N303 Care Plan # 1

Lakeview College of Nursing

Logan Sanford

Demographics (3 points)

Date of Admission **01/28/2019**	**Patient Initials** **RL**	**Age** **92 years old**	**Gender** **Male**
Race/Ethnicity **White/Caucasian**	**Occupation** **Technician**	**Marital Status** **Widow**	**Allergies** **ciprofloxacin (Ciloxan) and penicillins**
Code Status **Full Code**	**Height** **174 cm**	**Weight** **79.700 kg**	

Medical History (5 Points)

Past Medical History: Pulmonary edema, pacemaker, fall risk, non sustained ventricular tachycardia, dizziness, advanced age, hypertensive cardiovascular disease, paroxysmal atrial fibrillation, Vitamin B12 deficiency, hypertension, urge urinary incontinence, chronic GERD, COPD, arthritis, skin cancer, and establishing care with new doctor

Past Surgical History: Cholecystectomy, appendectomy, cataract extraction, transurethral resection of the prostate, exploration of the maxillary sinus

Past Family History- Father: congestive heart failure, Brother: heart attack

Social History (tobacco/alcohol/drugs, pertinent social factors): Patient stated he smoked a pack and a half of cigarettes per day for 15 years and stopped smoking in 1965. Patient denies any substance abuse and stated that he currently drinks a glass of wine "on occasion." Patient said he started drinking beer around 17 years old but drank about once a week. When asked how often he currently drinks wine he stated he drinks a glass of wine one or two nights a week. Patient uses a cane to go out in public but does not use it at home around the house. Patient is a widow and lives at home by himself in his house. Patient

stated he does not have family around to help him out. Patient stated that he is a retired model shop technician and holds a GED and 5 certificates.

Admission Assessment

Chief Complaint (2 points): Patient came in to the emergency room with uncontrolled blood pressure stating he has been unable to get his blood pressure up all morning.

History of present Illness (10 points): Patient is a 92 year old male with a history of pulmonary edema, pacemaker, fall risk, non sustained ventricular tachycardia, dizziness, advanced age, hypertensive cardiovascular disease, paroxysmal atrial fibrillation, hypertension, urge urinary incontinence, vitamin B12 deficiency, chronic GERD, COPD, arthritis, skin cancer, and brought himself to the emergency room by car with complaints of low blood pressure since the morning of January 28, 2019. The patient presented to the emergency room with a blood pressure of 92/64 and stated he began to feel lightheaded and dizzy. Patient stated he had those symptoms for the previous two days before admission to the hospital on January 29. Patient stated that the two days prior to admission he was able to get his blood pressure up on his own by taking his blood pressure medicine and "waiting it out." He stated that the morning of admission to the hospital he was "unable to get his blood pressure back up and his symptoms would not go away" so he brought himself in. Patient claimed these problems started when his pacemaker was placed in June and these symptoms have been occurring since his blood pressure medicine was changed in August. Patient describes his symptoms of feeling lightheaded, dizzy, and feels "weightless." He stated he has these episodes at least once a month. Patient stated sitting down and taking

his blood pressure medicine helps his symptoms when occurring. Patient claims the symptoms are very "random" and are not triggered by anything. Patient did not take his blood pressure medicine the morning of being admitted to the hospital because he claimed that he "did not feel right" when he woke up that morning and that "the symptoms were far worse than normal." Patient stated he had no chest pain, fever, chills, shortness of breath, shakes, pain, nausea, vomiting, or diarrhea. Patient denied having any motor or sensory symptoms.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Orthostatic hypotension

