N441 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 5/11/21	**Patient Initials** T. P.	**Age** 71	**Gender** Male
Race/Ethnicity White/Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** Doxazosin (seizures)
Code Status Full Code	**Height** 5’ 11”	**Weight** 179 lbs	

Medical History (5 Points)

Past Medical History: atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus type 2, hypertension, seizures

Past Surgical History: hernia repair, laparoscopic colon resection, coronary artery bypass graft (2017)

Family History: no significant family history

Social History (tobacco/alcohol/drugs): quit smoking 10 years ago, previous alcohol use, previous illicit drug use

Assistive Devices: cane, walker

Living Situation: lives at home with wife

Education Level: high school

Admission Assessment

Chief Complaint (2 points): intermittent chest pain, shortness of breath

History of present Illness (10 points): This patient is a 71-year-old male with a history of atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, and hypertension and has presented to the OSF Danville emergency department with complaints of intermittent chest pain and shortness of breath that began 2 hours prior. His chest pain was not relived with nitroglycerin and his dyspnea was not relieved with supplemental

oxygen in the emergency department. He says his chest pain and dyspnea are worse on exertion. A chest x-ray suggested congestive heart failure exacerbation. His initial serum troponin in the emergency department was negative. 2D echocardiogram showed an ejection fraction of 35-40% with global hypokinesia of the left ventricle. He was admitted for a bilateral cardiac catheterization 3/12 and then transferred to OSF Urbana.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): Congestive heart failure, or CHF, is the inability of the heart to pump blood efficiently (Macon, 2018). CHF can have many causes, but this patient's CHF was likely caused by hypertension. Due to the increased blood pressure, the heart has to pump harder, and the walls of the left ventricle eventually becomes hard and stiff (Cleveland Clinic, 2017). This lowers the ejection fraction of the heart (below 55%) (Cleveland Clinic, 2017). When the heart cannot pump efficiently, fluid builds up in the heart and body tissues (Macon, 2018). Early manifestation of CHF include edema of the ankles, feet, legs, and abdomen; coughing; wheezing; dyspnea; fatigue; weight gain; tachycardia; anorexia; nausea; and confusion (Macon, 2018). To diagnose CHF, the provider will order a serum brain natriuretic peptide (BNP) test and an echocardiogram to test the ejection fraction of the heart (Macon, 2018). If the BNP test shows a result above 100 pg/mL and the echocardiogram shows an ejection fraction of less than 55%, then the provider will diagnose the patient with CHF and begin treatment (Macon, 2018). This patient presented with a BNP of 1212 pg/mL and an ejection fraction of 35-40% on his echocardiogram. CHF is treated with medications such as

ACE inhibitors and beta-blockers to treat the underlying causes (Macon, 2018). Edema and fluid overload are treated with diuretics (Macon, 2018). This patient was being treated with all three of these medication types. If medications fail or the patient is not compliant, an angioplasty may be performed to help open up blocked arteries and relieve stress on the heart (Macon, 2018). This patient was recently treated with a bilateral cardiac catheterization.

Pathophysiology References (2) (APA):

Cleveland Clinic. (2017). *Understanding Heart Failure | Cleveland Clinic*. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/17069-heart-failure-understanding-heart-failure

Macon, L. (2018, August 8). *Congestive Heart Failure (CHF)*. Healthline; Healthline Media. https://www.healthline.com/health/congestive-heart-failure#chf-and-genetics

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	4.4 - 5.8 10^6 cells/mcL	3.54 10^6 cells/mcL	4.55 10^6 cells/mcL	The red blood cell levels are decreased due to anemia (Pagana et al., 2019).
Hgb	13 – 16.5 g/dL	8.7 g/dL	10.2 g/dL	The hemoglobin level is decreased due to anemia (Pagana et al., 2019).
Hct	38 – 50%	27.1%	33.5%	The hematocrit level is decreased due to anemia (Pagana et al., 2019).
Platelets	140 – 440 10^3 cells/mcL	529 10^3 cells/mcL	538 10^3 cells/mcL	The platelets are elevated due to iron-deficiency anemia (Pagana et al., 2019).
WBC	4 –12 10^3	9.9 10^3	9.5	N/A

