophobia	Patient voiced extreme headaches due to hypertension that would come and go during the shift.	1. Stay up on medication administration of PO Tylenol to alleviate headache 2. Encourage fluid intake	Patient was given PO Tylenol with his morning meds and stated his pain went from 5/10 to 0/10. Patient had 4 cups of water and stated improvement of pain.
5. Risk for infection related to truck driving profession as evidenced by not voiding for 12 or more hours at a time.	Patient stated he never pulls over to use the bathroom and often only goes one time during the day to not waste time/mileage.	1. Education regarding adequate fluid intake and output. 2. Monitor I&O while in the hospital	Patient agreed on the importance of staying hydrated and urinating at regular intervals when on the road. Patient was educated on the average amount of output per hour to be 30mL and was interested in monitoring and assessing independently.

Other References (APA): Swearingen, P. L. (2016). *All-in-One Nursing Care Planning 4th Edition.* St. Louis, Missouri: Elsevier

Concept Map (20 Points):

Subjective Data

Chest pressure
Weight gain
Headache
SOB
Fatigue

Nursing Diagnosis/Outcomes

1. Activity intolerance related to generalized weakness as evidenced by voiced concern from patient.
   - Patient reported being physically exhausted upon ambulation and changing positions in bed.
2. Imbalanced nutrition related to excessive intake of calories, sodium, or fats as evidenced by LDL/HDL results and voiced concern from pt.
   - Patient received education regarding healthy food choices when he is driving his semi for long hours/miles a day.
3. Deficient knowledge related to unfamiliarity with the disease, precautions, and side effects of hypertension as evidenced by new diagnosis and prescriptions
   - Cardiologist and nurses gave verbal and visual education regarding of importance to maintain medication regime, disease process, and diet modifications.
4. Acute pain related to headache as evidenced by photophobia and phonophobia
   - Patient reported headache pain decreased from 5/10 to 0/10 after oral hydration and PO Tylenol was administered.
5. Risk for infection related to truck driving profession as evidenced by not voiding for 12 or more hours at a time.
   - Patient stated he often waits over 12 hours to use the bathroom when he is driving his truck and was educated on the importance of voiding at regular intervals. In addition, patient was instructed to receive more hydration therefore will increase his need to void.

Objective Data

Ultrasound of the abdomen- pending results

EKG unremarkable normal sinus rhythm 77 beats per minute

2-day stress test- pending results

2019 Head CT- nonspecific patchy cerebral white matter

60-pound weight gain in 2 weeks

Patient Information

49-year-old male presented to the ER for complaints of severe headache accompanied by increased blood pressure. Patient's blood pressure readings in the Emergency Department (ED) were above 200 for systolic pressure and was transferred to the CCU. Patient reports occasional shortness of breath, chest pressure, and fatigue.

Nursing Interventions

1. Assess vital signs before and after activity

2. Administer CCB and diuretics as ordered

3. Encourage food diary for visual of healthy vs unhealthy choices

4. Provide education regarding meal prepping to plan for long days.

5.Assess the patient's overall comprehension ability

6. Discuss lifestyle changes that will need to be implemented

7. Stay up on medication administration of PO Tylenol to alleviate headache

8. Education regarding adequate fluid intake and output.

9. Monitor I&O while in the hospital

10. Encourage fluid intake of at least 2500 mL/day