N321 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 02/20/2022	**Client Initials** ML	**Age** 72	**Gender** F
Race/Ethnicity Hispanic	**Occupation** Retired	**Marital Status** Widowed	**Allergies** Bananas, Shellfish, Cyclobenzaprine
Code Status Full Code	**Height** 5’ 2” (62 in)	**Weight** 106 lbs	

Medical History (5 Points)

Past Medical History:

Hypertension, atrial fibrillation, hyperlipidemia, and congestive heart failure (CHF).

Past Surgical History:

In 1995, this patient had a cholecystectomy. In 2009, this patient had a total knee replacement.

Family History:

There is a family history of diabetes, present in both the patient’s mother and brother. The patient’s father has a history of myocardial infarctions.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

The patient denies any history alcohol, tobacco, or drug usage.

Assistive Devices:

The patient denies use of any assistive devices.

Living Situation:

The patient lives at the Oaks Manor Assisted Living Facility.

Education Level:

GED, not applicable to learning barriers.

Admission Assessment

Chief Complaint (2 points):

The patient presents to the care setting following weight gain and swelling of the ankles

History of Present Illness – OLD CARTS (10 points):

Patient was admitted following an onset of peripheral edema presenting in the lower extremities, detailed as the bilateral ankle and pedal areas, alongside an abnormal 12-pound weight gain over the course of the last four days. Edema has not receded since the onset, though is relieved with rest and elevation and aggravated with ambulation. Patient has not stated any attempts at treating the edema, and does not express pain alongside the edema.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Exacerbation of CHF

Secondary Diagnosis (if applicable): No secondary diagnosis is applicable for this patient.

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

Congestive heart failure (CHF) is defined as a "complex clinical syndrome in which the heart cannot pump enough blood to meet the body's requirements" (Malik, 2021). Congestive heart failure has a wide range of risk factors, it is the most common diagnosis in the older adult population and is a contributing cause in one out of nine deaths (Blumenthal, 2022). The most substantial risk factors for congestive heart failure include obesity, hypertension, age, diabetes, african-american descent, and sedentary lifestyle (Malik, 2021). The patient detailed by this care plan has a medical history of hypertension and CHF, and the patient's CHF exacerbation may indicate poor adherence to medical interventions for the CHF and/or hypertension (Malik, 2021). The exacerbation may also indicate an acute stressor in the patient's life (Malik, 2021).

The pathophysiology of congestive heart failure is directly related to the maladaptive consequences of the body's adaptive mechanics which increase cardiac output in response to insufficient cardiac output (Malik, 2021). To maintain the body's demands for blood circulation, the heart adjusts by compensating through myocardial hypertrophy and and hypercontractility, both of which increase stress on the heart (Malik, 2021). The decreased cardiac output also

stimulates an endocrine release of epinephrine, and stimulates the renal renin-angiotensin-aldosterone system (RAAS) (Malik, 2021). The stimulation of the RAAS is substantially important for the patient detailed in this care plan, as the role of the RAAS is to increase sodium and water retention by the body (Malik, 2021).

The signs and symptoms related to CHF include orthopnea, fatigue, swelling of the lower extremities, and rapid or irregular heart rhythms (Mayo Clinic, 2022). Swelling of the lower extremities is the strongest indication of CHF in the patient detailed by this care plan, though the EKG finding of atrial fibrillation is also symptomatic of CHF. Patients with untreated CHF are expected to be tachypneic with abnormal rhythm and are expected to demonstrate hypertension, and the patient detailed by this care plan initally presented with an irregular rhythm alongside hypertension and tachypnea (Mayo Clinic, 2022). Diagnostically, there is no singular test for CHF. Alongside the EKG previously discussed, chest x-rays and echocardiograms are valuable to determine structural abnormalities in the cardiac region (Blumenthal, 2022). B-type natriuretic peptide (BNP) laboratory blood tests mark the severity of the heart failure (Blumenthal, 2022).

