N321 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10/15/2021	Patient Initials P.S.	Age 06/18/1952	Gender Male
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Married	Allergies No known allergies
Code Status Full Code	Height 171.5 cm	Weight 158.4 kg	

Medical History (5 Points)

Past Medical History: Morbid obesity, type 2 diabetes, chronic obstructive pulmonary disease, obstructive sleep apnea, and spinal stenosis in lumbar area status.

Past Surgical History: Aortic valve replacement, heart surgery, appendix removal, and shoulder surgery.

Family History: The patient's father died of chronic heart failure.

Social History (tobacco/alcohol/drugs): The patient quit smoking cigarettes 13 years ago and used to smoke 2 packs a day. The patient takes a shot of alcoholic creamer in coffee every morning but is not sure how long he has been doing this. The patient also uses about one gummy bear a month that contains THC for pain for 5 years.

Assistive Devices: The patient states that he only uses a walker when it is needed.

Living Situation: The patient lives at home with wife and two great Danes.

Education Level: The patient's highest level of education is high school.

Admission Assessment

Chief Complaint (2 points): Shortness of breath and insomnia

History of present Illness (10 points): On 10/15/2021, the patient came to the emergency room presenting with shortness of breath and insomnia. The patient stated, "I have not been able to sleep for 3 days now and have not been able to breathe well". The patient denied having any discomfort or pain related to the current reason for being in the hospital. The patient just stated he just felt bad all over. The patient stated the shortness of breath or insomnia had not gone away since it started 3 days ago. The patient did not experience any additional characteristics besides shortness of breath and insomnia. I asked the patient if anything made his symptoms worse or better, and the patient stated, "no, that is why I finally came to the hospital after 3 days". The patient is currently on oxygen to help him breathe, but it is no longer helping. I asked the patient how severe his symptoms were on a numerical scale of 1-10, and the patient stated that it was a 3 out of 10. The pain is located bilaterally in his legs, and he is currently not taking medication for the pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Chronic heart failure

Secondary Diagnosis (if applicable): N/A

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

Chronic heart failure is when the heart is not pumping enough blood adequately as it should. The heart depends on the rhythm and strength of all its chambers and valves to produce a healthy pumping heart (Capriotti, 2020). Heart failure can lead to the left and right sides of the heart being affected. Many patients who have chronic heart failure can have signs of both. When the left ventricle cannot pump blood into the aorta, this can decrease systemic arterial pressure (Capriotti, 2020). This can then lead to hypotension,

decreased circulation to the kidneys, and decreased circulation to the pituitary gland. Low blood pressure can lead to activation of the sympathetic nervous system and will increase the heart rate (Capriotti, 2020). If kidney circulation is decreased, RAAS will initiate and increase the blood volume and stimulate peripheral vasoconstriction. Finally, the last system that is affected is the pituitary gland. If this is affected, the antidiuretic hormone will let out and increase the reabsorption of water in the bloodstream, increasing blood volume (Capriotti, 2020). When the heart is not functioning properly, it can lead to many complications.

There are many signs and symptoms of chronic heart failure. Some of the general signs of heart failure are dyspnea, orthopnea, weight gain, cough, sleep disturbances, pulmonary crackles, muscle weakness, pallor or cyanosis, anorexia, weight loss, and lightheadedness or dizziness (Hinkle & Cheever, 2018). Risk factors leading to chronic heart failure include age, gender, family history, medications, obesity, diabetes, and sleep apnea (Hinkle & Cheever, 2018). The patient has many risk factors like obesity, sleep apnea, and diabetes, leading him to chronic heart failure.

Expected findings in chronic heart failure are fatigue, shortness of breath, fluid build-up, and sleep disturbances (Hinkle & Cheever, 2018). The patient came into the emergency room with shortness of breath and insomnia, expected findings of chronic heart failure. Labs that would be drawn for chronic heart failure include a BNP, serum electrolytes due to blood volume excess (Hinkle & Cheever, 2018). Vitals that can be seen with chronic heart failure are a rapid or irregular heart rate and high blood pressure (Hinkle & Cheever, 2018). Diagnostic tests that can be done are chest x-ray, electrocardiogram, echocardiogram, cardiac catheterization, and angiography (Capriotti,

2020). The patient had an electrocardiogram done and a chest x-ray when the patient came into the emergency room.

Treatment for chronic heart failure can be treated with lifestyle changes, increasing physical activity, smoking cessation, and taking prescribed medications (Capriotti, 2020). When the patient is being discharged, he can be educated on the types of medications that can be used and what type of diet is best for chronic heart failure.

