N441 Care Plan

Lakeview College of Nursing

Ana Punsalan

Demographics (3 points)

Date of Admission 10/25/2020	**Patient Initials** C.P.	**Age** 77	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** Azithromycin, Iodine, Demerol (Meperidine)
Code Status FULL	**Height** 5'4	**Weight** 150 lbs.	

Medical History (5 Points)

Past Medical History: Rheumatoid Arthritis, Diffuse large B-cell Lymphoma, Type 2 Diabetes, Hypothyroidism, Major Depressive Disorder, Chronic Hyponatremia

Past Surgical History: Hysterectomy, Joint replacement, Carpal Tunnel release, Rotator cuff repair, Cardiac catheterization

Family History: Father – Myocardial Infarction

Social History (tobacco/alcohol/drugs): C.P. does not use tobacco, alcohol, or drugs.

Assistive Devices: C.P. does not have any assistive devices.

Living Situation: C. P. lives in a house with her husband.

Education Level: The highest level of education C.P. has is a GED.

Admission Assessment

Chief Complaint (2 points): Shortness of breath, elevated blood sugar, and generalized body aches and weakness for the past two weeks.

History of present Illness (10 points): C.P. is a 77-year-old Caucasian who came to the Care Center due to dyspnea, elevated blood sugar from 180-185, generalized body aches, and weakness. Onset about two weeks ago, constant timing, mild severity. C.P. denies any cough and phlegm. She occasionally feels wheezing. She tried her husband's inhaler and received a new

prescription from the Care Center. She finds some relief with the inhaler, never smoked, and denies exposure to secondhand smoking. She feels her ankles are being swollen up for the past week bilaterally; she refuses DVT or P.E. in the past. She acknowledges chronic hyponatremia. The chest pressure lasts for a few minutes, and she cannot keep her mask on for a more extended period. Medications were given include Furosemide (Lasix) 40 mg IV x2, Acetaminophen (Tylenol) 650 mg oral q4h, Apixaban (Eliquis) 10mg oral x2, and 4 liters of oxygen. Diagnostic tests needed include a chest x-ray, EKG, and cardiac C.T.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Congestive Heart Failure

Secondary Diagnosis (if applicable): N/A

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

Congestive Heart Failure (CHF)

Congestive heart failure (CHF) is a long-term progressive condition that affects your heart muscles' pumping. CHF distinctively refers to the stage in which fluid builds up around the heart and causes it to pump ineffectively (Luo, 2019). CHF emerges when the ventricles cannot pump enough blood volume to the body. In due course, blood and other fluids can back up inside your lungs, abdomen, liver, and lower body (Luo, 2019).

Signs and symptoms of CHF people include fatigue, swelling in the ankles, feet, legs, weight gain, increased need to urinate, irregular heartbeat, and a cough that develops from congested lungs (Mayo Clinic, 2020). Other symptoms that people experience include wheezing, shortness of breath, chest pain that radiates through the upper body, rapid breathing, skin that

appears blue, and fainting (Luo, 2019). C.P. complained of having shortness of breath, occasionally wheezing, generalized body aches, and swelling in her ankles bilaterally.

Expected findings related to CHF include dyspnea, cardiomegaly, nocturia, peripheral edema, jugular venous pressure, extra heart sounds and murmurs, crackles, and pleural effusion (Luo, 2019). C.P. has dyspnea, cardiomegaly, and peripheral edema.

Diagnostic testing for CHF patients includes blood tests, chest x-ray, EKG tests, Cardiac MRI, and a stress test (Mayo Clinic, 2020). C.P.'s blood test shows a chloride level of 84, a BNP level of 645, and a D-Dimer level of 2040. Her chest x-ray shows cardiomegaly with central pulmonary vascular congestion suggestive of heart failure and a calcified right hilar node. C.P.'s C.T. scan of the chest shows a small to moderate pulmonary interstitial edema. Her electrocardiogram shows a ventricular rate of 126, there is no S.T. segment deviation, and QTC is 475.