Heart failure is treated for management, there is no cure. Treatment aims to relieve symptoms alongside either slowing or preventing any further substantial damage (Blumenthal, 2022). Many cardiac medications may be prescribed for the management of heart failure, some of the most notable of which being diuretics for the associated fluid retention, vasodilators to reduce blood pressure, and antiplatelets to prevent blood clots (Blumenthal, 2022). As CHF may be associated with structural damage to the heart, surgical interventions may be required to bypass blocked arteries or replace heart valves (Blumenthal, 2022).

Pathophysiology References (2) (APA):

Congestive heart failure: Prevention, treatment and research. Johns Hopkins Medicine. (2022). Retrieved February 26, 2022, from https://www.hopkinsmedicine.org/health/conditions-and-diseases/congestive-heart-failure-prevention-treatment-and-research

Malik, A. (2021, November 2). *Congestive heart failure*. StatPearls [Internet]. Retrieved February 26, 2022, from https://www.ncbi.nlm.nih.gov/books/NBK430873/

Mayo Foundation for Medical Education and Research. (2021, December 10). *Heart failure*. Mayo Clinic. Retrieved February 26, 2022, 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.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.3-5.5x10E6 cells/mcL	N/A	N/A	N/A
Hgb	12-15 g/dL	13.6	N/A	N/A
Hct	36-47%	N/A	N/A	N/A
Platelets	150-400 K/mcL	N/A	N/A	N/A
WBC	4-10 K/mcL	9.4	N/A	N/A
Neutrophils	40-60%	N/A	N/A	N/A
Lymphocytes	20-40%	N/A	N/A	N/A
Monocytes	4-8%	N/A	N/A	N/A

Eosinophils	1-3%	N/A	N/A	N/A
Bands	0-5%	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 mmol/L	138	N/A	N/A
K+	3.5-5 mmol/ L	3.1	N/A	This patient takes a loop diuretic (furosemide) as a medication. As loop diuretics do not spare potassium, this patient's hypokalemia is most probably related to furosemide intake (MedlinePlus, 2022).
Cl-	95-105 mmol/L	N/A	N/A	N/A
CO2	23-29 mmol/L	N/A	N/A	N/A
Glucose	65-110 mg/dL	94	N/A	N/A
BUN	8-21 mg/dL	24	N/A	Associated with the RAAS response to the patient's acute CHF, a decrease in renal perfusion causes elevated levels of BUN (Mayo Clinic, 2022).
Creatinine	0.8-1.3 mg/dL	2.8	N/A	Creatinine levels, alongside BUN levels, are indicative of renal perfusion. Similarly to the elevated BUN levels, the decreased renal perfusion as a response to CHF is the most probable explanation for elevated creatinine levels (Mayo Clinic, 2022).
Albumin	3.4-5.4 g/dL	N/A	N/A	N/A
Calcium	8.6-10.3 mg/ dL	N/A	N/A	N/A
Mag	1.5-2 mEq/L	N/A	N/A	N/A

Phosphate	0.8-1.5 mmol/L	N/A	N/A	N/A
Bilirubin	1-1.2 mg/dL	N/A	N/A	N/A
Alk Phos	50-100 unit/L	N/A	N/A	N/A
AST	8-48 units/L	N/A	N/A	N/A
ALT	7-55 units/L	N/A	N/A	N/A
Amylase	25-151 units/L	N/A	N/A	N/A
Lipase	10-140 units/L	N/A	N/A	N/A
Lactic Acid	0.5-1 mmol/L	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	approx. 1	N/A	N/A	N/A
PT	11-13 seconds	N/A	N/A	N/A
PTT	25-35 seconds	N/A	N/A	N/A
D-Dimer	<500 ng/mL	N/A	N/A	N/A
BNP	<100 pg/mL	4923	N/A	BNP is the lab value most directly correlated to the cardiac damage associated with heart failure, and this remarkably elevated level is diagnostically relevant to confirm an incidence of CHF in this patient (Blumenthal, 2022)
HDL	30-70 mg/dL	N/A	N/A	N/A
LDL	<130 mg/dL	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	<7%	N/A	N/A	N/A
TSH	0.2-5.4 microunits/mL	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	N/A	N/A
pH	4.5-8	N/A	N/A	N/A
Specific Gravity	1.005-1.025	N/A	N/A	N/A
Glucose	<130	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	None	N/A	N/A	N/A
WBC	0-5	N/A	N/A	N/A
RBC	0-4	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):

