

N321 Care Plan # 3

Lakeview College of Nursing

Name: Claire Zumbahlen

Demographics (3 points)

Date of Admission 4/12/21	Patient Initials SB	Age 84	Gender F
Race/Ethnicity White	Occupation Retired	Marital Status Widow	Allergies NKA
Code Status Full code	Height 160 cm	Weight 62.9 kg	

Medical History (5 Points)

Past Medical History: Chronic cough, depression, skin cancer, murmur, arthritis, anxiety, UTIs, restless leg, non-Hodgkin's lymphoma, severe back pain

Past Surgical History: tonsils and adenoids (as a child), appendectomy (as a child), hysterectomy (approximately 30 years old), face lift (approximately 50 years old)

Family History: Cardiovascular disease: brother X2, mother and father

Social History (tobacco/alcohol/drugs) Denies use of any tobacco, alcohol, and drugs.

Assistive Devices: Walker

Living Situation: At home with 24 hour care

Education Level: College (Bachelors)

Admission Assessment

Chief Complaint (2 points): SOB and weakness

History of present Illness (10 points): The patient was brought to the emergency room by her son for weakness and fatigue that has been going on for the past 3-4 days. The patient said that this morning she had increased shortness of breath with wheezing. She said "I just could not catch my breath and then I started to vomit which made it worse." Nothing seemed to relieve the SOB and vomiting, but activity made it worse.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): Hypoxia and hyponatremia

Pathophysiology of the Disease, APA format (20 points): Congestive heart failure (CHF) is known as heart failure and is a medical condition that involves the decrease in the heart's capacity to pump blood to the other parts of the body. The major criteria for congestive heart failure includes at least one of the following, paroxysmal nocturnal dyspnea, jugular vein distension, pulmonary crackles, cardiomegaly, auscultation of S3 heart sounds, positive hepatojugular reflux (Capriotti, 2020). My patient had the following signs and symptoms as the criteria for diagnosing CHF proximal nocturnal dyspnea and pulmonary crackles. Diagnostic tests for heart failure include physical examination, blood tests, imaging such as a chest x-ray, CT scan, MRI and coronary angiogram, stress test and myocardial biopsy (Heart Failure, 2020). With my patient when diagnosing for heart failure the patient had crackles in the lungs on auscultation, blood tests such as a BNP which was elevated, and a chest x-ray which showed fluid on the lungs and an enlarged heart. There is a several medications that are used for treatment in combination. These medications include angiotensin-converting enzymes, beta blockers, digoxin, inotropes, and diuretics (Heart failure, 2020). With my patient she was just diagnosed with CHF, but they had on Lasix in order to get rid of her excess fluid, and a consult with a cardiologist to look at starting a combination of different medication.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

Heart failure. (2020, May 29). Retrieved February 21, 2021, from <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.

*****Patient was just admitted today so today's values and admission values are the same.****

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.41	3.56		Anemia frequently occurs in congestive heart failure therefore resulting in low RBC (Capriotti, 2020)
Hgb	11.3-15.2	11.4	N/A	
Hct	33.2-45.3	34.2	N/A	
Platelets	149-393	278	N/A	
WBC	4.0-11.7	8.8	N/A	
Neutrophils	45.3-79.0	79.0	N/A	
Lymphocytes	11.8-45.9	11.9	N/A	
Monocytes	4.4-12.0	10.2	N/A	
Eosinophils	0.0-6.3	0.3	N/A	
Bands	0.2-1.6	0.5	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
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Na-	136-145	122	N/A	Sodium levels are decreased due to the fluid over load (Capriotti, 2020)
K+	3.5-5.1	4.4	N/A	
Cl-	98-107	91	N/A	
CO2	21-31	23	N/A	
Glucose	74-109	106	N/A	
BUN	7-25	28	N/A	Renal perfusing is decreased and BUN rises in conditions such as congestive heart failure (Capriotti, 2020)
Creatinine	.84-1.21	1.15	N/A	
Albumin	3.5-5.2	3.5	N/A	
Calcium	8.6-10.3	9.1	N/A	
Mag	1.7-2.2	1.7	N/A	
Phosphate	2.4-4.5	N/A	N/A	
Bilirubin	0.3-1.0	0.7	N/A	
Alk Phos	7-52	17	N/A	
AST	0.3-1.0	0.5	N/A	
ALT	13-39	14	N/A	
Amylase	30-110	N/A	N/A	
Lipase	24-151	N/A	N/A	
Lactic Acid	0.5-1	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	0.81-1.20	0.97	n/a	
PT	11.5-15.0	13.2	n/a	
PTT	25-35	28.8	n/a	
D-Dimer	<250	n/a	n/a	
BNP	<100	2,074	n/a	The patients BNP was high due to the enlarged heart and fluid on the lungs. (Capriotti, 2020)
HDL	<60	n/a	n/a	
LDL	<100	n/a	n/a	
Cholesterol	<200	n/a	n/a	
Triglycerides	<150	n/a	n/a	
Hgb A1c	4-5.6%	n/a	n/a	
TSH	0.4-4	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	Pale yellow/clear	N/A	N/A	*these labs were not back for the patient due to just being admitted*
pH	5-8	N/A	N/A	
Specific Gravity	1.005-1.030	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	