Treatment available for CHF includes ACE inhibitors, Beta-Blockers, diuretics, and surgeries (Mayo Clinic, 2020). C.P. is currently taking furosemide (Lasix), losartan (Cozaar), and acetaminophen (Tylenol).

Pathophysiology References (2) (APA):

Luo, E. (2019). *Congestive heart failure (CHF)*. https://www.healthline.com/health/congestive-heart-failure

Mayo Clinic. (2020). *Heart failure*. https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142

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	4.40-5.80	3.63	3.85	Low levels due to Diffuse Large B-cell Lymphoma (Pagana et al., 2019).
Hgb	12.0-18.0	9.30	9.80	Low levels due to Diffuse Large B-cell Lymphoma (Pagana et al., 2019).
Hct	37.0-51.0	28.2	29.7	Low levels due to Diffuse Large B-cell Lymphoma (Pagana et al., 2019).
Platelets	140-440	316	347	
WBC	4.00-12.00	8.80	9.50	
Neutrophils	40.0-68.0%	82.2	90.2	High levels due to Diffuse Large B-cell Lymphoma (Pagana et al., 2019).
Lymphocytes	18.0-49.0%	9.60	7.40	Low levels due to Diffuse Large B-cell Lymphoma (Pagana et al., 2019).
Monocytes	3.0-13.0%	0.70	2.20	Low levels due to Diffuse Large B-cell Lymphoma (Pagana et al., 2019).
Eosinophils	0.0-8.0%	0.10	0.0	
Bands	<1	N/A	N/A	

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 Value
Na-	135-145	118	125	Low levels due to chronic hyponatremia (Pagana et al., 2019).
K+	3.5-5.2	3.7	3.9	
Cl-	98-108	84	88	Low levels due to heart failure (Pagana et al., 2019).
CO2	22-29	22	27	
Glucose	70-100	165	151	High levels due to Type 2 Diabetes (Pagana et al., 2019).
BUN	8-25	9	9	

Creatinine	0.6-1.3	0.65	0.65	
Albumin	3.5-5.7	4.3	N/A	
Calcium	8.6-10	9.0	8.7	
Mag	1.5-2.6	2.0	1.5	
Phosphate	2.5-4.5	N/A	N/A	
Bilirubin	0.2-0.8	0.5	N/A	
Alk Phos	34-104	59	N/A	
AST	10-30	27	N/A	
ALT	10-40	13	N/A	
Amylase	23-85	N/A	N/A	
Lipase	0-106	N/A	N/A	
Lactic Acid	0.5-1.0	N/A	N/A	
Troponin	0-0.4 ng/mL	0.030	N/A	
CK-MB	5-25 IU/L	N/A	N/A	
Total CK	22-198 U/L	N/A	N/A	

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	1.0	1.1	
PT	10.1-13.1	12.9	13.1	
PTT	25-36	26	34	

D-Dimer	<0.5	2040	N/A	High level due to severity of heart failure (Pagana et al., 2019).
BNP	<125	645	N/A	High level due to severity of heart failure (Pagana et al., 2019).
HDL	40-59	46	N/A	
LDL	100-129	41	N/A	Low level due to Type 2 Diabetes (Pagana et al., 2019).
Cholesterol	<200	106	N/A	
Triglycerides	<150	50	N/A	
Hgb A1c	2-5.6	6.2	N/A	High level due to Type 2 Diabetes (Pagana et al., 2019).
TSH	0.4-4.0	4.9	N/A	High level due to Hypothyroidism (Pagana et al., 2019).

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	Yellow Clear	N/A	N/A	
pH	5.0-8.0	N/A	N/A	
Specific Gravity	1.005-1.034	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	Negative	N/A	N/A	
RBC	Negative	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

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	N/A	N/A	
PaO2	80-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	95-100%	N/A	N/A	

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	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference* (14th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): A chest x-ray, EKG test, and a Cardiac CT are to help diagnose C.P. with CHF.