Pathophysiology References (2) (APA):

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

Hinkle, J. L., & Cheever, K. H. (2018). ***Brunner & Suddarth's textbook of medical-surgical nursing*** **(14th ed). Wolters Kluwer**

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	3.90-4.98 (mill/cumm)	3.06	3.07	Decreased RBCs could be from possible anemia (Pagana, 2018).
Hgb	12.0-15.5 (gm/dL)	7.3	7.3	Decreased because of possible anemia or iron deficiency (Pagana, 2018).
Hct	35-45%	23.6	23.3	Decreased because of possible anemia or iron deficiency (Pagana, 2018).
Platelets	140-400 (1000/mm3)	253	255	n/a
WBC	4.0-9.0 (10 x 3/uL)	7.9	7.6	n/a
Neutrophils	40-70%	68.8	78.5	Increased because of possible

				infection (Pagana, 2018).
Lymphocytes	**10-20%**	**17.4**	**13.0**	**n/a**
Monocytes	**5%?**	**8.8**	**6.8**	**n/a**
Eosinophils	**1-4%**	**3.9**	**3.7**	**n/a**
Bands	**0.0-10.0%**	**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 (mEq/L)**	**138**	**138**	**n/a**
K+	**3.5-5.1 (mEq/L)**	**3.9**	**3.9**	**n/a**
Cl-	**98-107 (mEq/L)**	**99**	**98**	**n/a**
CO2	**21-31 (mEq/L)**	**33**	**33**	**Increased because of the patient's shortness of breath retaining CO2 and it not being emitted properly (Pagana, 2018).**
Glucose	**60-110 (mg/dL)**	**87**	**109**	**n/a**
BUN	**8-23 (mg/dL)**	**31**	**29**	**Increased because of a possible acute kidney function (Pagana, 2018).**
Creatinine	**0.05- 1.00 (mg/dL)**	**1.6**	**1.67**	**Increased because of a possible acute kidney function impairment (Pagana, 2018).**
Albumin	**3.5-5.2 (gm/dL)**	**3.7**	**3.9**	**n/a**
Calcium	**8.4-10.0 (mg/dL)**	**9.0**	**9.0**	**n/a**
Mag	**1.3-2.1 (mg/dL)**	**2.0**	**2.0**	**n/a**
Phosphate	**2.5-5 (mg/dL)**	**n/a**	**n/a**	**n/a**
Bilirubin	**0.0-1.2**	**n/a**	**n/a**	**n/a**
Alk Phos	**35-105 (U/L)**	**n/a**	**n/a**	**n/a**

AST	**13-39 U/L**	**n/a**	**n/a**	**n/a**
ALT	**7-52 U/L**	**n/a**	**n/a**	**n/a**
Amylase	**60-100 U/L**	**n/a**	**n/a**	**n/a**
Lipase	**0-160 U/L**	**n/a**	**n/a**	**n/a**
Lactic Acid	**0.5-1.5 mEq/L venous**	**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	**1-2**	**n/a**	**n/a**	**n/a**
PT	**10-12 seconds**	**n/a**	**n/a**	**n/a**
PTT	**30-45 seconds**	**n/a**	**n/a**	**n/a**
D-Dimer	**Negative, less than 250 mg/mL**	**n/a**	**n/a**	**n/a**
BNP	**Less than 100 pg/mL**	**n/a**	**n/a**	**n/a**
HDL	**< 60 md/dL**	**n/a**	**n/a**	**n/a**
LDL	**< 100 mg/mL**	**n/a**	**n/a**	**n/a**
Cholesterol	**< 200 mg/dL**	**n/a**	**n/a**	**n/a**
Triglycerides	**< 150 mg/dL**	**n/a**	**n/a**	**n/a**
Hgb A1c	**< 5.7%**	**n/a**	**n/a**	**n/a**
TSH	**0.5-5.0%**	**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	Yellow	n/a	n/a
pH	5.0-8.0	7.0	n/a	n/a
Specific Gravity	1.005-1.034	1.008	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	0-0.5	n/a	n/a	n/a
RBC	0-3	n/a	n/a	n/a
Leukoesterase	Negative	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	n/a	n/a	n/a
Blood Culture	Negative	n/a	n/a	n/a
Sputum Culture	Negative	n/a	n/a	n/a
Stool Culture	Negative	n/a	n/a	n/a

Lab Correlations Reference (1) (APA):

