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Acute coronary syndrome Comfort & daily function

Adult Health Nursing | Comfort & daily function

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

59-year-old man with suspected myocardial ischemia. Care stage: During supported recovery and essential daily activity.

Medical history: New central chest pressure occurred at rest and is being investigated urgently. A history of hypertension is reported; previous coronary procedures are not reported in this vignette. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Central chest pressure with sweating and nausea.

Objective findings and required checks: Distress and possible circulation changes; urgent cardiac assessment is underway.

Physical examination and investigations: Obtain urgent ECG and serial cardiac biomarkers according to the pathway; monitor rhythm and observations.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Acute coronary syndrome: Reduced coronary blood flow threatens myocardial tissue and may cause arrhythmia or pump failure.

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Medical / surgical management

Activate the acute coronary pathway, limit exertion and prepare prescribed antiplatelet and reperfusion-related care.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed antiplatelet therapy	Reduce platelet-related thrombosis when indicated	Check contraindications, allergy and bleeding
prescribed nitrate	Relieve ischemic symptoms in suitable patients	Monitor blood pressure and contraindications.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Central chest pressure with sweating and nausea. Distress and possible circulation changes; urgent cardiac assessment is underway. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize reduced circulation to vulnerable tissues; pain interfering with rest or activity; emotional distress affecting participation in care; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

During the next agreed care or activity session: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Activate the acute coronary pathway, limit exertion and prepare prescribed antiplatelet and reperfusion-related care. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This

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vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about dizziness, chest discomfort, fatigue and cold extremities. Assess: Assess consciousness, pulse, blood pressure, capillary refill and urine trend.	Reduced circulation to vulnerable tissues. Possible factors: altered blood flow or cardiac function. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Circulation and consciousness remain within the clinician-agreed targets. Longer-term: Before the clinically approved transition or agreed follow-up: Describes symptoms that require immediate review and the agreed follow-up plan.	1. Trend perfusion findings and escalate new chest pain, shock or altered consciousness immediately. Rationale: Poor circulation can rapidly threaten organ function. 2. Balance activity and rest and maintain the ordered monitoring schedule. Rationale: Reducing demand supports recovery while trends guide treatment. 3. Administer prescribed therapy and monitor effects and adverse reactions. Rationale: Response monitoring supports safe correction of the underlying problem. 4. Activate the acute coronary pathway, limit exertion and prepare prescribed antiplatelet and reperfusion-related care. Rationale: Reduced coronary blood flow threatens myocardial tissue and may cause arrhythmia or pump failure. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about pain site, onset, severity, quality and the patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	Pain interfering with rest or activity. Possible factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Pain decreases toward the patient-agreed target after reassessment. Longer-term: Before the clinically approved transition or agreed follow-up: Uses agreed comfort strategies and explains when new or worsening pain needs review.	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication and helps evaluate relief. 2. Provide comfortable positioning, reassurance and appropriate non-drug measures. Rationale: Comfort measures can reduce distress and complement prescribed treatment. 3. Give prescribed analgesia and monitor sedation, breathing and other adverse effects. Rationale: Relief should improve function without creating medication-related harm.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: During the next agreed care or activity session: Explains the most	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. After stabilization explain medicines, cardiac rehabilitation, emergency symptom action and follow-up. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

After stabilization explain medicines, cardiac rehabilitation, emergency symptom action and follow-up.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Ongoing chest pain, arrhythmia, syncope, shock or pulmonary edema requires immediate escalation.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Reduced coronary blood flow threatens myocardial tissue and may cause arrhythmia or pump failure.

- Priority concerns: Reduced circulation to vulnerable tissues; Pain interfering with rest or activity; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- Ongoing chest pain, arrhythmia, syncope, shock or pulmonary edema requires immediate escalation.

- After stabilization explain medicines, cardiac rehabilitation, emergency symptom action and follow-up.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

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