# N321 Care Plan 3

Lakeview College of Nursing

Happy Kalavadia

## Demographics (3 points)

| **Date of Admission** | **Patient Initials** | **Age** | **Gender** |
|---|---|---|---|
| 3/10/2021 | LE | 88 | Female |
| **Race/Ethnicity** | **Occupation** | **Marital Status** | **Allergies** |
| Not Hispanic or Latino | Unable to obtain from the patient ( also not in the chart) | Unmarried | Atorvastatin - Swelling<br>Moxifloxacin- Hallucinations<br>Celecoxib- Hives and Rash<br>Cephalexin- Hallucinations<br>Clindamycin- Hives and Rash<br>Codeine – Diarrhea, Nausea Vomiting<br>Sulfa- Rash<br>Penicillin – swelling<br>Simvastatin - myalgia |
| **Code Status** | **Height** | **Weight** | |
| No CPR | 5 ' 4" | 66.9 kg | |

## Medical History (5 Points)

**Past Medical History:**

- Coronary Artery disease
- Degenerative Joint Disease of lumbar and pelvis
- Essential Hypertension
- Hyperlipidemia
- Measles
- Mitral Valve Stenosis
- Osteoarthritis
- Restless Leg Syndrome
- Sciatica
- Varicella

- Glaucoma

**Past Surgical History:**

- Appendectomy and Hysterectomy

**Family History:** The patient stated," I do not have family". Not mentioned in the chart.

**Social History (tobacco/alcohol/drugs):** The patient denied use of drugs, alcohol, and tobacco.

**Assistive Devices:** Uses walker and cane but very minimally. Most of the time patient is bedridden due to her physical and medical comorbidities.

**Living Situation:** Lives alone in Assisted living ( obtained from the patient ).

**Education Level:** The patient is a high school graduate.

**Admission Assessment**

**Chief Complaint (2 points):** Shortness of breath and weakness. The patient was not in a condition to describe her symptom and answered no ( nodded her head to no ). when asked about chest pain.

**History of present Illness (10 points):** On 3/9 of evening patient presented to the emergency department due to shortness of breath and weakness. She had mild shortness of breath for many days, especially when lying down in her assisted living facility. But on 3/9 she experienced persistent shortness of breath and weakness. As a result, she was admitted to OSF ED at Danville, IL. The patient did not have any chest pain and when asked about the onset of her shortness of breath she mentioned that it started after her dinner. The patient was stabilized at ED by giving a nebulizer for her shortness of breath and transferred to the Med Surg floor the next day after her vitals are stabilized. The patient is stable, active, and alert, but she has

impaired verbal communication due to age-related loss of hearing in both ears. For her to hear clearly, we had to talk loudly multiple times in her both ears. She spends most of the time sleeping in her bed and is confused when asked questions. Currently, the patient is stable with no use of oxygen and breathing room air. The patient has a dry nonproductive cough and reduced inspiration as well as expiration. As a result, I used multiple resources to derive information like her chart and her nurse to obtain an accurate history of the patient.

## Primary Diagnosis

**Primary Diagnosis on Admission (2 points):**

- Acute on Chronic Diastolic congestive heart failure.

**Secondary Diagnosis (if applicable):**

- Severe Aortic Stenosis
- Hypertension
- Restless Leg syndrome.

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

Congestive heart failure can be defined as a failure of ventricles to pump blood to the body (Capriotti & Frizzell, 2016). The fluid gets backed up in the systemic organs like the lungs, abdomen, liver, and lower body. Congestive heart failure can result from systolic or diastolic heart failure. The patient had diastolic heart failure in which ventricles are not filled properly due to stiff ventricles and eventually blood backs up in the systemic circuit. Primary diastolic heart failure mostly affects patients with valvular heart disease like aortic stenosis, essential hypertension. and most common in the elderly population. (Capriotti & Frizzell, 2016, 280).

The pathophysiology of diastolic heart failure includes impaired LV filling, increased stiffness, and delayed relaxation of the left ventricle(Van Leeuwen & Bladh, 2017, 180). The main problem in diastolic heart failure is the impaired ability of the left ventricle to accommodate blood volume during diastole at low filling pressure (Van Leeuwen & Bladh, 2017). There is low cardiac output typically in patients with diastolic heart failure because the stiff ventricle cannot eject enough blood to the systemic organs**.** Due to the stiff left ventricle, the blood backs up in the left atria and eventually, it causes pulmonary venous congestion causing pulmonary hypertension(Van Leeuwen & Bladh, 2017).