Pagana, K.D, Pagana, T. N. (2018). Mosby's diagnostic and laboratory test reference (6th ed.). St. Louis, MO.: Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. **Electrocardiogram (EKG) - The patient has a right bundle branch with first degree atrioventricular block.**
2. **Chest X - ray - The patient have mild pulmonary edema**

Diagnostic Test Correlation (5 points):

1. **Electrocardiogram is a graph that shows the activity of the heart. An Electrocardiogram is used to measure time and velocity (Hinkle & Cheever, 2018). The patient will have electrodes that are placed throughout the body on specific parts to measure the heart. The patient has a right bundle branch with first degree atrioventricular block.**
2. **A chest x-ray produces images of a person's heart, lungs, blood vessels and the bones of a chest (Hinkle & Cheever, 2018). A chest x- ray also shows if there is fluid around the lungs (Hinkle & Cheever, 2018). The patient's results came back concluding that he had mild pulmonary edema.**

Diagnostic Test Reference (1) (APA):

Hinkle, J. L., & Cheever, K. H. (2018). ***Brunner & Suddarth's textbook of medical-surgical nursing*** **(14th ed). Wolters Kluwer**

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

Home Medications (5 required)

Brand/Generic	**Furosemide/ Lasix**	**Metformin/ Glucophage**	**Aspirin/ Dulaza**	**Pioglitazone/ Actos**	**Pregabalin/ Lyrica**
Dose	**20 mg**	**500 mg**	**325 mg**	**45 mg**	**150 mg**
Frequency	**Daily**	**BID**	**Daily**	**Daily**	**BID**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Loop diuretic; Antihypertensive, diuretic (Jones, 2021)**	**Biguanide; Antidiabetic (Jones, 2021)**	**Salicylate; NSAID, antipyretic, nonopioid analgesic (Jones, 2021)**	**Thiazolidinedione; Antidiabetic (Jones, 2021)**	**Gamma-aminobutyric acid analogue; Analgesic, anticonvulsant (Jones, 2021)**
Mechanism of Action	**Inhibits sodium and water absorption in the kidneys (Jones, 2021).**	**Could promote storage of glucose as glycogen, in the liver, which will reduce glucose production (Jones, 2021).**	**Blocks the activity of inflammatory response and causes vasodilation (Jones, 2021).**	**Decreases insulin resistance by enhancing insulin dependent tissues and reduces hyperglycemia (Jones, 2021).**	**With fewer neurotransmitters, pain sensation and seizure activity can decrease (Jones, 2021).**
Reason Client Taking	**To reduce edema caused by heart failure (Jones, 2021).**	**To reduce blood glucose level in type 2 diabetes**	**To reduce mild to moderate pain (Jones, 2021).**	**To reach glucose control (Jones, 2021).**	**To manage partial onset of seizures (Jones, 2021).**

		(Jones, 2021).			
Contraindications (2)	**Anuria and hypersensitivity to furosemide (Jones, 2021).**	**Acute or chronic acidosis and severe renal disease (Jones, 2021).**	**Active bleeding and breastfeeding (Jones, 2021).**	**Hypersensitivity to this drug and Class III or IV heart failure (Jones, 2021).**	**Hypersensitivity to pregabalin and these medications components (Jones, 2021).**
Side Effects/Adverse Reactions (2)	**Arrhythmias and paresthesia (Jones, 2021).**	**Hypoglycemia and hepatic injury (Jones, 2021).**	**Hepatotoxicity and Angioedema (Jones, 2021).**	**Congestive heart failure and edema (Jones, 2021).**	**Intracranial hypertension and heart failure (Jones, 2021).**
Nursing Considerations (2)	**Use caution in patients who have advanced cirrhosis. Monitor hepatic function, renal function, BUN, and blood pressure (Jones, 2021).**	**Monitor closely of symptoms of lactic acidosis and respiratory distress. Metformin should never be given to a patient with severe renal failure (Jones, 2021).**	**Do not crush medication if it's a timed release or controlled release tablet. Ask if the patient is having tinnitus. (Jones, 2021)**	**Monitor patients for signs and symptoms because it can cause fluid retention. This drug is not recommended for patients with heart failure (Jones, 2021).**	**Drugs should be stopped if an allergic reaction occurs. Monitor patients for suicidal ideation or behavior (Jones, 2021).**

Hospital Medications (5 required)