Secondary Diagnosis (if applicable): N/A

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

Orthostatic hypotension is defined as a systolic blood pressure decrease of at least 20mm Hg or a diastolic blood pressure decrease of at least 10mm Hg within three minutes of standing (Hinkle & Cheever, 2018, pp 933). The positional drop in blood pressure is directly related to the pooling of blood in the veins of the liver, intestines, organs, legs, and feet. As a result of the pooled blood the venous return and stroke volume decrease which results in cardiac output becoming compromised and the arterial blood pressure drops. Gravity also plays a major role in orthostatic hypotension by causing the blood to rush downward from the torso to the feet when the patient stands which then decreases venous return further. The body attempts to compensate for the sudden shift by activating baroreceptors located in the aorta and carrots arteries. These receptors are stimulated by pressure by the blood in the vessels. When the blood accumulates in the lower extremities,

the upper body vessel pressure falls which then causes the baroreceptor stimulation tot stop. This information by the body is then transmitted to the brain where the medulla then reacts by initiating vasoconstriction which increases the heart rate and cardiac output to return the pressure of the vessel walls and raise the blood pressure. Baroreceptors continuously work throughout our body to maintain normal blood pressure throughout the day. Compensation for the baroreceptors is not immediate so its may take several minutes to restore the body to normal blood pressure after the drop which is why orthostatic hypotension is described as a drop over a 3 minute period. Age plays a very large role in orthostatic hypotension. As a person ages, the hearts ability to pump blood becomes diminished. The anatomy of the heart as a person ages begins to change by the blood vessels stiffening and weakening causing decreased cardiac output which results in the decreased compensation after the patient is laying supine. Baroreceptors are also effected with age by becoming less sensitive to pressure changes and the signals sent to the brain become less effective with age (Mager, 2012.)

Common signs and symptoms seen in patients with orthostatic hypotension can range anywhere from diminished cognation and disturbed mental status to lightheadedness, dizziness, changes in vision, syncope/fainting, and death. Other common signs include weakness, fatigue, nausea, palpations, and headache. Expected findings include a drop in systolic blood pressure of at least 20mm Hg or a diastolic blood pressure decrease of at least 10mm Hg within three minutes of standing. Orthostatic hypotension is diagnosed by taking a blood pressure while the patient is laying down, sitting, and upright. This test was performed on my patient to determine the diagnosis. Other tests that may be

ordered are a blood test, electrocardiogram, echocardiogram, stress test, or tilt table test. As I was leaving the floor, orthostatic vital signs were being done on the patient to verify the diagnosis (Mager, 2012.)

Common treatments associated with this diagnosis are to improve the symptoms without causing supine hypertension. Patient education plays a very large role in the treatment of the diagnosis. Educating the patient to avoid carbohydrate rich meals, adding sodium-rich foods or sodium tablets to thee diet, limiting alcohol consumption, and ensuring adequate hydration. If pharmacological means are necessary to treat the diagnosis, the first line medication used are mineralocorticoids. Treatment for my patient had not yet been implemented but the patient was receiving 0.9% sodium chloride while admitted to the floor (Mager, 2012.)

References

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Mager, D. R. (2012, October). CEArticle. Retrieved February 2, 2019, from https://www.nursingcenter.com/cearticle?an=00004045-201210000-00005&Journal_ID=2695880&Issue_ID=1436309

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	4.28-5.56	5.42	5.42	Value was within normal limits.
Hgb	13.0-17.0	15.6	15.6	Value was within normal limits.
Hct	38.1-48.9	46.3	46.3	Value was within normal limits.
Platelets	149-393	241	241	Value was within normal limits.
WBC	4.0-11.7	9.2	9.2	Value was within normal limits.
Neutrophils	2.4-8.4	6.6	6.6	Value was within normal limits.
Lymphocytes	0.8-3.7	1.2	1.2	Value was within normal limits.
Monocytes	4.4-12.0	10.7	10.7	Value was within normal limits.
Eosinophils	0.0-6.3	3.4	3.4	Value was within normal limits.
Bands	0-5	N/A	N/A	N/A

Chemistry: Highlight Abnormal—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	137	137	Value was within normal limits.
K+	3.5-5.1	4.3	4.3	Value was within normal limits.
Cl-	98-107	99	99	Value was within normal limits.
CO2	22-29	28	28	Value was within normal limits.

