

N311 Care Plan #1

Lakeview College of Nursing

Matthew Catlett

Demographics (5 points)

Date of Admission 12/07/XX	Patient Initials R.D.	Age 54	Gender Male
Race/Ethnicity African American	Occupation Retired	Marital Status Married	Allergies Penicillin, Peanuts, Sulfa, Shellfish
Code Status Full Code	Height 168 cm (66 in)	Weight 110 kg (242 lbs.)	

Medical History (5 Points)

Past Medical History: Hypertension, Coronary artery disease with angina, asthma

Past Surgical History: Tonsillectomy (Spring, 1992); Appendectomy (Winter, 2000)

Family History: Hypertension, COPD, throat cancer (paternal); hypertension, atherosclerosis (maternal)

Social History (tobacco/alcohol/drugs): Client reports cessation of smoking tobacco one month ago, occasionally chews tobacco.

Admission Assessment

Chief Complaint (2 points): Chest tightness that is not relieved with nitroglycerin tablets

History of present Illness (10 points): The patient was at residence when chest pain developed, took nitroglycerin twice then proceeded to contact emergency services when chest pain did not resolve. Upon arrival to the hospital the patient received a STAT EKG, 325 mg of aspirin, labs were drawn, troponin came back elevated, and EKG showed NSTEMI.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Myocardial infarction

Secondary Diagnosis (if applicable): N/A

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

Myocardial infarction occurs when the heart does not receive enough oxygen to the cardiac tissue. This causes damage to the cardiac tissue, and the severity of damage done is caused by three factors: level of occlusion in the artery, length of time the tissue goes without oxygen, and the heart's availability of collateral circulation (Capriotti & Frizzell, 2016).

Myocardial infarctions are most caused by coronary artery disease (Mayo Clinic, 2018). When the muscles of the heart go without oxygen, this is called ischemia. When ischemia occurs for more than 30 minutes in a specific area of the cardiac muscle, this leads to necrosis, or death of the cells.

It is possible to have a complete blockage in an artery, or a partial blockage. The complete blockage is called an ST elevation myocardial infarction, or STEMI. A partial blockage in a coronary artery is called a non-ST elevation myocardial infarction, or NSTEMI.

The difference between the two occurs at the ST segment of the client's EKG. A STEMI is a medical emergency in which the client's best odds of survival are to be rushed to the cardiac catheterization lab within 30 minutes so that a physician can open up the occluded artery with stents. An NSTEMI is less serious. The client does not need to usually be sent to the catheterization lab but can be monitored for further advancements of symptoms and treatment with medication (Mayo Clinic, 2018)

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Heart attack. (2018, May 30). Retrieved from

<https://www.mayoclinic.org/diseases-conditions/heart-attack/symptoms-causes/syc-20373106>

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

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	4.10-6.10	5.2	4.9	
Hgb	14.0-18.0 g/dL	15.9 g/dL	15.3 g/dL	
Hct	37.0-51.0%	54%	48%	Hematocrit levels increased due to possible erythrocytosis, COPD, or severe dehydration. ATI. (2019). <i>RN Adult Medical Surgical Nursing</i> (11.0 ed., Content Mastery Series)
Platelets	150-400	220	280	
WBC	5.00-12.00	6	5	
Neutrophils	2.0-8.0 x 10 ⁹ /L	6.0 x 10 ⁹ /L	4.0 x 10 ⁹ /L	
Lymphocytes	1.0-4.0 x 10 ⁹ /L	2.5 x 10 ⁹ /L	2.0 x 10 ⁹ /L	
Monocytes	0.2-0.8 x 10 ⁹ /L	0.30 x 10 ⁹ /L	0.40 x 10 ⁹ /L	
Eosinophils	< 0.5 x 10 ⁹ /L	0.20 x 10 ⁹ /L	0.30 x 10 ⁹ /L	