WBC	0-5	N/A	N/A	
RBC	0-6	N/A	N/A	
Leukoesterase	Negative	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	None of these labs were done on the patient
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (1) (APA): Sarah bush reference information

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray showed fluid on the lungs and an enlarged heart.

Diagnostic Test Correlation (5 points): Chest X-ray was ordered for the shortness of breath (Marmor, D, Faber, J, 2006)

Diagnostic Test Reference (1) (APA): Marmor, D., Farber, J., & Gottlieb, J. (2006, May 01). Acute respiratory distress syndrome due to pulmonary involvement by neoplastic plasma cells in multiple myeloma. Retrieved February 23, 2021, from <https://thorax.bmj.com/content/61/5/455>

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

Home Medications (5 required)

Brand/ Generic	Baclofen/ baclofen tablets	Metoprolol/ Toprol	Tamsulosin/ flowmax	Ropinirole/ Requip	Escitalopra m/ lexapro
Dose	10 mg	25 mg	0.4 mg	2 mg	10 mg
Frequenc y	TID	BID	Daily	TID	Daily
Route	PO	PO	PO	PO	PO
Classifica tion	Skeletal muscle relaxer	Beta Blocker	Alpha 1 beta blocker	Dopamine agonist	SSRI
Mechanis m of Action	Reduces the relapse of excitatory neurotransmit ters and substance P by binding to the GABA-B receptor	Blocks the action of chemicals such as epinephrine on the heart and blood vessels	Alpha 1 receptors in the bladder neck, ureter are relaxed resulting in easier urination	Stimulates dopamine D2 receptors in the brain	Binds to the SERT and inhibits the reuptake of serotonin by the presynaptic neuron
Reason Client Taking	Muscle spasms	Heart failure	Urination troubles	Restless leg syndrome	Anxiety
Contrain dications (2)	Children under 12, hypersensitivi ty	Hypersensiti vity, Diabetes can mask hypoglycemi a	Hypersensiti vity, orthostasis	Renal impairment, pregnancy	Children,
Side Effects/A dverse	Mood changes, confusion	Shortness of breath, swelling	Drowsiness, weakness	Fainting, hypotension	Blurred vision, confusion

Reactions (2)					
Nursing Considerations (2)	Do not stop abruptly taking, Caution with renal impairment	Do not stop taking abruptly, monitor heart rate and blood pressure	Caution with many drugs, do not take if a sulfa allergy	Teach patient about how it can make them have drowsiness, and signs and symptoms toxicity	Watch baseline labs, check HR and ECG

Hospital Medications (5 required)

Prograph/tacrolimus	Furosemide/ Lasix	Acetaminophen/ Tylenol	Enoxaparin/ lovenox	Pantoprazole/ protonix	Montelukast/ singular
Dose	40 mg/ 4 mL	650mg	40 mg	40 mg	10 mg
Frequency	Daily	BID	Daily	BID	daily
Route	IV push	PO	Sub Q	PO	PO
Classification	Loop diuretic	Pain reliever, antipyretic	anticoagulant	Antiulcer	Leukotriene receptor antagonist
Mechanism of Action	Inhibits the ascending limb of the loop of Henle, by	Reduces the production of prostaglandins in the brain and decrease	Binds to and potentiates antithrombin to form a complex that	Interferes with gastric acid secretion by inhibiting hydrogen-potassiumadenosine phosphate	Blocks the action of leukotriene D4 in the lungs resulting in decreased

	binding to the chloride transport channel leading to urination	inflammation and swelling	irreversibly inactivates clotting factor XA	enzyme synthesis	inflammation and relaxation of the smooth muscle.
Reason Client Taking	Fluid overload/ CHF	Pain	Prevent blood clots	Prevent stomach ulcer and GERD	Allergic rhinitis
Contraindications (2)	Precaution with hypotension and dysthymias, sulfa allergy	GI bleeding, hypersensitivity	Hypothrombopenia,	Hypersensitivity, concurrent therapy with rilpivirine	Hypersensitivity,
Side Effects/Adverse Reactions (2)	Dry mouth, increased urination	Nausea, rash	Usual bleeding, easy bruising	Hepatic failure, thrombopenia	Fever, diarrhea
Nursing Considerations (2)	Push slowly, monitor electrolytes	Monitor vitals, do not exceed 4,000 mg in 24 hours	Inject in Sub Q fat, monitor PT/ INR	Expect to monitor PT or INR during therapy if taking anticoagulant, monitor patient for hypomagnesemia	Monitor for mood or behavior changes, monitor for weakness or muscle tremors