Diagnostic Test Correlation (5 points):

A chest x-ray provides images of the organs in the chest, including the heart and lungs. I heart failure diagnosis; the chest x-ray helps determine the cause of heart failure symptoms (Pagana et al., 2019). C.P.'s chest x-ray shows cardiomegaly with central pulmonary vascular congestion suggestive of heart failure and a calcified right hilar node.

An EKG test documents the electrical activity of the heart with electrodes attached to the skin. EKG helps providers diagnose heart rhythm problems and heart damage (Pagana et al., 2019). C.P.'s EKG shows a ventricular rate of 126 and a QTC of 475.

With a cardiac C.T. scan, an x-ray tube inside the machine rotates around the body and collects the heart and chest images in sync with the heartbeat. After, the cardiovascular radiologist analyzes the images to search for calcification in the coronary arteries, problems with the heart function and valves, and problems in the aorta (Pagana et al., 2019). C.P.'s C.T. scan of the chest shows a small to moderate pulmonary interstitial edema.

Diagnostic Test Reference (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2019). *Mosby's diagnostic and laboratory test reference* (14th ed.). Elsevier.

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

Home Medications (5 required)

Brand/Generic	Amitriptyline (Elavil)	Levothyroxine (Synthroid)	Losartan (Cozaar)	Metformin (Glucophage)	Sertraline (Zoloft)
Dose	100 mg	112 mcg	100 mg	1,000 mg	50 mg
Frequency	Nightly	Daily	Daily	2x Daily	Daily
Route	PRN	PRN	PRN	PRN	PRN
Classification	Antidepressant	Thyroid hormone replacement	Antihypertensive	Antidiabetic	Antidepressant
Mechanism of Action	Blocks serotonin and norepinephrine reuptake by adrenergic nerves.	Replaces thyroid hormone.	Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle.	May promote storage of excess glucose as glycogen in liver, which reduces glucose production.	Increases the amount of serotonin available in nerve synapses.
Reason Client Taking	To relieve depression.	To treat mild hypothyroidism.	To manage hypertension.	To reduce blood glucose level in type 2 diabetes.	To treat major depression.
Contraindications (2)	1. acute recovery phase after MI. 2. MOA inhibitor therapy within 14 days	1. acute MI 2. Uncoordinated adrenal insufficiency	1. Concurrent aliskiren therapy in pts. w/ diabetes or renal impairment. 2. hypersensitivity	1. Advanced renal disease 2. Metabolic acidosis	1. Concurrent use of disulfiram or pimozide. 2. Use w/in 14 days of an MAO inhibitor
Side Effects/Adverse Reactions (2)	1. arrhythmias 2. weight gain	1. muscle weakness 2. insomnia	1. diarrhea 2. hypotension	1. heart burn 2. Headache	1. Nausea/vomiting 2. Diarrhea
Nursing Considerations (2)	1.Watch patients closely for suicidal tendencies. 2. Stay alert for behavior changes, such as hallucinations and decreased interest in	1.. Therapy not used for treatment of obesity or for weight loss. 2. Overtreatment can increase cardiac contractility, cardiac wall thickness, and	1. Know that in some pts., losartan is more effective when given in 2 divided doses daily; it may be used with other antihypertensives. 2. Periodically monitor pt.'s potassium levels	1. Give metformin tablets w/ food, which decreases & slightly delays absorption, thus reducing risk of adverse GI reactions.	1. Monitor pt. for hypo-osmolarity of serum & urine & for hyponatremia, which may indicate sertraline-induced syndrome of inappropriate ADH secretion.