Glucose	70-99	128 (H)	128 (H)	Hyperglycemia is aresuly of several factors such as infrction, illness, streaa, and possibly the fact that the patient had just eaten lunch **(Hinkle & Cheever, 2018).**
BUN	6-20	20	20	Value was within normal limits.
Creatinine	0.70-1.20	1.24 (H)	1.24 (H)	The patient having low creatinine levels could be reealted to being ill and age. Low levels indeicate the muscles are less strong and are deteriorating **(Hinkle & Cheever, 2018).**
Albumin	3.5-5.2	3.8	3.8	Value was within normal limits.
Calcium	8.6-10.4	9.3	9.3	Value was within normal limits.
Mag	1.6-2.4	1.8	1.8	Value was within normal limits.
Phosphate	3.5-5.0	N/A	N/A	N/A
Bilirubin	0.0-1.2	1.0	1.0	Value was within normal limits.
Alk Phos	40-130	87	87	Value was within normal limits.
AST	0-40	14	14	Value was within normal limits.
ALT	0-41	12.0	12	Value was within normal limits.
Amylase	56-90	N/A	N/A	N/A
Lipase	13-60	N/A	N/A	N/A
Cholesterol	< 200	N/A	N/A	N/A
Triglycerides	< 150	N/A	N/A	N/A
Lactic Acid	0.6-2.2	N/A	N/A	N/A

Troponin	0.00-0.30	< 0.30	< 0.30	Value was within normal limits.
CK-MB	0.00-7.70	2.44	2.44	Value was within normal limits.
Total CK	20-200	38	38	Value was within normal limits.

Other Tests Highlight Abnormal—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	2.0-3.0	N/A	N/A	N/A
PT	9.6-11.8	N/A	N/A	N/A
PTT	20-36	N/A	N/A	N/A
D-Dimer	< 500	N/A	N/A	N/A
BNP	0.5-30	N/A	N/A	N/A

Urinalysis Highlight Abnormal—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	Yellow	**N/A**	**N/A**	**N/A**
pH	5.9-8.0	**N/A**	**N/A**	**N/A**
Specific Gravity	1.005-1.034	**N/A**	**N/A**	**N/A**
Glucose	Normal	**N/A**	**N/A**	**N/A**
Protein	Negative	**N/A**	**N/A**	**N/A**
Ketones	Negative	**N/A**	**N/A**	**N/A**
WBC	4.0-11.7	**N/A**	**N/A**	**N/A**
RBC	3.80-5.41	**N/A**	**N/A**	**N/A**
Leukoesterase	Negative	**N/A**	**N/A**	**N/A**

Arterial Blood Gas Highlight Abnormal—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**	**N/A**
PaO2	**80-100**	**N/A**	**N/A**	**N/A**
PaCO2	**35-45**	**N/A**	**N/A**	**N/A**
HCO3	**21-26**	**N/A**	**N/A**	**N/A**
SaO2	**95-99%**	**N/A**	**N/A**	**N/A**

Cultures Highlight Abnormal—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	**N/A**	**N/A**	**N/A**
Sputum Culture	Negative	**N/A**	**N/A**	**N/A**
Stool Culture	Negative	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Diagnostic Imaging—All Other Diagnostic Tests (EKG, Echocardiogram, X-rays, CT scan, etc.) (5 points):

- **CT of the brain/head without contrast**
    - **A computed tomography scanning (CT scan) uses a narrow x-ray beam tot scan body parts in successive layers. A CT scan was done on my patient to identify the reason for the patients lightheadedness.**
    - **Per the radiologist there was no acute intracranial abnormalities.**
- **X-ray of the chest: 1 view**

- **An x-ray is a noninvasive medical test that helps diagnose and treat medical conditions. Imaging involves exposing a part of the body to a small amount of ionized radiations to produce pictures of the inside of the body. An x-ray was done on my patient to determine the cause of hypotension upon admission.**
- **Per the radiologist there was no acute cardiopulmonary process.**