Mechanisms contributing to abnormal left ventricular diastolic failure include stiff large arteries like the aorta, ischemia, diabetes, and intrinsic myocardial changes with or without associated hypertrophy(Van Leeuwen & Bladh, 2017). The patient has essential hypertension, type 2 diabetes mellitus, aortic valve stenosis and calcification of aorta on 2D Echo, low cardiac output, low ejection fraction, and high BNP levels which indicates diastolic heart failure. (Van Leeuwen & Bladh, 2017). In diastolic heart failure, there is left ventricle hypertrophy because of excess blood volume which eventually leads to the stiff ventricle and myocardial fibrosis (Capriotti & Frizzell, 2016, 240). The mechanism of action of myocardial fibrosis is the loss of titin, a sarcomeric protein that is responsible for the distensibility of cardiac myocytes during diastole (Capriotti & Frizzell, 2016, 240).

The signs and symptoms of diastolic heart failure are shortness of breath, fatigue, peripheral edema, and dry nonproductive cough due to pulmonary congestion (Van Leeuwen & Bladh, 2017). Ejection fraction is reduced in patients with diastolic heart failure because LV is stiff and cannot eject blood resulting in low cardiac output. (Van Leeuwen & Bladh, 2017). Treatment is to give a diuretic to the patient to reduce excess fluid from the body and beta-

blockers as well as bronchodilators to relieve heart failure symptoms and pulmonary congestion respectively. The patient presents to ED with shortness of breath but does not have chest pain. Her onset of shortness of breath began after dinner at a local assisted living facility. When asked about the duration and location of pain she stated, "I do not have any kind of chest pain, but I can't breathe". She did not have any characteristic symptoms of pain as her major problem was shortness of breath. She was given a nebulizer and the health care provider ordered EKG which revealed nonspecific ST abnormality. The patient is confused due to age-related physical changes and hence is unable to give an exact history of her disease as well as symptoms. She was stabilized and then transferred to the Med Surg floor. The provider ordered a chest x-ray which showed hyper expansion of both lung fields and a tortuous, calcified aorta. 2D Echo was ordered by a cardiologist through a telemetry visit which showed an ejection fraction of 40 percent, aortic stenosis, decreased cardiac output, and grade I diastolic dysfunction. Also, pulmonary hypertension is seen on her 2D echo. The patient's blood troponin levels are 0.036 and her BNP is 750 which indicates heart failure. The patient had jugular venous distension and peripheral edema in both legs due to excess fluid in the systemic circuit.

The main goal of treatment for this patient is to reduce fluid by administering diuretics. She was also started on beta-blockers and bronchodilators to relieve her heart failure symptoms as well as to relieve her pulmonary congestion respectively.

**Pathophysiology References (2) (APA):**

Capriotti, T., & Frizzell, J. P. (2016). Pathophysiology Introductory Concepts and Clinical Perspectives. Philadelphia, PA: F.A. Davis Company.

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 ed.). Philadelphia, PA: F.A. Davis Company.

**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** | 3.80-5.41 | **N/A** | **4.19** | |
| **Hgb** | 11.3-15.2 | **N/A** | **11.0** | The patient has low production of RBC due to age-related decreased synthesis of heme and possible osteoporosis (Capriotti & Frizzell, 2016, pg.250) |
| **Hct** | 33.2-45.3% | **N/A** | **35.3** | - |
| **Platelets** | 149-493 K | **N/A** | **160** | - |
| **WBC** | 4-11.7 K | **N/A** | **5.20** | - |
| **Neutrophils** | 45.3-79 | **N/A** | **71.4** | - |
| **Lymphocytes** | 11.8-45.9 | **N/A** | **15.7** | - |
| **Monocytes** | 4.4-12.0 | **N/A** | **6.5** | - |
| **Eosinophils** | 0.0-6.3 | **N/A** | **4.2** | - |
| **Bands** | N/A | **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 |
|---|---|---|---|---|
| **Na-** | 135-145 | **N/A** | **143** | - |
| **K+** | 3.5-5.1 | **N/A** | **3.7** | |
| **Cl-** | 98-107 | **N/A** | **110** | Elevated chloride levels are seen in a patient who has dehydration as the patient was on furosemide which is |