	cells/mcL	cells/mcL	10^3 cells/mcL	
Neutrophils	40 – 68%	85.5%	72%	The neutrophils are elevated due to stress (Pagana et al., 2019).
Lymphocytes	19 – 49%	7.7%	17%	The lymphocytes are decreased due to displacement by elevated neutrophils (Pagana et al., 2019).
Monocytes	3 – 13%	5.4%	6.7%	N/A
Eosinophils	0 – 8%	1%	3.1%	N/A
Bands	0 – 1%	0.4%	1.2%	The bands are elevated due to prolonged elevated neutrophil levels (Pagana et al., 2019).

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-	133 – 144 mmol/L	138 mmol/L	137 mmol/L	N/A
K+	3.5 - 5.1 mmol/L	4.6 mmol/L	4.7 mmol/L	N/A
Cl-	98 – 107 mmol/L	104 mmol/L	102 mmol/L	N/A
CO2	21 – 31 mmol/L	25 mmol/L	25 mmol/L	N/A
Glucose	70 – 99 mg/dL	142 mg/dL	139 mg/dL	The blood glucose level is elevated due to type 2 diabetes mellitus (Pagana et al., 2019).
BUN	7 – 25 mg/dL	25 mg/dL	47 mg/dL	The BUN is elevated due to congestive heart failure (Pagana et al., 2019).
Creatinine	0.5 - 1.2 mg/dL	1.16 mg/dL	1.17 mg/dL	N/A
Albumin	3.5 - 5.7 g/dL	3 g/dL	N/A	The serum albumin is decreased due to acute skin injury (Pagana et al., 2019).
Calcium	8.8 - 10. mg/dL	8.9 mg/dL	9.7 mg/dL	N/A
Mag	1.3 - 2.1 mEq/L	N/A	N/A	N/A

Phosphate	2.8 - 4.1 mg/dL	N/A	N/A	N/A
Bilirubin	0.2 - 0.8 mg/dL	0.6 mg/dL	N/A	N/A
Alk Phos	34 – 104 U/L	73 U/L	N/A	N/A
AST	13 – 39 U/L	10 U/L	N/A	The AST is decreased due to type 2 diabetes mellitus (Pagana et al., 2019).
ALT	7 – 52 U/L	9 U/L	N/A	N/A
Amylase	60 – 120 U/L	N/A	N/A	N/A
Lipase	0 - 160 U/L	10.1 U/L	N/A	N/A
Lactic Acid	0.5 - 2 mmol/L	2.2 mmol/L	N/A	The lactic acid is elevated due to diabetes mellitus (Pagana et al., 2019).
Troponin	0 – 0.04 ng/mL	<0.03 ng/mL	N/A	N/A
CK-MB	0%	N/A	N/A	N/A
Total CK	0.5 - 1.2 mg/dL	1.16 mg/dL	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	1.3	N/A	The INR is elevated due to anticoagulant therapy (Pagana et al., 2019).
PT	10.1 - 13.1 seconds	16.8 seconds	N/A	The PT time is elevated due to anticoagulant therapy (Pagana et al., 2019).
PTT	24 – 33 seconds	N/A	N/A	N/A
D-Dimer	<0.4 mcg/mL	N/A	N/A	N/A
BNP	0 – 100 pg/mL	1212 pg/mL	N/A	N/A

HDL	>39 mg/dL	N/A	N/A	N/A
LDL	0 – 99 mg/dL	N/A	N/A	N/A
Cholesterol	100 – 199 mg/dL	N/A	N/A	N/A
Triglycerides	0 – 149 mg/dL	N/A	N/A	N/A
Hgb A1c	4.8 - 5.6%	N/A	N/A	N/A
TSH	0 –10 mU/L	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	Yellow, clear	N/A	N/A
pH	5 - 9	5	N/A	N/A
Specific Gravity	1.005 - 1.03	1.016	N/A	N/A
Glucose	Negative	Negative	N/A	N/A
Protein	Negative	Negative	N/A	N/A
Ketones	Negative	Negative	N/A	N/A
WBC	Negative	Negative	N/A	N/A
RBC	Negative	Negative	N/A	N/A
Leukoesterase	Negative	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	N/A
PaO2	80 – 100 mm Hg	N/A	N/A	N/A
PaCO2	35 – 45 mm Hg	N/A	N/A	N/A
HCO3	21 – 28 mm Hg	N/A	N/A	N/A
SaO2	95 – 100%	N/A	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	Distal urethral culture growth	N/A	The urine culture showed distal urethral culture growth due to contamination of the specimen (Pagana et al., 2019).
Blood Culture	Negative	Negative	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 (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest x-ray (3/10): basal lung infiltrations, cardiomegaly