Diagnostic Test Correlation, APA Format & References (5 points):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Philadelphia, Pa: Wolters Kluwer Health Lippincott Williams & Wilkins.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed
Hospital Medications (5 required)

Brand/Generic	**enoxaprin (Lovenox)**	**diltiazem (Cardizem)**	**mirabegron (Myrbetriq)**	**(acetylsalicylic acid) Aspirin**	**cyanocobalamin (vitamin B12)**
Dose	**0.4 mL daily**	**60 mg, 1 tablet, BID**	**25 mg, 1 tablet, daily**	**81 mg, 1 tablet, daily**	**1 tablet daily**
Route	**SQ**	**PO**	**PO**	**PO**	**PO**
Classification	**Anticoagulant**	**Calcium Channel Blocker**	**Beta-3 adrenergic agonist**	**Nonsteroidal anti-inflammatory drug**	**Vitamin**

Action	**Binds to and potentiates antithrombin to forma a complex that irreversibly inactivates clothing factor Xa.**	**Inhibits transport of calcium into myocardial and vascular smooth muscle.**	**Relaxes the detrusor smooth muscle during the storage phase of the urinary bladder fill-void cycle.**	**Inhibit the activator of the enzyme called cyclooxygenasee which leads to the formation of prostaglandins that cause inflammation, swelling, pain, and fever.**	**Aids body in using fat and carbohydrates for energy and make new protein.**
Reason Client Taking	**Patient is taking Lovenox as a preventative measure to prevent a DVT.**	**Patient is taking for past medical history of hypertension.**	**Patient is taking for history of urge urinary incontinence.**	**Patient is taking for history of arthritis.**	**Patient is taking for deficiency of vitamin B12.**
Contraindications (2)	**Active major bleeding and renal impairment**	**Congestive heart failure and hepatic impairment**	**Hypertension and hepatic disease**	**History of an active bleeding disorder and aortic aneurysm**	**Anemia and bone marrow suppression**
Side Effects/ Adverse Reactions (2)	**Hemorrhage and hepatotoxicity**	**Syncope and hepatic injury**	**Increased blood pressure and dizziness**	**Seizure and bloody, tarry stools**	**headache and diarrhea**

Nursing Considerations (2)	**Monitor labs and assess for bleeding and signs of hemorrhage**	**Monitor blood pressure and monitor serum digoxin levels**	**Monitor blood pressure and and for signs and symptoms of angioedema**	**Monitor vital signs and for signs of bleeding**	**Assess for signs of anemia and heart failure**
Client Teaching needs (2)	**Stop taking and call physician if they have black, tarry stools, excessive fatigue, difficult breathing or swallowing and swelling of the extremities**	**Avoid grapefruit juice and change positions slowly to minimize orthostatic hypotension**	**If you miss a dose, skip the dose and take as scheduled the following day and do not drink alcohol**	**Take with food or milk and store the medicine in a closed container at room temperature , away from heat, moisture, and direct sunlight**	**Foods high in vitamin B12 include meats, seafood, egg yolk, and fermented cheeses and patients self administering should not exceed the recommended amount**

Home Medications (5 required)

Brand/Generic	**diltiazem (Cardizem)**	**(acetylsalicylic acid) Aspirin**	**ranitidine (Zantac)**	**prednisone (Deltasone)**	**Furosemide (Lasix)**
Dose	**120 mg BID**	**81 mg, 1 tablet, daily**	**75 mg daily**	**20 mg daily**	**20 mg daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	**Calcium Channel Blocker**	**Nonsteroidal anti-inflammatory drug**	**H2 blockers**	**Corticosteroids**	**Diuretic**
Action	**Inhibits transport of calcium into myocardial and vascular smooth muscle.**	**Inhibit the activator of the enzyme called cyclooxygenasee which leads to the formation of prostaglandins that cause inflammation, swelling, pain, and fever.**	**Blocks the production of acid by acid-producing cells in the stomach.**	**Inhibits inflammatory cells and surpasses expression of inflammatory mediators**	**Blocks the absorption of sodium, chloride, and water from the filtered fluid in the kidney tubules**
Reason Client Taking	**Patient is taking for past medical history of hypertension.**	**Patient is taking for history of arthritis.**	**Patient has a past medical history of chronic GERD.**	**Patient has a past medical history of skin cancer and arthritis**	**Patient has a past medical history of pulmonary edema**