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|---|---|---|---|---|
| | | | | a diuretic **(**Van Leeuwen & Bladh, 2017, p. 397). |
| **CO2** | 22-29 | **N/A** | **25** | - |
| **Glucose** | 70-99 | **N/A** | **108** | Patient has type 2 Diabetes mellites for 30 years.(Van Leeuwen & Bladh, 2017, p. 857). |
| **BUN** | 6-20 | **N/A** | **19** | - |
| **Creatinine** | 0.5-0.9 | **N/A** | **0.80** | - |
| **Albumin** | 3.5-5.2 | **N/A** | **4.1** | - |
| **Calcium** | 8.6-10.4 | **N/A** | **8.9** | - |
| **Mag** | 1.6-2.4 | **N/A** | **1.9** | - |
| **Phosphate** | N/A | **N/A** | **N/A** | - |
| **Bilirubin** | 0.0-1.2 | **N/A** | **0.3** | - |
| **Alk Phos** | 35-105 | **N/A** | **107** | In patients with chronic CHF, alk phos levels are increased due to vascular calcification and can indicate a poor prognosis in patients with CHF. (Van Leeuwen & Bladh, 2017, p. 37) |
| **AST** | 0-32 | **N/A** | **20** | - |
| **ALT** | 0-33 | **N/A** | **13** | - |
| **Amylase** | 30-110 | **N/A** | **N/A** | - |
| **Lipase** | 24-251 | **N/A** | **N/A** | - |
| **Lactic Acid** | N/A | **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** | **0.9-1.1** | **N/A** | 1.1 | - |
| **PT** | **N/A** | **N/A** | **N/A** | |
| **PTT** | **25-35** | **N/A** | 33 | - |
| **D-Dimer** | **N/A** | **N/A** | **N/A** | - |
| **BNP** | **Less than 125** | **N/A** | **748** | BNP levels are elevated in heart failure due to the stretch of the myocardial muscle. The higher the level of BNP, the higher is the damage to the heart**.** (Capriotti & Frizzell, 2016, pg.134). |
| **HDL** | **N/A** | **N/A** | **N/A** | - |
| **LDL** | **N/A** | **N/A** | **N/A** | - |
| **Cholesterol** | **N/A** | **N/A** | **N/A** | - |
| **Triglycerides** | **N/A** | **N/A** | **N/A** | - |
| **Hgb A1c** | **N/A** | **N/A** | **N/A** | - |
| **TSH** | **N/A** | **N/A** | **N/A** | - |

**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** | Yellow, clear | - |
| **pH** | 5.0-8.0 | **N/A** | 5.0 | - |
| **Specific Gravity** | 1.005-1.034 | **N/A** | 1.013 | - |
| **Glucose** | Negative-normal | **N/A** | Negative | - |
| **Protein** | Negative-Normal | **N/A** | Negative | - |
| **Ketones** | Negative | **N/A** | Negative | - |

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|---|---|---|---|---|
| **WBC** | <5 | **N/A** | 2 | - |
| **RBC** | 0-3 | **N/A** | 2 | - |
| **Leukoesterase** | Negative | **N/A** | 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** | **N/A** | **N/A** | **N/A** | - |
| **Blood Culture** | **N/A** | **N/A** | **N/A** | - |
| **Sputum Culture** | **N/A** | **N/A** | **N/A** | - |
| **Stool Culture** | **N/A** | **N/A** | **N/A** | - |

**Lab Correlations Reference (1) (APA):**

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 ed.). Philadelphia, PA: F.A. Davis Company.Diagnostic Imaging.

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points):**

**EKG:**

The provider ordered this test to rule out any ST elevation or any kind of conduction abnormality because the patient presented to ED with shortness of breath (Van Leeuwen & Bladh, 2017, p. 450). It revealed nonspecific ST abnormality and acute ischemic stage of heart.

**Chest X ray:**

The test was ordered by the provider to rule out possible pulmonary hypertension due to diastolic CHF(Van Leeuwen & Bladh, 2017, p. 481). The chest X-ray showed hyper expansion of the right lower lung and cardiomegaly. Also, calcified granuloma in the right lung was seen. Aorta was tortuous with calcifications in the aortic knob. A pacemaker device was noted in the myocardium.