Bands	< 1.0 x 10 ⁹ /L	0.24 x 10 ⁹ /L	0.8 x 10 ⁹ /L	
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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-	136-145 mEq/L	140 mEq/L	142 mEq/L	
K+	3.5-5.0 mEq/L	3.6 mEq/L	4.2 mEq/L	
Cl-	98-106 mEq/L	104 mEq/L	100 mEq/L	
CO2	35-45 mm Hg	40 mm Hg	38 mm Hg	
Glucose	70-100 mg/dL	122 mg/dL	98 mg/dL	<p>Increased blood glucose due to increased stress from disease.</p> <p>ATI. (2019). <i>RN Adult Medical Surgical Nursing</i> (11.0 ed., Content Mastery Series)</p>
BUN	8-20 mg/dL	18 mg/dL	16 mg/dL	
Creatinine	0.7-0.13 mg/dL	0.8 mg/dL	0.9 mg/dL	
Albumin	3.5-5.5 g/dL	3.6 g/dL	4.2 g/dL	
Calcium	9.0-10.5 mg/dL	10.2 mg/dL	9.8 mg/dL	
Mag	1.5-2.4 mg	1.6 mg	2.2 mg	
Phosphate	3.0-4.5 mg/dL	4.2 mg/dL	3.4 mg/dL	
Bilirubin	0.3-1.2 mg/dL	0.8 mg/dL	0.7 mg/dL	
Alk Phos	36-92 U/L	68 U/L	77 U/L	

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	Pale yellow-Yellow; Clear	Yellow; Clear	Yellow; Clear	
pH	5-7	6.8	6.4	
Specific Gravity	1.005-1.025	1.030	1.015	Specific gravity increased due to possible dehydration. ATI. (2019). <i>RN Adult Medical Surgical Nursing</i> (11.0 ed., Content Mastery Series)
Glucose	None	None	None	
Protein	Negative	4 mg/dL	None	Protein present due to possible dehydration. ATI. (2019). <i>RN Adult Medical Surgical Nursing</i> (11.0 ed., Content Mastery Series)
Ketones	None	None	None	
WBC	<5	2	2	
RBC	<3	None	None	
Leukoesterase	Negative	Negative	Negative	

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*	N/A*

Blood Culture	Negative	*	*	*
Sputum Culture	Negative	*	*	*
Stool Culture	Negative	*	*	*

Lab Correlations Reference (APA): ATI. (2016). *RN Adult Medical Surgical Nursing* (10.0 ed., Content Mastery Series)

Diagnostic Imaging

All Other Diagnostic Tests (10 points): Patient received EKG due to MI. EKG showed sinus rhythm with occasional PVC. Patient also received chest x-ray which showed aorta and aortic arch has calcification and appears intact without dilation.

**Current Medications (10 points, 2 points per completed med)
*5 different medications must be completed***

Medications (5 required)

Brand/Generic	Prinivil/ Lisinopril	Bayer/ Aspirin	Plavix/ Clopidogrel	Narcan/ Naloxone	Arymo ER/ Morphine
Dose	10 mg	325 mg	75 mg	0.2 mg	2 mg
Frequency	10 mg daily	160-325 mg daily for 30 days	75 mg daily	PRN every 2 to 3 min if resp. rate is <10/min	PRN every 4 hr for moderate pain
Route	PO	PO	PO	IV	IV push
Classification	ACE inhibitor	Salicylate	P2Y₁₂ platelet inhibitor	Opioid antagonist	Opioid
Mechanism of Action	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II	Blocks the activity of cyclooxygenase , the enzyme needed for prostaglandin synthesis.	Binds to ADP receptors on the surface of activated platelets.	Briefly and competitivel y antagonizes mu, kappa, and sigma receptors in the CNS, thus reversing analgesia, hypotension, respiratory depression, and sedation caused by most opioids.	Binds with and activates opioid receptors in brain and spinal cord to produce analgesia and euphoria.
Reason Client Taking	Hypertensio n	M.I.	To reduce thrombotic event post M.I.	To treat known or suspected opioid overdose	To relieve pain severe enough to require opioid treatment
Contraindicatio ns (2)	-Concurrent aliskiren use in patients	-Active bleeding or coagulation	-Active pathological bleeding,	-Hyper- sensitivity to naloxone or	-Alcohol withdrawal syndrome