Brand/Generic	**Heparin /Heparin sodium injection**	**Rosuvastatin/ Crestor**	**Furosemide/ Lasix**	**Formoterol/ Perforomist**	**Metoprolol/ Lopressor**
Dose	**5000 Units**	**10 mg**	**10 mg**	**20 mcg**	**12.5 mg**
Frequency	**Daily**	**Daily**	**Twice a day**	**Twice a day**	**Twice a day**
Route	**Subcutaneous**	**Oral**	**IV push**	**Nebulizer**	**Oral**

Classification	**Anticoagulant; Anticoagulant (Jones, 2021).**	**HMG-CoA reductase inhibitor; Antilipemic (Jones, 2021).**	**Loop diuretic; Antihypertensive, diuretic (Jones, 2021)**	**Selective beta adrenergic agonist; bronchodilator (Jones, 2021).**	**Beta adrenergic blocker; Antianginal, antihypertensive (Jones, 2021).**
Mechanism of Action	**Heparin inactivates thrombin and prevents existing clot formation (Jones, 2021).**	**To control and lower bad cholesterol and triglycerides (Jones, 2021).**	**Inhibits sodium and water absorption in the kidneys (Jones, 2021).**	**Relaxes bronchial smooth muscle cells and stabilizes mast cells (Jones, 2021).**	**By inhibiting beta receptor sites it helps relieve angina, minimize cardiac tissue, and help relieve symptoms of heart failure (Jones, 2021).**
Reason Client Taking	**To treat and prevent peripheral arterial embolism (Jones, 2021).**	**To treat hyperlipidemia (Jones, 2021).**	**To reduce pulmonary edema (Jones, 2021).**	**To manage exercise induced bronchospasm (Jones, 2021).**	**Manage hypertension (Jones, 2021).**
Contraindications (2)	**Hypersensitivity to heparin or pork and disseminated intravascular coagulation (DIC) (Jones, 2021).**	**Active liver disease and unexplained persistent elevation of serum transaminase levels (Jones, 2021).**	**Anuria and hypersensitivity to furosemide (Jones, 2021).**	**Hypersensitivity to this drug or its components (Jones, 2021).**	**Heart rate less than 45 bpm and P-R interval 0.24 seconds or greater (Jones, 2021).**
Side Effects/Adverse Reactions (2)	**Excessive bleeding from wounds and Adrenal hemorrhage (Jones, 2021).**	**Hepatic failure and Angioedema (Jones, 2021).**	**Thromboembolism and hemolytic anemia (Jones, 2021).**	**Prolonged QT interval and arrhythmias (Jones, 2021).**	**Cardiac arrest and heart failure (Jones, 2021).**
Nursing Considerations (2)	**Give heparin only by subcutaneous or I.V. route.**	**Monitor the patient's serum lipoprotein**	**Patients who are allergic to sulfonamide**	**Should not be taken as monotherapy treatment**	**Expect to taper the drug over 1-2 weeks**

	Use caution because it can cause hematomas and pain at the injection site (Jones, 2021).	**levels to see if it exceeds three times the amount. Use cautiously in patients with myopathy. (Jones, 2021).**	**s can be allergic to furosemide. Monitor patients for hypokalemia (Jones, 2021).**	**for asthma. Patients should be aware that with deterioratin g COPD (Jones, 2021).**	**because you should not stop suddenly. Monitor orthostatic hypotension. (Jones, 2021).**

Medications Reference (1) (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient is alert and orientated to person, place, time, and situation (x4). The patient seemed to be in mild distress. The patient's pain is 3 out 10 on a numerical scale ranging from 1-10. The patient's overall appearance was well put together.**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐X** **Type: N/A**	**The patient's upper extremities were pink, warm, and intact. The patient's legs had bilateral reddened and had open sores due to extreme edema. The patient stated "Well sometimes my legs get so swollen they burst and start to leak." The patient's legs were reddened, cool, and had open wounds. The patient turgor was less than 3 seconds. The braden score is a 20 which is a limited risk of skin breakdown. The patient currently has no drains present. The patient had bruises on his arm and legs. There appeared to be no rashes.**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:**	**The patient's head and neck appeared to be midline with no deviation, and his ears were intact and symmetrical. He was hard of hearing in both ears. There was currently no**