**Echocardiogram ( 2D):**

The provider ordered this test on 3/10 to rule out cardiac functioning and ejection fraction( Van Leeuwen & Bladh, 2017, p. 481). Her EF was 40 percent which is low and could be due to diastolic heart failure. As per radiologist notes, the patient has moderate to severe calcification of the aorta and aortic stenosis. Also, mild concentric left ventricular hypertrophy and grade I diastolic dysfunction is noted on ECHO. Moderate pulmonary hypertension is also noted as well.

**Diagnostic Test Correlation (5 points):**

EKG was ordered to rule out cardiac functions and possible ST abnormality.

Chest X-ray was ordered to rule out any pulmonary and cardiac abnormality as the patient had shortness of breath.

Echo was ordered to measure her ejection fraction and possible congestive heart failure.

**Diagnostic Test Reference (1) (APA):**

Van Leeuwen, A. M., & Bladh, M. L. (2017). Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications (7 ed.). Philadelphia, PA: F.A. Davis Company.

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

**Home Medications (5 required)**

| **Brand/ Generic** | Lofibra/ Fenofibrate | Cyanocobalamin/ vitamin b12 | Demadex/ Torsemide | Antivert/ Meclizine (Vallerand, Sanoski, | Alphagan/ Brimonidine 0.2 % dro % drop (Vallerand, Sanoski, & Deglin, 2017, p. 80). |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| | (Valleran d, Sanoski, & Deglin, 2017, p. 120) | (Vallera nd, Sanoski, & Deglin, 2017, p. 300) | Vallerand , Sanoski, & Deglin, 2017, p. 280) | & Deglin, 2017, p. 100). | |
| **Dose** | 54 mg | 1000mc q | 10 mg | 25 mg | 0.2 % |
| **Freque ncy** | Daily | Daily | Daily | Take 8 hours PRN as needed | 1 drop-in affected eye 2 times daily |
| **Route** | Oral | Oral | Oral | Oral | Drop-in eye |
| **Classifi cation** | Antilipe mic | Vitamin s | Diuretic | Antihista mine | Alpha agonist and antiglaucoma |
| **Mechan ism of Action** | It lowers lipid levels by activating peroxiso me proliferat or-activated receptor-alpha. | It restores the blood vitamin B12 levels. | It inhibits sodium and chloride reabsorpt ion in the ascendin g loop of Henle and distal collecting tube by blocking Na+ K/2 Cl- transport. | It blocks the H1 histamine receptor reducing bronchoco nstriction and allergies. | It binds to the alpha 2 receptor and decreases intrac pressure with minimal effect on CVS thus reducing glaucoma symptoms. |
| **Reason Client Taking** | The patient has hyperlipi demia and higher LDL levels. | As the patient had neuropat hy( obtai ned from the patient chart as the patient has | The client has chronic CHF and peripher a l edema. She is taking to remove the excess fluid and | The patient was taking to relieve shortness of breath, especially in winter as she had a seasonal allergy. ( Obtained | The patient is taking to relieve the symptoms of gla which is pain and blurry vision in left eye. |

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|---|---|---|---|---|---|
| | | impaired hearing and understanding due to age). | relieve CHF exacerbation. | from the chart) . | |
| **Contraindications (2)** | Renal impairment<br>Primary biliary cirrhosis | Hypersensitivity to cyanocobalamin<br><br>Renal impairment | Dehydration<br>Hearing loss | Enlarged prostate<br><br>Closed-angle glaucoma | Depression<br><br>Orthostatic hypotension |
| **Side Effects/ Adverse Reactions (2)** | Stomach pain<br>Dark urine | Bleeding<br>Fatigue | Dizziness<br>Nausea | Dry mouth<br>Blurred vision | Redness<br>Drowsiness |
| **Nursing Considerations (2)** | Advise patient that they might experience drug-induced myopathy.<br><br>Monitor lipid levels. | Monitor serum B12 levels.<br><br>Educate the patient to eat fiber-rich food as it causes constipation. | Periodically assess weight.<br><br>Monitor electrolytes like potassium etc. | Monitor for urinary retention<br><br>Instruct patient to report side effects like dry mouth and blurred vision. | Monitor BP.<br><br>Monitor patient for drowsiness. |