	personal appearance.	HR, which can precipitate angina or arrhythmias.	to detect hyperkalemia.	2. Expect provider to alter dosage if pt. has a condition that decreases or delays gastric emptying, such as diarrhea, gastroparesis, GI obstruction, ileus, or vomiting.	2. Monitor pt. closely for evidence of GI bleeding, especially if pt. takes a drug known to cause it, such as aspirin, an NSAID, or warfarin.
Key Nursing Assessment(s) Prior to Administration	Weight; T; P, BP, perfusion; bowel sounds, normal output, liver evaluation; urine flow, normal output; usual sexual function, frequency of menses, breast and scrotal examination; LFTs, urinalysis, CBC, ECG	Skin lesions, color, T, texture; T; muscle tone, orientation, reflexes; P, auscultation, baseline ECG, BP; R, adventitious sounds; thyroid function tests	Obtain baseline status for weight, vital signs, overall skin condition, and laboratory tests like renal and hepatic function tests, serum electrolyte, and complete blood count (CBC) with differential to assess patient's response to therapy.	Skin color, lesions; T, orientation, reflexes, peripheral sensation; R, adventitious sounds; liver evaluation, bowel sounds; urinalysis, BUN, serum creatinine, LFTs, blood glucose, CBC	Perform a thorough physical assessment to establish baseline data before drug therapy begins, to determine the effectiveness of therapy, and to evaluate for the occurrence of any adverse effects associated with drug therapy.
Client Teaching needs (2)	1. Instruct pt. to avoid using alcohol or OTC drugs that contain alcohol during therapy because alcohol enhances CNS depressant effects. 2. Urge family or caregiver to watch pt. closely for	1. Inform pt. that therapy replaces a hormone that is normally produced by the thyroid and may probably need to take the medication for life. 2. Instruct pt. to separate antacids and calcium or iron supplements by	1. Instruct pts. to avoid potassium containing salt substitutes because they may increase risk of hyperkalemia. 2. Instruct pt. to notify provider if she has prolonged diarrhea, nausea, or vomiting.	1. Direct pt. to take drug exactly as prescribed & not to change the dosage or frequency unless instructed. 2. Emphasize importance of checking blood glucose level regularly, controlling	1. Advise pt. that drug may cause mild pupillary dilation, which may lead to an episode of acute closure glaucoma. Encourage pt. to have an eye exam before starting therapy to see if she is at risk. 2. Inform pt. that

	suicidal tendencies.	at least 4 hrs. from levothyroxine doses.		weight, exercising regularly, and following prescribed diet.	use of certain drugs, such as aspirin, NSAIDs, other antiplatelet drugs, warfarin, or other anticoagulants, with sertraline may increase risk for bleeding.

Hospital Medications (5 required)

Brand/Generic	Acetaminophen (Tylenol)	Apixaban (Eliquis)	Furosemide (Lasix)	Ondansetron (Zofran)	Pantoprazole (Protonix)
Dose	650 mg	10 mg	40 mg	4 mg	40 mg
Frequency	Every 4 hrs.	2x Daily	2x Daily w/ meals	Every 6 hrs.	Daily
Route	PRN	PRN	PRN	PRN	PRN
Classification	Antipyretic	Antithrombolytic	Antihypertensive	Antiemetic	Antiulcer
Mechanism of Action	Blocks prostaglandin production & interferes w. pain impulse generation in the PNS.	Inhibits free & clot-bound factor Xa & prothrombinase activity.	Inhibits sodium & water reabsorption & increases urine formation.	Blocks serotonin receptors centrally and peripherally.	Interferes w/ gastric acid secretions.
Reason Client Taking	To relieve mild to moderate pain.	To reduce risk of recurrence of DVT & PE.	To reduce edema caused by heart failure.	To prevent N/V.	To relieve heartburn.
Contraindications (2)	1. Hypersensitivity 2. Severe hepatic impairment	1. Active pathological bleeding 2. Severe hypersensitivity	1. Anuria unresponsive to furosemide 2. Hypersensitivity	1. Concomitant use of apomorphine 2. Congenital long QT syndrome	1. Concurrent therapy w/ rilpivirine containing products 2. Hypersensitivity
Side Effects/Adverse	1. Nausea	1. Chest pain	1. N/V	1. Weakness, Tiredness,	1. Dizziness, Headache