Contraindications (2)	**Congestive heart failure and hepatic impairment**	**History of an active bleeding disorder and aortic aneurysm**	**Stomach caner and liver problems**	**heart failure and high blood pressure**	**Hyperglycemia and diabetes mellitus**
Side Effects/ Adverse Reactions (2)	**Syncope and hepatic injury**	**Seizure and bloody, tarry stools**	**Constipation and insomnia**	**Heartburn and increased sweating**	**Diarrhea and vertigo**
Nursing Considerations (2)	**Monitor blood pressure and monitor serum digoxin levels**	**Monitor vital signs and for signs of bleeding**	**Assess for early signs of toxicity (jaundice, elevated transminases and LDH) and monitor labs for live functions**	**Report weight gain of 5 pounds and monitor serum potassium levels**	**Monitor daily weight and I/O's**

Client Teaching needs (2)	**Avoid grapefruit juice and change positions slowly to minimize orthostatic hypotension**	**Take with food or milk and store the medicine in a closed container at room temperature, away from heat, moisture, and direct sunlight Take with food or milk and store the medicine in a closed container at room temperature, away from heat, moisture, and direct sunlight**	**Long duration of actin provides ulcer pain relief that is maintained through the night as well as the day and do not smoke while on this medicaiton**	**Do not stop taking abruptly and laxatives and diuretics may increase severalty of hypokalemia**	**Contact provider immediately if rash, muscle cramps, nausea, dizziness or tingling of the extremities occur and notify provider of weight gain of 3 pounds in 1 day**

Medications Reference (APA Format):.

Cella, D. D. (2017). *Nurse's Drug Handbook* (Sixteenth ed.). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

NEUROLOGICAL (2 points): **MAEW: Y □ N□** **PERLA: Y □ N□** **Strength Equal: Y □ N □ if no -** **Legs □ Arms □ Both □** **Orientation, Mental Status, Speech, Sensory, LOC: LOC x4**	**Patient is A&O x4 with the ability to communicate his needs to the health care team. Patient is able to MAEW and has bilaterally equal strength for arms and legs. His response to PERRLA was WDL and has no signs of neurological deficits.**
MUSCULOSKELETAL (2 points): **Neurovascular status, ROM, Supportive devices/strength** **ADL Assistance Y□ N □** **Fall Risk: Y □ N□** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment: does not require assistance** **Needs support to stand and walk: does not need support to walk to stand**	**Fall risk: 45** **Patient does not need assistance to sit, stand, or walk. Patient does not require assistance with activities of daily living. Patient is a fall risk due to the fluctuation in blood pressure and symptoms of lightheadedness. Patients range of motion was WDL Anas well as his neuromuscular status.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): regular** **Peripheral Pulses: palpable** **Capillary refill: < 3 seconds** **Neck Vein Distention: Y □ N □** **Edema Y □ N □** **Location of Edema: N/A**	**Patients hears sounds were regular with a normal sinus rhythm. There was no murmur heard upon auscultation during the assessment. Patients peripheral pulses were palpable and capillary refill was < 3 seconds. Patient presented with no neck vein distention and no edema.**
RESPIRATORY (2 points): **Accessory muscle use: Y□ N □** **Breath Sounds: Location, character**	Patient showed no use of accessory muscles while assessing his breathing. Patients breath sounds were clear bilaterally with no wheezes or crackles.