**Hospital Medications (5 required)**

| **Brand/Generic** | Tylenol/ Acetaminophen (Vallerand, Sanoski, & Deglin, 2017, p. 120) | Lovenox/ Enoxaparin (Vallerand, Sanoski, & Deglin, 2017, p. 150) | Lasix/ furosemide (Vallerand, Sanoski, & Deglin, 2017, p. 110) | Neurontin/ gabapentin (Vallerand, Sanoski, & Deglin, 2017, p. 80) | Xalatan/ Latanoprost (Vallerand, Sanoski, & Deglin, 2017, p. 80) |
|---|---|---|---|---|---|
| **Dose** | 650 mg | 40 mg | 20 mg | 200 mg | 0.005% |
| **Frequency** | 6 hr PRN | Daily | 2 times with meals | 3 times | 1 drop |
| **Route** | Oral | Subcutaneous | Intravenous | Oral | In the eye, 1 drop |
| **Classification** | Analgesics and antipyretic | Anticoagulants | Loop diuretics | Anticonvulsants | Prostaglandin analogs |
| **Mechanism of Action** | It reduces prostaglandin production thus reducing pain and fever. | It binds antithrombin 3, an enzyme that causes blood clots. Inhibiting enzyme prevents blood clots. | It binds to ascending limb of the loop of Henle which causes diuresis. | It inhibits the alpha 2 delta subunit of voltage-gated calcium channels. | It is a prostanoid selective receptor agonist which decreases intraocular pressure by increasing the outflow of aqueous humor. |
| **Reason Client Taking** | The patient is taking as needed to relieve mild chest pain. | The patient is very less mobile and most of the time bedridden. She takes it to prevent blood | The patient is taking to relive congestive heart failure and to relieve peripheral edema. | The patient is taking to treat pain from varicella also | The patient has glaucoma and hence taking it. |

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| | | clots. | | called postherpetic neuralgia | |
| **Contraindications (2)** | Hepatic disease<br>Liver impairment | Hypersensitivity to Enoxaparin<br>Heparin-induced thrombocytopenia | Anuria<br><br>Hypersentivity to loop diuretics | Depression<br><br>Myasthenia gravis | Eye inflammation<br><br>Macular swelling |
| **Side Effects/Adverse Reactions (2)** | Nausea<br>Itching | Bleeding<br><br>Bruising | Hypokalemia<br><br>Hypernatremia | Dizziness<br>Blurred vision | Redness of eye<br><br>Dry eye |
| **Nursing Considerations (2)** | Periodically hepatic liver test.<br><br>Advise patient to stop alcohol. | Monitor for signs of bleeding.<br><br>Monitor platelet count. | Monitor electrolytes.<br><br>Monitor vital signs. | Prevent GI upset by giving with food.<br><br>Monitor patient for the confusion. | Give it after dinner to prevent drowsiness.<br><br>Monitor blood pressure. |

**Medications Reference (1) (APA):**

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). Davis's Drug Guide for Nurses (15 ed.).

Philadelphia, PA: F.A. Davis Company.

## Assessment

**Physical Exam (18 points)**

| | |
|---|---|
| **GENERAL (1 point):**<br>**Alertness:**<br>**Orientation:**<br>**Distress:**<br>**Overall appearance:** | The patient is alert, awake, and oriented to person, time, and place. The patient is not in distress, but she stated that she lacks energy and does feel extremely weak and lethargic. The patient has trouble understanding spoken sentences due to age-related impaired ability to hear. We had to talk with her repeatedly in her both ears for her to understand the sentences. |
| **INTEGUMENTARY (2 points):**<br>**Skin color:**<br>**Character:**<br>**Temperature:**<br>**Turgor:**<br>**Rashes:**<br>**Bruises:**<br>**Wounds:** .<br>**Braden Score:** 18<br>**Drains present: Y☐ N ☒**<br>**Type:** | The patient skin is dry and less elastic due to age-related skin thinning. She had peripheral edema on her both legs. The patient had bruises on her arms and when asked to the patient, she stated" I bleed more ". She is on a blood thinner and as a result, she has bruises**.** She does not have rashes and her skin turgor is poor. Skin is warm to the touch and is pale. There are no wounds present on her skin. The patient has poor skin integrity due to age-related thinning of the skin. |
| **HEENT (1 point):**<br>**Head/Neck:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth:** | The Head is midline with no deviations. Hair is sparse, especially on the frontal side. Ears show no abnormal drainage, tympanic membrane visible, pearly grey. The patient does not have any physical abnormality of the ear but has an age-related impaired ability to hear and understand words properly. PERRLA is noted. The patient uses glasses regularly. The nose shows no deviated septum, turbinates are equal bilaterally. The oral mucosa is pink and moist with no notable abnormalities. Dentition is not good, and teeth are yellow. |
| **CARDIOVASCULAR (2 points):**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.** | The patient has nonspecific ST abnormality upon admission on EKG. Upon auscultation of patient heart sounds, S3 gallop is heard. The apical |