	<p>with diabetes or patients with renal impairment.</p> <p>-hereditary or idiopathic angioedema or history of angioedema related to previous treatment with an ACE inhibitor</p>	<p>disorders.</p> <p>-Current or recent GI bleed or ulcers.</p>	<p>including peptic ulcer and intracranial hemorrhage.</p> <p>-Hyper-sensitivity to clopidogrel and its components.</p>	<p>its components.</p> <p>-N/A</p>	<p>-Brain tumor</p>
<p>Side Effects/Adverse Reactions (2)</p>	<p>Arrhythmias, hypotension</p>	<p>Bronchospasm , hepatotoxicity</p>	<p>Hypotension , aplastic anemia</p>	<p>Cardiac arrest. Ventricular fibrillation</p>	<p>Cardiac arrest, hypotension</p>

Medications Reference (APA): Jones & Bartlett Learning. (2020). *2020 Nurses drug handbook*. Burlington, MA.

Assessment

Physical Exam (18 points)

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>-Client was alert and oriented. -Client showed signs of distress due to angina. -Client was well groomed.</p>
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INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: 22 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	<ul style="list-style-type: none"> -Clients skin was ashen grey -Clients skin temperature was warm to the touch -Clients skin turgor showed signs of dehydration -No rashes, bruises, or wounds present.
HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:	<ul style="list-style-type: none"> -Head/Neck: Normal; no deviations. -Ears: TM pearly grey; without drainage -Eyes: Sclera's are white, positive RLL -Nose: Moist, pink; no septal deviation -Teeth: Dentition good, client does not use dentures.
CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	<ul style="list-style-type: none"> -S1 and S2 sounds audible, no murmurs present. - Clear heart sounds throughout. -Capillary refill < 3 seconds. -Pulses present bilaterally on upper and lower extremities.
RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	<ul style="list-style-type: none"> -Breath sounds audible in left and right lung. -No adventitious breath sounds heard.
GASTROINTESTINAL: Diet at home: Non-restrictive Current Diet: NPO Height: 168 cm Weight: 110 kg Auscultation Bowel sounds: Last BM: 12/06/XX Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds:	<ul style="list-style-type: none"> -Bowel sounds audible in all four quadrants. -Client reports no special diet. -No masses palpable. -No pain present in abdomen. -No distention present. -Scars present from previous appendectomy. -No drains present.

<p>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Indwelling Size: N/A</p>	<p>-Urine is yellow; clear. -No odor present.</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Full, without deficit. Supportive devices: None Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 0 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>-Client is independent. -Client is able to ambulate on his own. -No supportive devices used.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>-Client was alert and oriented. -Pupils were equal and reactive to light. -Speech was normal. -No mental impairments present.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>-Client is African American -Client does not identify with any religion. -Uses meditation to cope. -Retired, lives with wife. -Client has 3 children, all live separate from client.</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
2100	96	112/66	14	36 C	98% 2L/min/ NC

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
2100	Number	Chest	0	N/A	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
0 mL	0 mL

Nursing Diagnosis (15 points)