Reactions (2)	2. Headache	2. Excessive bleeding	2. Vertigo	Drowsiness 2. Constipation	2. Joint pain
Nursing Considerations (2)	1. Do not exceed recommended dose. 2.. Treatment of overdose: Monitor serum levels regularly, N-acetylcysteine should be available as a specific antidote; basic life support measures may be necessary.	1. Be aware that manufacturer guidelines should be followed when pt. is switching from or to other anticoagulants. 2. Be aware that if apixaban is discontinued prematurely & adequate alternative anticoagulation is not present, the risk of thrombosis increases.	1. Notify provider if pt. experiences hearing loss, vertigo, or ringing, buzzing, or sense of fullness in her ears. Drug may need to be discontinued. 2. Be aware that elderly pts. are more susceptible to hypotensive & electrolyte-altering effects & thus are at greater risk for shock & thromboembolism.	1. Monitor pt. closely for s/s of hypersensitivity b/c anaphylaxis & bronchospasm may occur. If present, discontinue drug, notify provider, and provide support care. 2. Monitor pt.'s ECG b/c ondansetron therapy can prolong QT interval resulting in life-threatening arrhythmias such as torsade de pointes.	1. Monitor pt.'s urine output b/c pantoprazole may cause acute interstitial nephritis. Notify provider if urine output decreases or there is blood in the pt.'s urine. 2.. Monitor pt. for diarrhea from C. diff which can occur w/ or w/out antibiotics in pts. taking pantoprazole. If severe diarrhea occurs, notify provider & expect to withhold drug & treat with electrolytes, fluids, protein, & an antibiotic effective against C. diff.
Key Nursing Assessment(s) Prior to Administration	Skin color, lesions; T; liver evaluation; CBC, LFTs, renal function tests	Monitor INR levels	Skin color, lesions, edema; orientation, reflexes, hearing; pulses, baseline ECG, BP, orthostatic BP, perfusion; R, pattern, adventitious sounds; liver evaluation, bowel sounds; urinary output patterns; CBC, serum	Monitor potassium & magnesium	Monitor PT and INR

			electrolytes (including calcium), blood sugar, LFTs, renal function tests, uric acid, urinalysis, weight		
Client Teaching needs (2)	1. Tell pt. that tablets may be crushed or swallowed whole. 2. Teach pt. to recognize signs of hepatoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs w/ chronic overdose.	1. Tell pt. not to stop taking apixaban w/out first consulting provider. If pt. misses a dose, instruct pt. to take is as soon as possible on the same day & resume the dosing schedule the next day. Caution pt. not to double dose to make up for the missed dose the day before. 2. Inform pt. that it may take longer for her to stop bleeding & to take bleeding precautions, such as avoiding the use of a razor & using a soft-bristle toothbrush.	1. Instruct pt. to take furosemide at the same time each day to maintain therapeutic effects. Urge pt. to take it as prescribed, even if pt. feels well. 2. Advise pt. to change position slowly to minimize effects of orthostatic hypotension & to take furosemide w/ food or milk to reduce GI distress.	1. Advise pt. to immediately report signs of hypersensitivity, such as rash. 2. Advise pt. to use calibrated container or oral syringe to measure oral solution.	1.. Instruct pts. to swallow pantoprazole tablets whole & not to chew or crush them. Warn pt. not to exceed dosing or take for longer than prescribed, long-term use increases risk of serious adverse reactions. 2.. Remind pt. to notify all providers of pantoprazole use & not to take any OTC medication, including herbal supplements, w/out discussing w/ a provider.

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2019 Nurse's Drug Handbook* (18th ed.).

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented x3; no apparent distress; looks her age; clean; pleasant; appears comfortable but unable to keep her mask on
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Skin is within patient's norm Fair skin; warm & dry; Not diaphoretic. Temperature is within the average range. There is good skin turgor. No rashes, bruises, or wounds. **Braden Score: 20**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head & neck are symmetrical; trachea is midline without deviation; Auricle is moist & pink without lesions; sclera is white; conjunctiva is clear; PERRLA; lids are moist & pink; septum is midline; nose is moist, no bleeding, no polyps; sinuses are nontender; dentition is good
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:**	 Patient is tachycardic; S1 & S2 without murmurs, or rubs; gallop radial pulses 2+ bilaterally; DP pulses 2+ bilaterally; capillary refill less than 3 seconds Mild edema on ankles bilaterally.
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:**	Breath sounds are present and equal bilaterally. No adventitious breath sounds are auscultated. Rate & quality are the same. Patient has NO ET Tube.