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| **Cardiac rhythm (if applicable):**<br>**Peripheral Pulses:**<br>**Capillary refill:**<br>**Neck Vein Distention: Y ☒ N ☐**<br>**Edema Y ☐ N ☐**<br>**Location of Edema:**<br>Edema in both her calf muscles. Pitting edema noted. | impulse is displaced. Peripheral pulses 1+ bilaterally and her capillary refill was 5 seconds. The patient has jugular vein distension. On 2d echo, there is moderate aortic stenosis, left concentric hypertrophy, and pulmonary hypertension. The patient has a troponin level of 0.036 which indicates heart failure. |
| **RESPIRATORY (2 points):**<br>**Accessory muscle use: Y☐ N ☒**<br>**Breath Sounds: Location, character** | No accessory muscle use when breathing. Trachea midline. No deviations. The patient is denying current shortness of breath. The patient was short of breath on admission. The patient breathing pattern is altered. She has decreased inspiration and expiration. The patient presents with a non-productive cough**.** Anterior and posterior lung sounds auscultated. Lung sounds are regular bilaterally. The patient currently breathing room air. The patient denies the use of oxygen at home. |
| **GASTROINTESTINAL (2 points):**<br>**Diet at home: The p**atient did not understand but her diet is mostly beans and meat obtained from the nurse.<br>**Current Diet:** Cardiac diet<br>**Height:** 5' 4"<br>**Weight:** 66.9 kg<br>**Auscultation bowel sounds:**<br>**Last BM:** Today Morning<br>**Palpation: Pain, Mass etc.:**<br>**Inspection:**<br>**Distention:**<br>**Incisions:**<br>**Scars:**<br>**Drains:**<br>**Wounds:**<br>**Ostomy: Y ☐ N ☐**<br>**Nasogastric: Y ☐ N ☐**<br>**Size:**<br>**Feeding tubes/PEG tube Y ☐ N ☐**<br>**Type:** | The patient was not able to give detailed history, so the information was taken from the chart and her nurse. Her diet is a 1200 calorie cardiac diet. She cannot feed herself and the staff does feed them three times a day. Her bowel sounds are regular in all four quadrants. There is no distension of the stomach. The patient has a hysterectomy scar on her abdomen, and she does not have any drains and wounds. |
| **GENITOURINARY (2 Points):**<br>**Color:**<br>**Character:**<br>**Quantity of urine:** | The patient can void on bedside commode with the help of staff members.<br>The patient can ambulate to the bedside commode x1. No dialysis and catheterization are |

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| **Pain with urination: Y ☐ N ☐**<br>**Dialysis: Y ☐ N ☐**<br>**Inspection of genitals:**<br>**Catheter: Y ☐ N ☐**<br>**Type:**<br>**Size:** | noted. No genital abnormalities were noted. The urine is dark yellow. The patient denies pain, hesitancy, or urgency on urination. No abnormal odor. The patient is on I&O's. |
| **MUSCULOSKELETAL (2 points):**<br>**Neurovascular status:**<br>**ROM:**<br>**Supportive devices:**<br>**Strength:**<br>**ADL Assistance: Y☐ N ☐**<br>**Fall Risk: Y ☐ N☐**<br>**Fall Score:** 30<br>**Activity/Mobility Status:**<br>**Independent (up ad lib)** ☐<br>**Needs assistance with equipment** ☒<br>**Needs support to stand and walk** ☒ | The patient is alert and oriented to person, place, and time but she is confused occasionally. She is not able to hear properly due to age-related impaired ability to hear. She ambulates very minimally with the help of supportive devices like a walker and cane. The patient refused to perform a range of motion. The patient stated, " I feel weak " and does not have the desire to ambulate. |
| **NEUROLOGICAL (2 points):**<br>**MAEW: Y ☐ N☐**<br>**PERLA: Y ☐ N☐**<br>**Strength Equal: Y ☐ N ☐ if no -**<br>**Legs ☐ Arms ☐ Both ☐**<br>**Orientation:**<br>**Mental Status:**<br>**Speech:**<br>**Sensory:**<br>**LOC:** | The patient is alert and oriented times 4. She does not have normal MAEW. She speaks very slowly and is unable to comprehend verbally due to age-related impaired ability to hear. The patient shows no signs of neurological damage or deficit. The patient's sensory function is intact with no loss of consciousness. |
| **PSYCHOSOCIAL/CULTURAL (2 points):**<br>**Coping method(s):**<br>**Developmental level:**<br>**Religion & what it means to pt.:**<br>**Personal/Family Data (Think about home environment, family structure, and available family support):** | The patient lives alone and is not married. She is catholic by religion. When asked about family, the patient stated " I do not have family and I live in the assisted living facility at Danville, IL. The patient states that she finished high school and is currently unemployed. |