Nose: **Teeth:**	**drainage present. The client's eyes appeared to be symmetrical with no drainage. The patient's dentures were in place, and his tongue appeared to be pink and midline.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐X N ☐** **Edema Y x N ☐** **Location of Edema: Bilaterally in legs**	**S1, S2, S3 were heard. I was able to hear S3 because the patient was diagnosed with chronic heart failure. The heart rate was abnormal due to being able to hear S3. The patient's upper extremities pulses were palpable and bilateral. The lower extremities were non palpable bilaterally. The patient had pitting edema stage 4 in both legs.** **The patient did not appear to have neck vein distention. He had edema in his lower extremities bilaterally.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐X** **Breath Sounds: Location, character**	**The lung sounds were not clear as I listened to the patient. I was able to hear the crackle bilaterally in the lungs. The crackles were heard in the base of the lungs. The patient was not using accessory muscles, and I did not see any chest deformities.**
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 ☐X** **Nasogastric: Y ☐ N ☐X** **Size: N/A** **Feeding tubes/PEG tube Y ☐ N ☐X** **Type: N/A**	**The patient eats mostly frozen dinners or fast foods at home and has a 1200-1400 calorie heart healthy restricted diet at the hospital. The patient height is 171.5 cm and weight is 158.4 kg.** **The patient's last bowel movement was this morning. The patient bowel sounds were active 5 -30 seconds in all four quadrants for a minute. The patient had abdominal distention. The patient had no drains present. The patient had scars near his umbilicus. There was no ostomy, nasogastric, or feeding tubes.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:**	**The patient's urine was yellow and transparent. The patient denied any pain or burning while urinating. The patient voided 420 mL of urine while I was there. The patient**

Pain with urination: Y ☐ N ☐X **Dialysis: Y ☐ N ☐X** **Inspection of genitals:** **Catheter: Y ☐ N ☐X** **Type:N/A** **Size:N/A**	**was not on dialysis. The patient did not have a catheter and could urinate on his own.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: YX N ☐** **Fall Risk: Y X N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Neurovascular status is intact and is in control. The patient was able to show me active ROM in the upper extremities but passive in the lower extremities. The client needs assistants with a walker as needed to get around. The patient's strength is equal but strong in upper extremities and weak in lower extremities, but they all were bilateral. The patient needs moderate assistance with activities of daily living. The patient is a low fall risk with a score of 45. The patient does not need help with standing or walking.**
NEUROLOGICAL (2 points): **MAEW: Y ☐X N☐** **PERLA: Y ☐X N☐** **Strength Equal: Y ☐X N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC: Alert**	**The patient's lower and upper extremities are bilateral, but the lower extremities are weak. The patient is alert and orientated (x4). Mental status is appropriate for age. Patient exhibited PERLA. Speech is normal and audible. Sensory is intact, and level of consciousness is alert and oriented. The patient had pain and paresthesia in both legs but denied paralysis. The upper pulses were palpable and bilateral, but the lower pulses were not palpable and bilateral. The patient described his pain being a 3 out of 10 using the numerical scale. The patient's skin appeared pink.**
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):**	**The patient lives at home with his wife and 3 great Danes. The patient's wife is very supportive and accommodates the patient to make sure he is comfortable. Coping methods are used by redirecting the patient's attention and taking walks. The client's religion is Christian but does not affect the patient's care. Developmental level is appropriate for his age.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0930	**77 bpm**	**111/60 mmHg**	**13 rpm**	**36.4 C**	**94%**
1100	**73 bpm**	**128/63 mmHg**	**16 rpm**	**36.5 C**	**96%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0930	**Numerical scale 0-10**	**Bilateral leg pain**	**3 out of 10**	**Tingling/ sharp pain**	**The patient was taking aspirin for pain**
1100	**Numerical scale 0-10**	**Bilateral leg pain**	**3 out of 10**	**Tingling/ sharp pain**	**Help patient ambulate**

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:**	**The patient has a 20-gauge IV central port in the right forearm. The IV was placed on 10/15/2021.** **IV site is dry, and intact. IV is patent.** **No Drainage, erythema, swelling, inflammation, or warmth.** **IV dressing was clear and intact.** **The patient has a saline lock until iron will be administered**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
760 mL	**420 mL of urine**

The patient ate all of his breakfast which consisted of eggs and pancakes.	

Nursing Care

Summary of Care (2 points)

Overview of care: The care for the client consisted of reducing fluid overload, pain, and overall discomfort. The patient could not lay in the bed due to fluid overload, so he sat in the recliner chair. The patient is going to start getting iron through the IV before he is discharged. The patient's vital signs were done every 4 hours due to doctor orders. The patient had his glucose checked before breakfast and lunch due to poor control of type 2 diabetes.

Procedures/testing done: The patient did not receive any procedures or testing while I was there besides checking blood glucose.