Mayo Foundation for Medical Education and Research. (2021, December 10). *Heart failure*. Mayo Clinic. Retrieved February 26, 2022, from https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142

Taylor, C., Lynn, P., & Bartlett, J. L. (2019). CoursePoint for Fundamentals of nursing: The art and science of person-centered care (9th ed.). Wolters Kluwer

Tompkins, J, et al. (2017, January 1). *Academy of Acute Care Physical Therapy - cdn.ymaws.com*. APTA. Retrieved February 24, 2022, from https://cdn.ymaws.com/www.aptaacutecare.org/resource/resmgr/docs/2017-Lab-Values-Resource.pdf.

U.S. National Library of Medicine. (2022). *Furosemide: Medlineplus drug information*. MedlinePlus. Retrieved February 26, 2022, from https://medlineplus.gov/druginfo/meds/a682858.html

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

A. Chest X-Ray
    a. A chest X-Ray attempts to visualize any cardiac or lung dysfunction, and was performed on this patient as an attempt to visualize any structural cardiac abnormalities which may have pertained to congestive heart failure.
B. Electrocardiogram (EKG)

a. An EKG determines the electrical activity of the heart and may indicate abnormal rhythms consistent with congestive heart failure.

Diagnostic Test Correlation (5 points):

A. Chest X-ray

a. The findings demonstrated an enlarged heart alongside pulmonary vascular congestion. The enlarged heart is indicative of cardiac hypertrophy which occurred in response to low cardiac output, and the pulmonary vascular congestion is indicative of pulmonary edema caused by CHF (MedlinePlus, 2022). Both outcomes of the chest x-ray are abnormalities consistent with the patient's CHF diagnosis (MedlinePlus, 2022).

B. Electrocardiogram (EKG)

a. The findings demonstrated atrial fibrillation, indicative of irregularly rapid contraction of the atria of the heart (Mayo Clinic, 2022). Atrial fibrillation is a dysrhythmia which is a symptom consistent with the diagnosis of congestive heart failure (Mayo Clinic, 2022).

Diagnostic Test Reference (1) (APA):

https://medlineplus.gov/ency/article/000140.htm

https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142

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

Home Medications (5 required)

Brand/Generic	**Qbrelis/ lisinopril**	**Nexterone/ amiodarone**	**Aspirin/ acetylsalicylic acid**	**Lipitor/ atorvastatin**	**Lopressor / metoprolol**
Dose	40 mg	200 mg	81 mg	40 mg	50 mg
Frequency	daily	daily	daily	daily at bedtime	twice daily
Route	oral	oral	oral	oral	oral

Classification	PHARM: ACE Inhibitor THERA: Antihypertensive	PHARM: Benzofuran derivative THERA: Class III antiarrhythmic	PHARM: Salicylate THERA: NSAID	PHARM: HMG-CoA reductase inhibitor THERA: Antihyperlipidemic	PHARM: Beta Blocker THERA: Antianginal/ Antihypertensive
Mechanism of Action	Lisinopril inhibits the RAAS to reduce blood preassure by inhibiting the conversion of angiotensin I to angiotensin II (Comerford, 2021).	Amiodarone prolongs the refractory period and cardiac repolarization, which improves myocardial blood flow (Comerford, 2021).	Aspirin inhibits production of thromboxane A2, a platelet aggregation stimulating substance, and therefore interferes with clotting (Comerford, 2021).	Atorvastatin reduces plasma cholesterol by inhibiting cholesterol synthesis in the liver and increasing LDL receptors on liver cells to encourage breakdown (Comerford, 2021).	Metoprolol lowers blood pressure by beta blocking the effects of epinephrine. It also reduces elevated renin plasma levels (Comerford, 2021).
Reason Client Taking	CHF and HTN	Atrial fibrillation	Prevent clot formation (risk of CHF)	Hyperlipidemia	CHF and HTN
Contraindications (2)	Lisinopril is contraindicated by a history of angioedema related to previous treatment with ACE inhibitors, and is also contraindicated with aliskeren use in diabetic patients (Comerford,	Amiodarone is contraindicated by syncopal bradycardia, cardiogenic shock, and and SA node dysfunction (Comerford, 2021).	Aspirin (and NSAIDs as a whole) are contraindicated with active bleeds, as aspirin will reduce clotting time and may increase the risk for excessive bleeding (Comerford, 2021).	Active liver diseases, breastfeeding, and pregnancy are all contraindicated with atorvastatin (Comerford, 2021)	Metoprolol is contraindicated by abnormal sinus rhythms (of which the patient's ECG confirmed there weren't any) and hypersensitivity to