Chest x-ray (3/19): unchanged from 3/10 results

Diagnostic Test Correlation (5 points): A chest x-ray is done to examine the lungs and heart for abnormalities related to the patient's history of COPD and CHF (Pagana et al., 2019).

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

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

Home Medications (5 required)

Brand/Generic	Bayer/ aspirin	Lipitor/ atorvastatin	Zyban/ Bupropion SR	Cymbalta/ duloxetine	Lasix/ furosemide
Dose	81 mg	40 mg	150 mg	30 mg	20 mg
Frequency	Daily	Nightly	Daily	Daily	Daily
Route	Oral	Oral	Oral	Oral	Oral
Classification	Salicylate (Vallerand et al., 2019)	HMG CoA reductase inhibitor (Vallerand et al., 2019)	Norepinephrine/ dopamine-reuptake inhibitor (Vallerand et al., 2019)	Selective serotonin and norepinephrine reuptake inhibitor (Vallerand et al., 2019)	Loop diuretic (Vallerand et al., 2019)
Mechanism of Action	Decreases platelet aggregation; inhibits the	Lowers low-density liproteins and	Inhibits the enzymes involved in the reuptake	Inhibits the enzymes involved in the reuptake	Prevents the absorption of salt in

	production of prostaglandins, reducing pain, fever, and inflammation (Vallerand et al., 2019)	triglycerides and increases high-density lipoproteins in the blood (Vallerand et al., 2019)	of norepinephrine and dopamine (Vallerand et al., 2019)	of norepinephrine and serotonin (Vallerand et al., 2019)	the kidneys, allowing it to be passed in the urine (Vallerand et al., 2019)
Reason Client Taking	Myocardial Infarction Prophylaxis (Vallerand et al., 2019)	Hyperlipidemia (Vallerand et al., 2019)	Smoking cessation (Vallerand et al., 2019)	Nerve pain caused by diabetes mellitus (Vallerand et al., 2019)	Edema associated with congestive heart failure (Vallerand et al., 2019)
Contraindications (2)	Perioperative pain from CABG (Vallerand et al., 2019), thrombocytopenia (Vallerand et al., 2019)	Liver disease (Vallerand et al., 2019), kidney disease (Vallerand et al., 2019)	Suddenly stopped using alcohol (Vallerand et al., 2019), use caution in hypertension (Vallerand et al., 2019)	Alcohol use disorder (Vallerand et al., 2019), hypertension (Vallerand et al., 2019)	Hypovolemia (Vallerand et al., 2019), kidney disease (Vallerand et al., 2019)
Side Effects/Adverse Reactions (2)	Gastric upset (Vallerand et al., 2019), heartburn (Vallerand et al., 2019)	Joint pain (Vallerand et al., 2019), diarrhea (Vallerand et al., 2019)	Dry mouth (Vallerand et al., 2019), insomnia (Vallerand et al., 2019)	Drowsiness (Vallerand et al., 2019), nausea (Vallerand et al., 2019)	Dehydration (Vallerand et al., 2019), hearing loss (Vallerand et al., 2019)
Nursing Considerations (2)	Assess the client for bleeding (Vallerand et al., 2019). Assess the client for	Monitor lipid and triglyceride levels (Vallerand et al., 2019). Monitor for	Monitor for suicidal ideation (Vallerand et al., 2019). Monitor for smoking	Monitor nerve pain from diabetes (Vallerand et al., 2019). Monitor for	Ensure the patient is taking the correct dose to prevent hearing