Complaints/Issues: The patient was complaining about his mild pain in the lower extremities due to neuropathy pain due to poor control of his diabetes.

Vital signs (stable/unstable): The patient vitals signs were stable when I checked them at 0930 and 1100.

Tolerating diet, activity, etc.: The patient went to the bathroom once while I was there and did not need any assistance with the bathroom.

Physician notifications: There were no notifications to the physician needed from the nurse.

Future plans for the patient: The patient will be discharged later once he receives the iron. The patient will follow up with a cardiologist and dietitian when he is discharged from the hospital.

Discharge Planning (2 points)

Discharge location: The patient will be discharged to his trailer home with his wife and 2 great Danes.

Home health needs (if applicable): The patient does not currently need home health because his wife helps him with many things he can not do himself.

Equipment needs (if applicable): The patient already has portable oxygen that he carries around with him.

Follow up plan: The patient already has cardiologist and dietician appointments lined up after being discharged from the hospital.

Education needs: The patient needs further education on how to control his type 2 diabetes and eat healthier.

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	● Explain why the nursing diagnosis was chosen		● How did the patient/family respond to the nurse's actions? ● Client response, status of goals and outcomes,

by" components			modifications to plan.
1. Excess fluid volume related to chronic heart failure as evidenced by pitting edema stage 4.	**The patient cannot lay flat due to excess fluid volume, which causes extreme discomfort and aids his insomnia.**	**1. The use of compression socks to help push the blood back to the heart.** **1. Patient elevated his leg in the recliner chair due to excessive fluid in lower extremities.**	**• The goal was met because the patient felt relief in his lower extremities once the compression socks and legs were elevated for a while.** **• The goal was met because the patient felt relief from pressure in his lower extremities.**
3. Decreased cardiac output related to chronic heart failure evidenced by pitting edema stage 4.	**The patient's heart cannot pump adequately, causing fluid excess, and it is getting difficult for the client to ambulate on his own.**	**1. Monitor the patient's input and output status to monitor for fluid excess** **2. Fluid restriction to be under a 1000 mL to reduce extra work on the heart.**	**• The goal was not met because the patient input and output did not equal out. The patient consumed 760 mL but only urinated 420 mL.** **• The goal was met because the patient did not consume over 1000 mL of fluids.**
4. Ineffective airway clearance related to chronic heart failure as evidenced by shortness of breath.	**The patient came into the hospital because of extreme shortness of breath in which airway, breathing, and circulating is the priority of the patient-centered care.**	**1. Auscultate the patient's lung sounds** **2. Keeping the patient in a high fowler's position.**	**• The goal was not met because, on auscultation, crackles were heard in the base of the lungs.** **• The goal was met because the patient agreed to stay in a high fowler's position, which helped him breathe more efficiently.**

Other References (APA):

Concept Map (20 Points):

Objective data

1.) The patient has a distended abdomen
2.) The patient has pitting edema stage 4 in the lower extremities.
3.) The patient's CO2 labs are elevated due to shortness of breath and retaining CO2.

Subjective data

1.) “Well sometimes my legs get so swollen they burst and start to leak.”
2.) “I have not been able to sleep for 3 days now and have not been able to breath well”.
3.) I asked the patient if anything made his symptoms worse or better, and the patient stated, “no that is why I finally came to the hospital after 3 days”.

Patient information: The patient is a 68 year old Caucasian old male who admitted himself to the hospital due to shortness of breath and insomnia. The patient has abnormal labs and was diagnosed with chronic heart failure.

Nursing Diagnosis/Outcomes

Excess fluid volume related to chronic heart failure as evidenced by pitting edema stage 4.
Outcome: The patient was able to feel relief in his lower extremities once the compression socks were on and legs were elevated for a while.
Decreased cardiac output related to chronic heart failure evidenced by pitting edema stage 4.
Outcome: The patient was able to restrict fluids but was not able to balance out the input and output.
Ineffective airway clearance related to chronic heart failure as evidenced by shortness of breath.
Outcome: The patient still had crackles in the base of his lungs but was able to stay in high fowlers positions.

Nursing interventions

The use of compression socks to help push the blood back to the heart.
Patient elevated his leg in the recliner chair due to excessive fluid in lower extremities.
Monitor the patient’s input and output status to monitor for fluid excess
Fluid restriction to be under a 1000 mL to reduce extra work on the heart.
Auscultate the patient’s lung sounds
Keeping the patient in a high fowler's position.