Medications Reference (1) (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert. (2020). *2020 Nurse's Drug Handbook*. (Nineteenth ed.). Burlington, MA: Jones & Bartlett learning.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient was alert and oriented to time, place, date and person A & O times 4 No distress shown Well groomed and appropriately dressed</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Pink Dry Warm Turgor 2+ None None None 20</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck were symmetrical with normal range of motion in face, head and neck. Ears pink with free of discharge Nose symmetrical with no drainage Teeth intact and good condition</p>
<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Heart sounds normal S1 and S2 heard with a murmur no gallops or rub present. Patient was sinus rhythm. Carotid, radial, ulnar, brachial, femoral, popliteal, dorsal pedis, and posterior tibial pulses 2+ bilaterally. Patients capillary refill was less than 3 seconds</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Respirations were normal. Lungs had slight crackles in the lower lobes.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight:</p>	<p>Regular Heart Healthy with 1,200 fluid restriction 160 cm 62 kg</p>

<p>Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Bowel sounds present and active in all four quadrants 4/11 No pain or masses present Palpitation of abdomen was soft and non-tender. No scars, drains, or wounds present</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Yellow Clear 400 mL</p> <p>Pink, clean and dry</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Normal strength, reflexes and ROM in all extremities, patient denies any pain as described 0/10 Walker and Gait belt Within normal limits for age 5/5 bilaterally in all extremities</p> <p>85 Up with assistance with walker and gaitbelt</p> <p>Needs assistance with equipment</p>
<p>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</p>	<p>Has support from her son. Fully developed Methodist Has son and 24 hour care givers that care for her.</p>

available family support):	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1154	99	122/65	18	36.6	94
1522	93	111/56	18	36.5	95

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0823	numeric	N/A	0	N/A	N/A
1048	numeric	N/A	0 (denies pain)	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:	18-gauge Left AC 4/12 Open not blocked None Clean, dry, and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
200 mL + 40 mL lasix	400 urine

Nursing Care

Summary of Care (2 points)

Overview of care: Patient had admission done. Patient also had vitals, medications, and was put on a heart monitor. The patient had a chest x-ray done which showed fluid in the lungs. The patient had no complaints or issues. The patient did not eat very much for lunch after arriving to the floor and stating she had not ate much all day. The patient was tolerating the fluid restriction and took her medications as prescribed; the physician was never called during the shift. In the future the patient will be seen by the impatient cardiologist.

Discharge Planning (2 points): The patient will be discharged back home with her 24 hour care. The patient may need a home health nurse to help with the new diagnosis of her CHF. The patient already has plenty of equipment at home such as walkers, railings, and many support devices. The patient will need to follow up with her primary care provider and need educated on CHF due to the recent diagnosis. The patient could also use education on hyponatremia.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Excess fluid volume excess as evidenced</p>	<p>I chose this diagnosis because my patient had</p>	<p>1. Monitor urine output and calculate 24 hour intake</p>	<p>Goal met the patient was put on a 24 hour intake and output calculation and will</p>

<p>by crackles in the lungs and respiratory distress.</p>	<p>crackles upon auscultation.</p>	<p>and output. 2. Monitor weight daily and breath sounds.</p>	<p>have her weight monitored daily. The patient was educated on the importance of this and how a gain of 5 lbs. is approximately 2 L of fluid.</p>
<p>2. Risk for electrolyte imbalance due to the excess fluid and low sodium levels.</p>	<p>The patient had fluid over load causing low sodium levels.</p>	<p>1. Administer Lasix as prescribed and auscultate the lungs. 2. 1,200 mL fluid restriction</p>	<p>Goal met the patient was taught about the importance of the Lasix and the fluid restriction due to her very low sodium levels.</p>
<p>3. Risk for impaired skin integrity as evidence by the frequent urination and not realizing the urge to go and limited mobility.</p>	<p>The patient has limited mobility, is incontinent, and the presences of edema.</p>	<p>1. Inspect skin noting boney prominences, presence of edema and areas of altered circulation. 2. Frequent skin care and changing of position.</p>	<p>This goal was met. The patient was educated on the importance of keeping the skin clean and dry and turning to keep the skin intact and prevent pressure injuries or tears in the skin.</p>

Other References (APA):

Concept Map (20 Points):