	gastric upset (Vallerand et al., 2019).	side effects (Vallerand et al., 2019).	cessation (Vallerand et al., 2019).	suicidal ideation (Vallerand et al., 2019).	loss (Vallerand et al., 2019). Monitor edema (Vallerand et al., 2019).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain a baseline coagulation study and platelet count (Vallerand et al., 2019).	Obtain a baseline liver, kidney, and lipid profiles (Vallerand et al., 2019).	Obtain a baseline mental health assessment (Vallerand et al., 2019).	Obtain a baseline mental health assessment (Vallerand et al., 2019)	Obtain a baseline edema assessment (Vallerand et al., 2019). Obtain a baseline complete metabolic panel (Vallerand et al., 2019).
Client Teaching needs (2)	Do not take if you have a history of gastric ulcers or bleeding (Vallerand et al., 2019). Stop taking this medication if you have an allergic reaction (Vallerand et al., 2019).	This medication works together with a proper diet (Vallerand et al., 2019). Avoid drinking alcohol (Vallerand et al., 2019).	Tell your doctor about any other medications you take (Vallerand et al., 2019). Tell your doctor if you have thoughts of suicide (Vallerand et al., 2019).	Do not stop taking this medication suddenly (Vallerand et al., 2019). Tell your doctor about any other medications you take (Vallerand et al., 2019).	Do not take more than directed (Vallerand et al., 2019). Avoid changing positions quickly (Vallerand et al., 2019).

Hospital Medications (5 required)

Brand/Generic	Feosol/ ferrous sulfate	Neurontin/ gabapentin	heparin	Lantus/ insulin glargine	Zestril/ lisinopril
Dose	325 mg	100 mg	5000 U	12 U	2.5 mg
Frequency	Daily	Nightly	Q8H	Daily	Daily
Route	Oral	Oral	Subcutaneous	Subcutaneous	Oral
Classification	Dietary supplement (Vallerand et al., 2019)	Anticonvulsant (Vallerand et al., 2019)	Anticoagulant (Vallerand et al., 2019)	Long-acting insulin (Vallerand et al., 2019)	ACE inhibitor (Vallerand et al., 2019)
Mechanism of Action	Replaces iron in the body where it is needed (Vallerand et al., 2019)	Affects nerves and chemicals in the brain involved in seizures (Vallerand et al., 2019)	Prevents the formation of blood clots by inactivating thrombin and factor X (Vallerand et al., 2019)	Allows glucose to be taken up by cells and begins working several hours after administration and works evenly for 24 hours (Vallerand et al., 2019)	Inhibits angiotensin, causing vasodilation and lowering blood pressure (Vallerand et al., 2019)
Reason Client Taking	Iron-deficiency anemia (Vallerand et al., 2019)	History of seizures (Vallerand et al., 2019)	Prevention of blood clots while in the hospital (Vallerand et al., 2019)	Type 2 diabetes mellitus (Vallerand et al., 2019)	Hypertension (Vallerand et al., 2019), congestive heart failure (Vallerand et al., 2019)
Contraindications (2)	Hemolytic anemia (Vallerand	COPD (Vallerand et al., 2019),	Thrombocytopenia (Vallerand	Hypoglycemia (Vallerand	Hypotension (Vallerand