**Vital Signs, 2 sets (5 points)**

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| **13:00** | **76** | **110/60**<br>**Right arm** | **12** | **96.7**<br>**Oral** | **98 percent**<br>**room air** |

| | | | | | |
|---|---|---|---|---|---|
| **14:45** | **70** | **100/50**<br><br>**Right arm** | **14** | **98.8**<br><br>**Oral** | **97 percent**<br><br>**room air** |

**Pain Assessment, 2 sets (2 points)**

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| 13:00 | Numeric scale<br>0 to 10 | Patient denies pain | Patient denies pain | Patient denies pain | No interventions implemented |
| 14:45 | Numeric scale<br><br>0 to 10 | Patient denies pain | Patient denies pain | Patient denies pain | No interventions implemented |

**IV Assessment (2 Points)**

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|---|
| **Size of IV:** 20 gauge<br>**Location of IV:** Left hand<br>**Date on IV**: 3/10/2021<br>**Patency of IV:** Patent<br>**Signs of erythema, drainage, etc.:** None<br>**IV dressing assessment:** clean, dry, and intact | None |

**Intake and Output (2 points)**

| Intake (in mL) | Output (in mL) |
|---|---|
| 600 (strawberry flavored popsicle, 300 ml<br><br>water, jello, broth, and hamburger). | 600 |

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care:**

The patient presented to ED due to severe shortness of breath when the patient was lying on her bed in assisted living. She was given a nebulizer and her condition was stabilized. Her troponin levels are 0.036. Her EKG revealed nonspecific ST abnormality. She was transferred to the Med Surg floor after her condition was stabilized. Overview of care is to continue diuresis to reduce peripheral edema and monitor her oxygen and electrolyte levels. As per the provider's notes, the plan of care is to continue diuresis and keep until her troponin levels are back to normal.

**Procedures/testing done:**

EKG showed nonspecific ST abnormality.

Chest x ray showed cardiomegaly, hyper expansion of both lung fields, and granuloma in right lower lung, and cardiomegaly.

2d Echo showed moderate aortic stenosis, mild concentric hypertrophy and grade I diastolic dysfunction.

**Complaints/Issues:**

The patient currently does not have shortness of breath but has a dry nonproductive cough. She stated, " I feel weak and just want to rest". The patient blood pressure was low, and her peripheral pulses were 1+. The provider wants to repeat her troponin levels after few hours and then decided her plan of stay accordingly.

**Vital signs (stable/unstable):**

Blood pressure is low and must be monitored every 4 hours. ( Mentioned in the chart).

**Tolerating diet, activity, etc.:** The patient does ambulate minimally and today she ambulated from her room to the bedside commode. Her activity is very minimal, and she spends

most of the time sleeping. She cannot eat by herself and needs someone to feed her. The patient's diet is cardiac and eats normally.

**Physician notifications:**

Notify the physician if her blood pressure is low and if she has signs of respiratory distress.

**Future plans for patient:**

The plan for the patient is to continue diuretic therapy and monitor electrolyte levels. Her troponin level will provide more specific direction for the provider regarding the discharge or stay at the hospital.