GASTROINTESTINAL (2 points): **Diet at home: Regular** **Current Diet: Heart healthy** **Height: 174 cm** **Weight: 79.700 kg** **Auscultation Bowel sounds: hypoactive** **Last BM:** 1/27/2019 **Palpation: Pain, Mass etc: no pain or masses were present upon palpation and inspection of the abdomen.** **Inspection: distention, incisions, scars, drains, wounds: none** **Ostomy: Y □ N □** **Nasogastric: Y □ N □** **Feeding tubes/PEG tube Y □ N □** **Type:_____**	**Patient follows a regular diet at home but is currently following a heart healthy diet on the floor. Patients height is 74 cm and he weights 79.700 kg. Patients bowel sounds were hypoactive and he stated his last bowel movement was on 1/27/2019. Patient had no masses present upon palpation and complained of no abdominal pain. There was no distention present. There was no incisions, scars, drains, or wounds. Patient did not have an ostomy and did not have a nasogastric tube. Patient did not have tube feedings.**
INTEGUMENTARY (2 points): **Skin color** **character, turgor, rashes, bruises:** **wounds:** skin turgor "tented," patient had no rates or open wounds, patient did not have any bruises **Braden scale: 21** **Drains present: Y□ N □** **Type_____**	**Patients skin appeared healthy, pink, warm, and dry with no rashes, bruises, or wounds. Patients skin tumor appeared to "tent" upon assessment. Patient did not appear to have discoloration on the skin and did not have any drains present. Patients braden scale was a 21..**
HEENT (2 points): **Head: normocephalic.** **Ears: normal hearing** **Eyes: no visual problems** **Nose: no sinus tenderness** **Teeth: partial dentures that appeared healthy**	**Patients head, ears, eyes, and teeth appeared healthy. Patient had partial dentures and the gums and teeth appeared healthy upon assessment.**

GENITOURINARY (2 Points): **Color, character, quantity of urine, pain** **Dialysis Y □ N □** **Inspection of genitals: healthy with no open wounds or discoloration** **Catheter: Y □ N □ Type: N/A**	**Patient stated his urine was yellow and light. Patient stated no discomfort upon urination. Patient is not on dialysis and patient does not have a catheter.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping methods: dancing** **Educational level: GED with 5 certificates** **Developmental level: psychological and developmental level coincide** **Ethnicity,** **Religion & what it means to pt: methodist** **Occupation (previous if retired): retired model shop technician** **Personal/Family Data (Think about home environment, family structure, and available family support): no help or support at home**	Upon assessing the patient he stated he uses line dancing as a way of coping and "staying young." Patient stated he got his GED and received 5 certificates after completing his GED. Patients psychological and developmental skills coincide. Patient is white/caucasian. Patient is a retired model shop technician and lives at home by himself. Patient stated he grew up Methodist but he does not attend church anymore. Patient has a daughter and a son with grandkids but does not receive any help at home. Patients plans on going home after discharge.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1210	81 bpm	137/80	20 bpm	36.7C	93%
1600	64 bpm	119/81	18 bpm	36.6C	95%

Vital Sign Trends:

Patients vital signs were at a desirable level and appeared normal throughout my shift.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1210	Numeric scale	M/A	0/10	N/A	No interventions were needed
1600	Numeric scale	N/A	0/10	N/A	No interventions were needed

IV Assessment (2 Points)

Site Location, Patency/Condition & Date	Fluid Type/Rate or Saline Lock
Right peripheral anti cubital 20 gauge placed on 1/28/2019. IV was dry, intact, and there was no phlebitis present.	Sodium Chloride 0.9% intravenous solution 1,000 mL @ 100 mL/hr

Intake and Output during Your Shift (2 points)

Intake	Output
500 mL	**550 mL**

Nursing Care

Summary of care- Narrative of Nursing care provided, patient status throughout the day, any major concerns, etc. (2 points):