	et al., 2019), alcohol use disorder (Vallerand et al., 2019)	kidney disease (Vallerand et al., 2019)	et al., 2019), active bleeding (Vallerand et al., 2019)	et al., 2019), diabetic ketoacidosis (Vallerand et al., 2019)	et al., 2019), kidney disease (Vallerand et al., 2019)
Side Effects/Adverse Reactions (2)	Gastric upset (Vallerand et al., 2019), constipation (Vallerand et al., 2019)	Respiratory distress (Vallerand et al., 2019), headache (Vallerand et al., 2019)	easy bruising (Vallerand et al., 2019), blood in urine or stool (Vallerand et al., 2019)	Hypoglycemia (Vallerand et al., 2019), mild rash (Vallerand et al., 2019)	Headache (Vallerand et al., 2019), cough (Vallerand et al., 2019)
Nursing Considerations (2)	Monitor for medication side effects (Vallerand et al., 2019). Monitor labs for iron levels (Vallerand et al., 2019).	Monitor for respiratory distress (Vallerand et al., 2019). Monitor for seizures (Vallerand et al., 2019).	Initiate bleeding precautions (Vallerand et al., 2019). Monitor coagulation studies (Vallerand et al., 2019).	Monitor blood glucose levels (Vallerand et al., 2019). Monitor for symptoms of hypoglycemia (Vallerand et al., 2019).	Monitor blood pressure (Vallerand et al., 2019). Monitor side effects (Vallerand et al., 2019).
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain a baseline iron level (Vallerand et al., 2019).	Obtain baseline vitals (Vallerand et al., 2019). Assess for respiratory distress before administering (Vallerand et al., 2019).	Obtain baseline platelet count and coagulation study (Vallerand et al., 2019).	Obtain a baseline blood glucose level (Vallerand et al., 2019).	Obtain baseline vital signs (Vallerand et al., 2019)
Client Teaching needs (2)	Avoid taking an antibiotic within 2 hours of	Do not stop taking this medication suddenly (Vallerand	Report uncontrolled bleeding to your provider	This medication should be injected once each	Take your own blood pressure daily (Vallerand

	taking this medicine (Vallerand et al., 2019). Avoid taking antacids (Vallerand et al., 2019).	et al., 2019). Contact your provider immediately if you are having trouble breathing (Vallerand et al., 2019).	immediately (Vallerand et al., 2019). Do not take this medication with NSAIDs (Vallerand et al., 2019).	morning (Vallerand et al., 2019). Do not freeze this medication (Vallerand et al., 2019).	et al., 2019). Do not stop this medicatio n if you are feeling better (Vallerand et al., 2019).

Medications Reference (1) (APA):

Vallerand, A. H., Sanoski, C. A., & Quiring, C. (2019). *Davis's drug guide for nurses*. F.A. Davis Company.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** awake, alert **Orientation:** oriented to time, place, person, and situation **Distress:** no acute distress **Overall appearance:** clean, appropriate	Awake, alert and oriented x4. No acute distress. The patient is clean and dressed appropriately.
INTEGUMENTARY (2 points): **Skin color:** pale **Character:** dry **Temperature:** warm	The skin is pale, dry, and warm with adequate turgor. The patient has several scabs in various stages of healing on his lower extremities. He has a stage II left gluteal pressure injury and a left

Turgor: good **Rashes:** none **Bruises:** none **Wounds:** Stage II left gluteal pressure injury, left calf wound, scrotal moisture-associated skin damage, multiple scabs on lower extremities, multiple small open areas on perineum **Braden Score:** 13 **Drains present: Y☐ N ☐** **Type:**	calf wound, both of which are dressed with an occlusive dressing. The patient has multiple small open areas on his perineum and moisture-associated skin damage on his scrotum. No bruises or rashes noted.
HEENT (1 point): **Head/Neck:** normocephalic **Ears: unremarkeable** **Eyes: equal and blue in color** **Nose: midline, no fractures noted** **Teeth: permanent teeth present**	The patient's head and neck are midline and normocephalic. His ears, eyes, nose, and teeth are WDL. All permanent teeth present, no dentures noted.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** atrial fibrillation **Peripheral Pulses:** 2+ bilaterally **Capillary refill:** <3 seconds **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:** N/A	S1, S2 sounds noted. No murmur or rubs noted. His cardiac rhythm was in atrial fibrillation and his heart rate was WDL. Peripheral pulses were 2+ bilaterally and capillary refill was <3 seconds. No neck vein distention or edema noted.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character** Diminished bilaterally in lung bases **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Lung sounds are diminished in both bases. No accessory muscle use noted. No ET tube noted. Client is breathing room air.
GASTROINTESTINAL (2 points): **Diet at home:** unrestricted **Current Diet:** diabetic, heart healthy	. The client is on a diabetic, heart healthy diet while in the hospital. His bowel sounds are present in all four quadrants. His last bowel