**Discharge Planning (2 points)**

**Discharge location:** Danville, IL

**Home health needs (if applicable):** monitor for blood pressure and shortness of breath.

**Equipment needs (if applicable):** Sphygmomanometer

**Follow up plan:** Currently, the follow-up plan is on hold until the patient's blood troponin levels are stable.

**Education needs:** Monitor blood pressure regularly at home.

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

| Nursing Diagnosis | Rational | Intervention (2 per dx) | Evaluation |
|---|---|---|---|
| • Include full nursing diagnosis with “related to” and “as evidenced by” components | • Explain why the nursing diagnosis was chosen | | • How did the patient/family respond to the nurse’s actions?<br>• Client response, status of goals and |

| | | | |
|---|---|---|---|
| | | | outcomes, modifications to plan. |
| 1. Ineffective gas exchange related to decreased inspiration, expiration and dry nonproductive cough and evidenced by left concentric hypertrophy of ventricle and pulmonary hypertnesion. (Swearingen, 2016, p. 112). | This is in relation to patient's dry nonproductive cough and impaired breathing pattern by decreased inspiration and expiration. | **1.** The head of the bed should be elevated or 30 degrees to help the patient's breathing pattern.<br><br>**2.** Monitor pulse oximetry. | Patient has impaired hearing due to age-related hearing impairment and hence cannot describe and interact, but her vitals and overall condition appear stable. |
| **2.** Risk for fall related to patient's limited mobility due to age-related physical changes and evidenced by impaired ambulation ( from bed to bed side commode and gait disturbances. (Swearingen, 2016, p.200). | This is in relation to patient's impaired mobility due to age-related changes in her physical ability. | **1.** Provide fall sign in room and patient's wrist band to remind healthcare providers for fall precautions.<br><br>**2.**Patient's call light and other necessary items like tv remote and cell phone should be within patient's reach. | 1. Patient did sustain the fall prevention and did not have a fall due to fall precautions.<br>2. Since the patient's call light was within reach, she was able to call the nurse when she wanted to use the restroom and did ambulate to the bedside commode for the first time with assistance. |
| 3. Impaired verbal communicatio n related to the patient's | This is in relation to the patient's impaired ability to hear and understand | **1.**Speak loudly but slowly so that patient can understand the words properly. | 1. Patient did understand when used loud but when spoke each word slowly. |

| | | | |
|---|---|---|---|
| age-related impaired ability to hear and interpret spoken words as evidenced by the patient's impaired ability to understand about her family when asked about family history. (Swearingen, 2016, p.120). | spoken words by nursing staff. | 2 Use facial expressions and gestures when talking with the patient. | **2.** Using facial expressions and gestures when asking for ordering food helped the patient to understand more easily. |

**Other References (APA):**

Swearingen, P. L. (2016). All-In-One Nursing Care Planning Resource (4 ed.). St. Louis, Missouri: ELSEVIER

**Concept Map (20 Points):**

**Subjective data**

Patient has impaired ability to hear and understand spoken sentences due to age related physical changes in her ears.
Patient mentioned that she does not have any shortness of breath or chest pain .
She mentioned that she feels weak and wants to sleep in her bed.

**Nursing Diagnosis/Outcomes**

1)Risk for fall
Outcome- Patient will to place the side table and call light within reach .
Impaired verbal communication
Outcome- Patient will agree to lower tv volume down so that spoken words can be easily understood.
Impaired gas exchange
Outcome- Patient will agree to keep the head of bed elevated.

**Objective Data**

Patient's blood pressure is low.
Her EKG shows nonspecific ST abnormality.
Chest x ray shows granuloma in right lower lung and calcifications in aortic knob.
2D Echo shows aortic stenosis and left concentric hypertrophy with grade I diastolic dysfunction.
Primary diagnosis is acute on chronic congestive heart failure.
Troponin is 0.036.
BNP is 750.

**Patient Information**

A 88 year female present to ED with shortness of breath and mild chest pain. Her troponin and BNP levels are 0.036 and 750 respectively. Her weight is 66.9 kg and height are 5' 4''. 2D echo shows grade I diastolic failure.

**Nursing Interventions**

Monitor blood pressure every 4 hours.
Elevate the head of bed to prevent shortness of breath.
Place patient on fall precaution list and wrist band for fall prevention
Ambulate patient with the help of assistive devices like walker and cane.
Ambulate patient with the help of other staff members to prevent fall
Teach the patient to inhale and exhale deeply.
Talk in a loud but slow speech so that patients can easily understand spoken words.
Spend some time with the patient and show empathy towards her.
Monitor electrolyte levels
Develop good listening skills.
Monitor patient for any signs of respiratory distress.