

Student Case Study CHF

The following patient has just arrived to the medical intensive care unit (MICU) and you take the following report at 0500 from the emergency department (ED) nurse: We have a patient for you; Fanny Mae is an 81-year-old frail woman who has come to us from a nursing home at 0200. Her primary admitting diagnoses are sepsis, pneumonia, and dehydration, and she has a known stage III right hip pressure ulcer. Her past medical history includes cerebrovascular accident with residual right-sided weakness and paresthesia, a myocardial infarction, and peripheral vascular disease. She is a full code. Her vital signs on arrival were: blood pressure 98/62, heart rate 88 bpm and regular, respirations 38 and labored, and a temperature of 100.4 F (38 C). She is on oxygen at 4 liters per nasal cannula, she has an 18-gauge intravenous to the right forearm with D5 ½ NS at 100 mL/hr. We just inserted a 16 French Foley catheter. Her current vital signs are: blood pressure 91/59, heart rate 92, respirations 38, and temperature of 101.2 F. There are no home medications listed, the infectious disease doctor has been notified, and the respiratory therapist is with the patient. The patient is just leaving the ED and should arrive shortly.

0700 Fanny Mae arrives to MICU. You connect her to the cardiac monitor and her vital signs are: blood pressure 80/48, heart rate 121, respirations 39 and labored on 4 liters per nasal cannula and temperature 102.5 F. Lab results are as follows:

Lab:	Nursing Home:	ED:	MICU
WBC	13	15	17
HGB	10	10.1	9.0
HCT	38	40	42
RBC	4	3.9	3.0
PT	12	13	15
INR	1.8	1.9	2.5
Lactic Acid	2.1	3.8	4.0