Height: 5’ 11” **Weight:** 179 lbs **Auscultation Bowel sounds:** present in all four quadrants **Last BM:** 3/22 **Palpation: Pain, Mass etc.:** none **Inspection:** **Distention:** none **Incisions:** none **Scars:** none **Drains:** none **Wounds:** none **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**		movement was 3/22. No tenderness, masses, distention, incisions, scars, drains, wounds, ostomy, feeding tube, or nasogastric tube noted. The client is incontinent and wearing a diaper.
GENITOURINARY (2 Points): **Color:** yellow **Character:** clear **Quantity of urine:** Not measured **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** well-developed, scrotal moisture associated skin damage, multiple open areas on perineum **Catheter: Y ☐ N ☐** **Type:** **Size:** **CAUTI prevention measures:**	The client’s urine is yellow and clear, though output was not measured this shift. He had one wet diaper while before being discharged at 1000. His genitals are well-developed. Scrotal moisture-associated skin damage and multiple open wounds on his perineum noted. No urinary catheter noted. The client does not report pain with urination.	
MUSCULOSKELETAL (2 points): **Neurovascular status:** WDL **ROM:** full ROM in all extremities **Supportive devices:** cane, walker **Strength:** 5/5 bilaterally **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** 30 **Activity/Mobility Status:** 1-person assist with walker **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	.	No paresthesia noted. Full range of motion in all extremities. Strength 5/5 bilaterally. The client uses a walker and a cane to move around.
NEUROLOGICAL (2 points):	.	The client moves all extremities well and is

MAEW: Y ☐ N☐ **PERLA:** Y ☐ N☐ **Strength Equal:** Y ☐ N ☐ **if no -** **Legs** ☐ **Arms** ☐ **Both** ☐ **Orientation:** person, place, time, situation **Mental Status:** appropriate for age **Speech:** clear **Sensory:** intact **LOC:** awake, alert		PERRLA. Strength is equal among all extremities and is awake, alert, and oriented to time, place, person, and situation. His speech is clear and his senses are intact.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** watching TV **Developmental level:** appropriate for age **Religion & what it means to pt.:** Catholic, though "not very religious lately" **Personal/Family Data (Think about home environment, family structure, and available family support):** lives at home with wife, though care team suspects elder abuse due to multiple wounds on his body	.	The client is well-developed and claims to be Catholic, but he is "not very religious lately." He lives at home with his wife, but the patient care team suspects elder abuse due to multiple wounds at various stages of healing.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0647	74	143/72	16	97.3	97% on room air
0930	80	145/70	16	97.3	98% on room air

Vital Sign Trends/Correlation: This client's vital signs are stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0647	0-10	General	0	None	Continued to monitor
0930	0-10	General	0	None	Continued to monitor

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:**	No IV catheter present, dressing over site is clean, dry, and intact.
Other Lines (PICC, Port, central line, etc.)	
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:**	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
300	Not documented

Nursing Care

Summary of Care (2 points)

Overview of care: The client was being discharged to a skilled nursing facility that morning, so the nurse's job was to give him his morning medications, perform his morning assessment, and prepare him for discharge. The student nurse helped pass medications and cleaned the client prior to discharge.

Procedures/testing done: none during this shift

Complaints/Issues: The client had wet his diaper, but he did not ask for help. The nurse knew he would not want to ask for help and asked the student nurse to check his diaper and clean him if necessary.

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: The patient is tolerating his prescribed diet and activity well.

Physician notifications: Notify the physician of any changes in status prior to discharge.

Future plans for patient: The patient was discharge to a skilled nursing facility, where he will stay indefinitely.

Discharge Planning (2 points)

Discharge location: Skilled nursing facility

Home health needs (if applicable): N/A

Equipment needs (if applicable): walker, cane

Follow up plan: The client will be cared for in a skilled nursing facility for the foreseeable future.

Education needs: The client needs to learn how to ambulate to prevent the formation of blood clots. He also needs to learn how to tell the nurses when something is wrong and to ask for help when needed.

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. Risk for infection related to multiple wounds as evidenced by perineal and scrotal wounds exposed to feces and urine (Health-Conditions, 2020).	Infection can be very dangerous in older adults and can lead to septicemia.	**1.** Monitor WBC daily. **2.** Monitor open wounds and change dressings as ordered.	The patient did not acquire an infection during his stay at the hospital. Will continue to monitor.