VAP prevention measures:	
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Eats a regular balanced diet at home. Currently on a cardiac diet – 480mL ice chips. Height: 5'4 Weight: 150 lbs. Normal bowel sounds are auscultated in all quadrants. Last BM: One day ago. Abdomen is soft, nontender, no distention, no pain, no masses. No incisions, scars, drains, or wounds.
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:**	Yellow Clarity – Clear Urine output: 200 mL Genitals appear pink & moist.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☒**	CV II-XII are intact; Reflexes are 2+ throughout; Coordination: Normal finger to nose bilaterally; No pain, paralysis; No paresthesia; Not pallor; No swelling or increased pressure; No supportive devices needed; Needs support to stand. **Fall Score: 14**

NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	No facial deficits noted; 5/5 motor strength bilaterally in UE & LE. Alert & oriented to person, place, and time. Judgment and thought content normal; speech is articulate; Sensory intact to light touch bilaterally; No LOC
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):**	Coping methods: watching TV and reading books. Ego integrity, wisdom & the ability to participate in life with a sense of satisfaction; C.P. is nondenominational. C.P. lives with her husband.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	90	124/78	18	97.6°F	97% R.A.
1100	92	126/82	18	97.6°F	99% R.A.

Vital Sign Trends/Correlation: C.P.'s vitals are stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	Numeric	N/A	0	N/A	N/A
1100	Numeric	N/A	0	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	N/A
Other Lines (PICC, Port, central line, etc.)	N/A
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:**	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL – ice chips (480ml)	200 mL

Nursing Care

Summary of Care (2 points)

Overview of care: C.P. is cooperative and has no complaints. Education video given about Congestive Heart Failure. C.P. is not in pain and is continuing taking her medications as prescribed.

Procedures/testing done: C.P. did not leave the floor for any procedures or have any testing done during my clinical roation.

Complaints/Issues: C.P. did not have any complaints or issues.

Vital signs (stable/unstable): C.P.'s vital signs are within her baseline.

Tolerating diet, activity, etc.: Patient tolerates diet and activity.

Physician notifications: C.P. is available for discharge. C.P. will have a follow-up at the hospital five days after discharge.

Future plans for patient: C.P. is clear for discharge and must see a physical therapist five times a week and an occupational therapist three-four times a week.

Discharge Planning (2 points)

Discharge location: C.P.'s discharge location is to home.

Home health needs (if applicable): C.P. does not need home health needs.

Equipment needs (if applicable): C.P. does not require any equipment needs.

Follow up plan: C.P. will be seen by a physical therapist five times a week and an occupational therapist three-four times a week to address impairments and functional limitation.

Education needs: Education on weight monitoring, discharge medications, diet, what to do if heart failure symptoms worsen, and the importance of keeping a follow-up schedule.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis	Rational	Intervention (2 per	Evaluation

• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen	**dx)**	• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired gas exchange related to altered oxygen supply as evidenced by shortness of breath.	C.P. has complained of having shortness of breath for the past two weeks.	1. Assess respiratory status every 2-4 hours. 2. Administer combination inhaled corticosteroids and bronchodilator therapy.	C.P. has improved oxygenation and does not show any signs of respiratory distress.
2. Decreased cardiac output related to increased preload and afterload and impaired contractility as evidenced by irregular heartbeat, elevated heart rate, dyspnea upon exertion, and fatigue.	C.P.'s EKG displays a heart rate of 126, she has shortness of breath and feels weak.	1. Assess the patient's vital signs and characteristics of heartbeat at least every 4 hours. Assess breath sounds via auscultation. 2. Observe for signs of decreasing peripheral tissue perfusion such as slow capillary refill, facial pallor, cyanosis, and cool, clammy skin.	C.P. has adequate cardiac output as evidenced by vital signs within acceptable limits, dysrhythmias absent/ controlled, no symptoms of failure. C.P. participates in activities that reduce cardiac workload.
3. Ineffective tissue perfusion related to decreased cardiac output as evidenced by generalized weakness, difficulty breathing, and edema.	C.P. has shortness of breath, generalized body aches and weakness, and has bilateral ankle edema.	1. Assess patient pain for intensity using a pain rating scale, for location and for precipitating factors. 2. Provide oxygen and monitor oxygen saturation via pulse oximetry, as ordered.	C.P. identifies factors that improves circulation, identifies necessary lifestyle changes, and exhibits growing tolerance to activity.
4. Risk for infection	C.P.'s blood	1. Educate the	C.P. verbalizes measures