The patient referred doing things on his own and was very independent. The major of the care I provided to the patient was assisting him to the bathroom, getting him water, and assisting his vital signs. The patient did not leave the floor during my shift for any testing or procedures. The patient felt lightheaded when admitted to the hospital so my main focus

throughout the day was preventing him from falling and assisting him in any way possible. It was also my focus to assess him for any signs of hypotension. The education I provided to the patient was the importance of sitting down when signs of hypotension come on to prevent further complications and the patient from falling due to him being 92 years old. The patient expressed his understanding for the teaching provided by repeating back the importance of preventing falls due to his increased age. Patient had no complaints or concerns during my shift. The patients vital signs were stable throughout the whole shift. There were not concerns as far as labs or diagnostic imaging to report to the nurse. The patient tolerated activity well and showed no signs of hypotension upon mobilization to the bathroom. I anticipate the patient will need assistance at home at least once a week to help him around the house and to check in to make sure there are no safety hazards.

Discharge Planning- Identify discharge needs, education, home health services/equipment, family involved, etc. (2 points):

Patient will go home by himself to his house upon discharge. The patient will need someone to come in and check for safety hazards in the home and occasionally check in to make sure he does not need assistance with anything due to his children not coming around. Patient has a cane that he uses on occasion and when he leaves his home. The patient should be sent home with an order for a manual blood pressure reading to check his vital signs when he feels symptoms approaching. Patient should follow up with his cardiologist to look over his mediation due to these being fairly new symptoms after his recent medication change.

Patient should keep a log of his blood pressure to bring to his cardiologist to show trends in his vital signs.

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. Decreased cardiac output related to low blood pressure as evidenced by blood pressure reading of 93/64	**Patient has a past medical history of pulmonary edema related to the heart not perfusing appropriately**	**1.** Monitor vital signs every 4 hours **2.** Administer fluids to the patient to increase perfusion	**Patient did not have family present but he expressed an understanding of the importance of assessing his blood pressure and the goal was meet. The patients vital signs were stable and he verbalized what a good blood pressure should read (120/80)**
2. Fluid volume deficit related to decreased cardiac output as evidenced by low blood pressure	Patients symptoms are stemming from the patient not having enough fluid which results in the patient experiencing signs of low blood pressure	**1.** Encourage 2-3 L of fluids daily **2.** Assess I/O's	**Patient did not have family present but the expressed an understanding of the importance of fluid intake and was pushing fluids throughout my shift. The goal was met and his blood pressure was 119/81 at the end of my shift.**

3. Ineffective tissue perfusion related to decreased cardiac output as evidenced by syncope	Patient is at an increased risk for ischemia due to the heart not pursuing appropriately and the patients age puts him at an even higher risk for ischemia, confusion, and dizziness	**1.** Assess patient for signs of ineffective tissue perfusion such as discoloration of the extremities and dizziness **2.** Monitor daily weight	**Patient did not have any family present but he expressed an understanding of the importance of reporting signs of lack of tissue perfusion. The goals was met and the patient verbalized signs of decreased tissue perfusion (discoloration of the extremities, syncope, and confusion)**
4. Risk for falls related to syncope as evidenced by low blood pressure	Patients age and history of low blood sugar place him at an increased risk for falls which could lead to further complications	**1.** Implement fall risk precautions **2.** Educate the patient on the prevention of falls	**Patient did not have family present but he expressed his understanding of the importance of using the call light during admission and using his cane when discharged from the hospital. The goal was met and the patient verbalized the importance of fall prevention.**
5. Risk for dehydration related to decreased fluid volume as evidenced by tenting of the skin	Due to the patient being at an increased age he is more at risk for dehydration which can lead to symptoms that he is currently experiencing	**1.** Monitor labs (BUN) **2.** Assess skin turgor	**The patient did not have any family present but he expressed the understanding of the importance of drinking fluids and maintainting a fluid intake of 2-3L per day. The goal was met during my shift and the patients I/Os were desirable (intake: 500, output: 550).**

Overall APA Format/Neatness/Grammar (5 point):

Concept Map (20 Points):