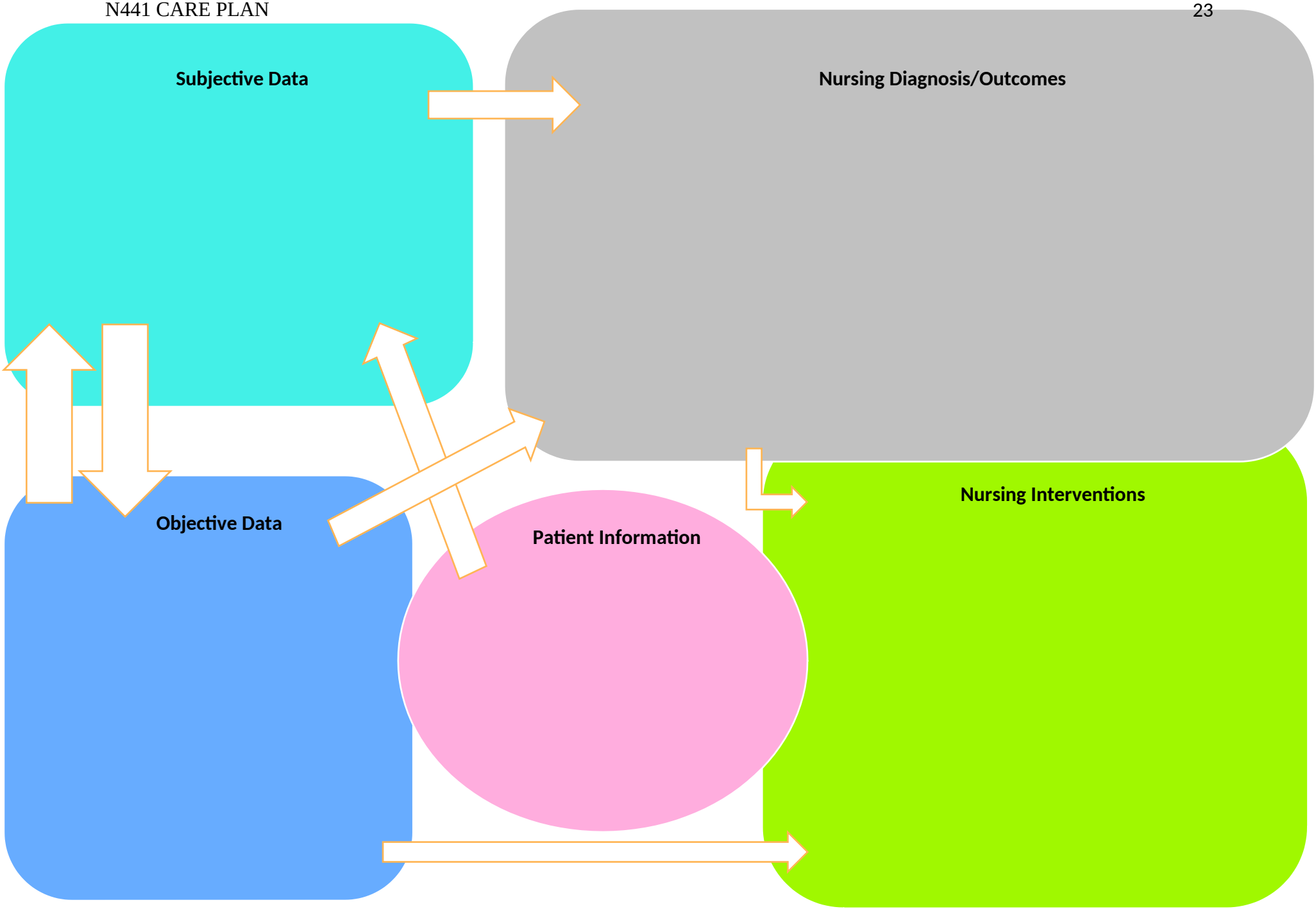
2. Impaired gas exchange related to chronic obstructive pulmonary disease as evidenced by diminished basilar lung sounds (Health-Conditions, 2020).	Maintaining the patient's airway is one of the top priorities in nursing care.	**1.** Monitor the patient's oxygen saturation Q4H. **2.**Assess lung sounds Q4H.	The client did not have any breathing difficulties during this shift. Will continue to monitor.
3. Risk for bleeding related to anticoagulation therapy as evidenced by elevated INR and PT time (Health-Conditions, 2020).	Circulation is one of the top priorities in nursing care.	**1.**Monitor daily coagulation studies. 2.Administer anticoagulants per provider's order and per hospital protocol.	The client did not experience any bleeding events during his hospital stay. Will continue to monitor.
4. Decreased cardiac output related to congestive heart failure as evidence by an ejection fraction of 35-40% (Health-Conditions, 2020).	Circulation is one of the top priorities in nursing care. This client was admitted due to congestive heart failure exacerbation.	**1.**Monitor the client for edema during assessment. **2.** Monitor perfusion during assessment.	The client did not experience complications associated with decreased cardiac output during this shift. His congestive heart failure symptoms were well-managed. Will continue to monitor.
5. Impaired tissue integrity related to bedbound status and incontinence as	Due to diabetes mellitus, this client will have a difficult time healing from wounds. It is	**1.**Treat the client's wounds and change dressings as ordered. **2.** Turn and	The client's wounds did not improve during his stay at the hospital, but they did not worsen. Will continue to monitor.