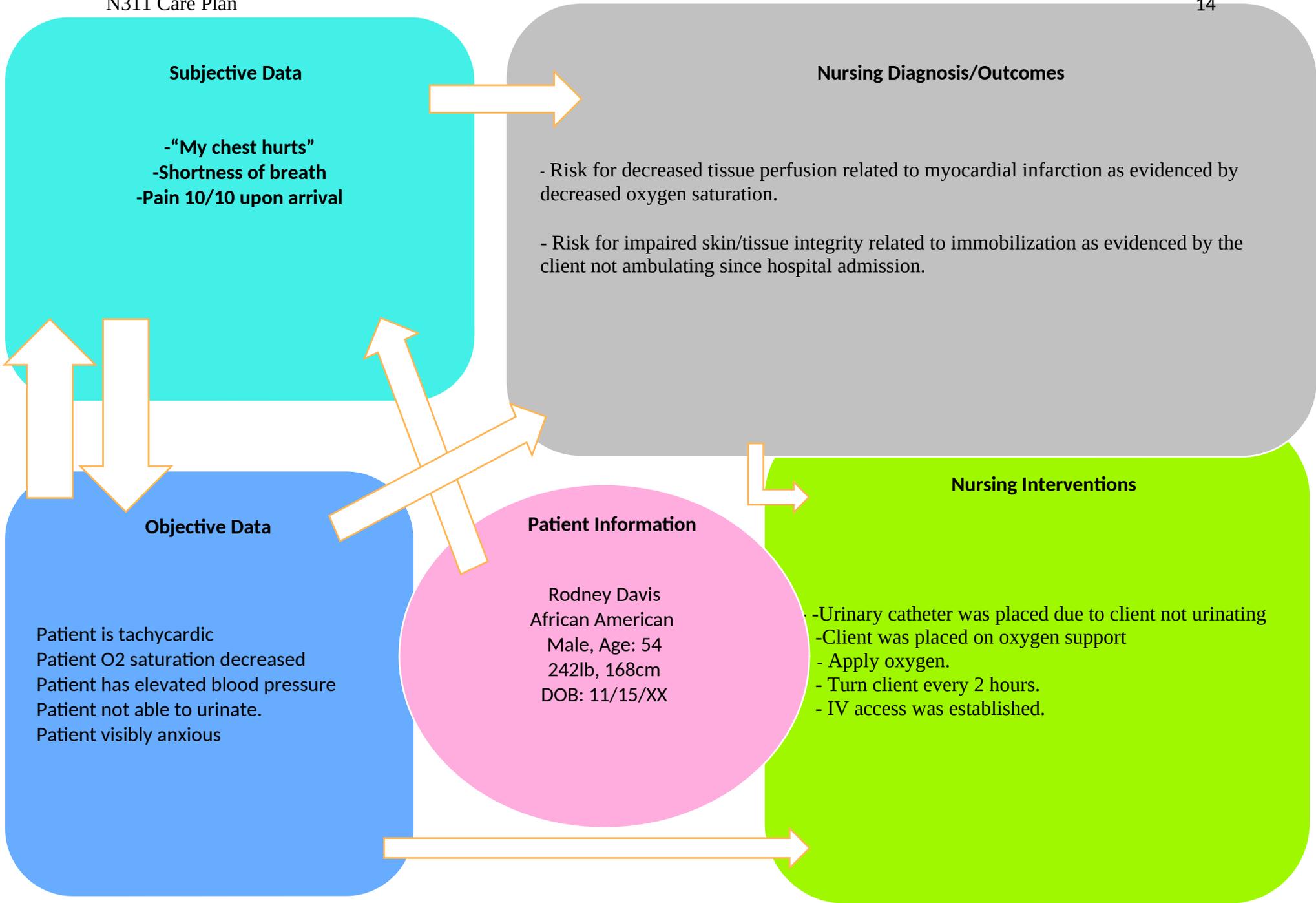
Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 		<ul style="list-style-type: none"> 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 tissue perfusion related to myocardial infarction	As evidenced by decreased oxygen saturation	1. Apply oxygen. 2. Elevate head of the bed > 30 degrees.	-Oxygen saturation increased to greater than 95% after oxygen was administered and bed was elevated. -Client's breathing was unlabored.
2. Risk for impaired skin/tissue integrity related to immobilization	As evidenced by the client not ambulating since hospital admission.	1. Turn client every 2 hours. 2. Keep client clean and dry.	-Client is not showing signs of skin breakdown.

Other References (APA):

Concept Map (20 Points):



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