related to Diabetes Mellitus as evidenced by high blood glucose 185.	glucose has risen from 180 to 185.	patient on diet regime for diabetics. 2. Instruct the patient in the principle of hygiene: wash the feet daily in warm water using mild soap; avoid soaking the feet.	that prevent risk for infection, diabetic diet, and proper hygiene.
5. Risk for falls related to impaired physical mobility as evidenced by dizziness.	C.P. needs assistance in standing and walking.	1. Always keep patient's bed in the lowest position. 2. Place call light within reach and show how to call for assistance.	C.P. is uses the call light whenever she needs assistance and did not have fall today.

Other References (APA):

Swearingen, P., & Wright, J. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier

Concept Map (20 Points):

Subjective Data

C.P. admitted with SOB, elevated blood sugar, generalized body aches, weakness, and states, "this has been going on for the past two weeks."

Nursing Diagnosis/Outcomes

Diagnosis #1 Impaired gas exchange related to altered oxygen supply as evidenced by shortness of breath.
Outcome C.P. has improved oxygenation and does not show any signs of respiratory distress.
Diagnosis #2 Decreased cardiac output related to increased preload and afterload and impaired contractility as evidenced by irregular heartbeat, elevated heart rate, dyspnea upon exertion, and fatigue.
Outcome C.P. has adequate cardiac output as evidenced by vital signs within acceptable limits, dysrhythmias absent/controlled, no symptoms of failure. C.P. participates in activities that reduce cardiac workload.
Diagnosis #3 Ineffective tissue perfusion related to decreased cardiac output as evidenced by generalized weakness, difficulty breathing, and edema.
Outcome C.P. identifies factors that improves circulation, identifies necessary lifestyle changes, and exhibits growing tolerance to activity.
Diagnosis #4 Risk for infection related to Type 2 Diabetes as evidenced by elevated blood glucose.
Outcome C.P. verbalized measures that prevent risk for infection, diabetic diet, and proper hygiene.
Diagnosis #5 Risk for falls related to impaired physical mobility as evidenced by generalized body aches and weakness.
Outcome C.P. uses the call light whenever she needs assistance and did not have any falls today.

Objective Data

Chest X-ray shows cardiomegaly with central pulmonary vascular congestion suggestive of CHF. Calcified right hilar node.
CT Chest shows small to moderate pulmonary interstitial edema borderline enlarged mediastinal nodes.
EKG shows a ventricular rate of 126 and a QTC of 475.
BNP – 645
D-dimer – 2040
Chloride – 84 & 88

Patient Information

C.P.
77-years-old
Admitted: 10/25/2020
Female, Caucasian
Retired
Married
Allergies – Azithromycin, Iodine & Demerol
H: 5'4"
W: 150 lbs.
Code: Full Code

Nursing Interventions

Intervention #1:
Assess respiratory status every 2-4hrs.
Administer combination inhaled corticosteroids & bronchodilator therapy.
Intervention #2:
Assess vitals and breath sounds via auscultation.
Observe for signs of peripheral tissue perfusion.
Intervention #3:
Assess pt. for intensity using a pain rating scale.
Provide O2 & monitor O2 sat via pulse oximetry.
Intervention #4:
Educate pt. on diet regimen for diabetes.
Instruct pt. in the principle of proper hygiene.
Intervention #5:
Always keep pt.'s bed in the lowest position.
Place call light w/in reach & show how to call for assistance.