evidenced by stage II pressure injury and moisture-associated scrotal skin damage (Health-Conditions, 2020).	important to focus on wound healing for this patient to prevent infection.	ambulate the client as ordered.	

Other References (APA):

Health-Conditions. (2020). *Approved NANDA Nursing Diagnosis List 2018-2020*. Health-Conditions.

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Objective Data
Patient Information
Nursing Interventions

Subjective Data:

- **The patient states he began feeling short of breath and pain in his chest 2 hours before entering the emergency department.**
- **The patient states he has not had any pain since recovering from his bilateral cardiac catheterization surgery.**

Objective Data:

- **He was admitted on 3/11 for congestive heart failure exacerbation.**
- **His chest x-ray suggested CHF exacerbation and echocardiogram showed an ejection fraction of 35-40%. His labs were consistent with this diagnosis. He had a bilateral cardiac catheterization and was transferred to Urbana. His vital signs remained stable during his hospitalization. He had diminished basilar lung sounds and multiple wounds in various stages of healing on his genitals, perineum, and lower extremities.**

Patient Information:

- **The patient is a 71-year-old male with a history of atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus type 2, hypertension, and seizures.**

Nursing Diagnosis

1. Risk for infection related to multiple wounds as evidenced by perineal and scrotal wounds exposed to feces and urine (Health-Conditions, 2020).
2. Impaired gas exchange related to chronic obstructive pulmonary disease as evidenced by diminished basilar lung sounds (Health-Conditions, 2020).
3. Risk for bleeding related to anticoagulation therapy as evidenced by elevated INR and PT time (Health-Conditions, 2020).
4. Decreased cardiac output related to congestive heart failure as evidence by an ejection fraction of 35-40% (Health-Conditions, 2020).

5. Impaired tissue integrity related to bedbound status and incontinence as evidenced by stage II pressure injury and moisture-associated scrotal skin damage (Health-Conditions, 2020).

Interventions/Outcomes:

1. Monitor WBC daily. Monitor open wounds and change dressings as ordered. The patient did not acquire an infection during his stay at the hospital. Will continue to monitor.
2. Monitor the patient's oxygen saturation Q4H. Assess lung sounds Q4H. The client did not have any breathing difficulties during this shift. Will continue to monitor.
3. Monitor daily coagulation studies. Administer anticoagulants per provider's order and per hospital protocol. The client did not experience any bleeding events during his hospital stay. Will continue to monitor.
4. Monitor the client for edema during assessment. Monitor perfusion during assessment. The client did not experience complications associated with decreased cardiac output during this shift. His congestive heart failure symptoms were well-managed. Will continue to monitor.
5. Treat the client's wounds and change dressings as ordered. Turn and ambulate the client as ordered. The client's wounds did not improve during his stay at the hospital, but they did not worsen. Will continue to monitor.