	2021).				beta blockers (Comerford, 2021).
Side Effects/Adverse Reactions (2)	Adverse reactions to lisinopril include arrythmias, hypotension, myocardial infarction, acute renal failure, and bronchospasm (Comerford, 2021).	Adverse reactions to amiodarone include further arrhythmias, hypotension, acute renal failure, and erythema among many others (Comerford, 2021).	Adverse reactions to aspirin include CNS depression, GI bleeding, hepatotoxicity, and bronchospasm (Comerford, 2021).	Cardiac arrhythmias, hypoglycemia, and pancreatitis are all adverse reactions of atorvastatin (Comerford, 2021).	Side effects of Metoprolol may include bradycardia, AV block, and pulmonary edema (Comerford, 2021).
Nursing Considerations (2)	Angioedema must be strictly monitored for as adverse reactions to this medication may result in airway obstruction (Comerford, 2021).	More serious adverse reactions to amiodarone may include arrhythmias, which is why it is absolutely essential to discontinue for heart rate below 60 and to monitor continuous ECG (Comerford, 2021).	As aspirin regularly comes in timed/controlled-release capsules, one consideration is the importance of not crushing such capsules (Comerford, 2021).	Monitor the patient and withold medication for signs and symptoms of myopathy and/or renal failure, as both are indicative of serious adverse reaction to atorvastatin (Comerford, 2021).	Discontinuation of drug must be done over the course of 1-2 weeks, as abrupt discontinuation is associated with myocardial infarction and ischemia (Comerford, 2021).

Hospital Medications (5 required)

Brand/Generic	**Lasix/ furosemide**	**Potassium chloride**	**Tylenol/ acetaminophen**	**Colace/ docusate**	**MorphaBond/ morphine**
Dose	40 mg	40 mEq	650 mg	100 mg	1 mg
Frequency	twice daily	once	every six hours and as needed	twice daily and as needed	every four hours and as needed
Route	IV	oral	oral	oral	IV
Classification	PHARM: Loop diuretic THERA: antihypertensive, diuretic	PHARM: Electrolyte cation THERA: Electrolyte replacement	PHARM: Nonsalicylate, paraminophenol derivative THERA: antipyretic, nonopioid analgesic	PHARM: Surfactant THERA: Laxative, stool softener	PHARM: Opioid THERA: Opioid analgesic
Mechanism of Action	Furosemide, as a loop diuretic, inhibits sodium and water reabsorption in the loop of henle, reducing blood pressure over time due to the reduced fluid volume (Comerford, 2021).	Potassium is a major cation involved with cardiac muscle contraction (Comerford, 2021).	Acetaminophen is famous for our lack of understanding of its mechanisms of action. Acetaminophen does not possess antiinflammatory qualities and may block peripheral pain impulses. It is	Colace has a surfactant effect within the intestine, promoting stool softening by enabling fat and water to remain in fecal contents (Drugbank, 2021).	Morphine binds with and activates opioid receptors within the brain to produce an analgesic effect (Comerford, 2021).

			metabolized in the liver (Comerford, 2021).		
Reason Client Taking	treatment of fluid retention in lower extremities	treatment of hypokalemia	administered in response to 1100 pain assessment	constipation / reduce strain during bowel movements due to potential cardiac complications	severe pain
Contraindications (2)	Furosemide is primarily contraindicated with anuria and any hypersensitivities to furosemide (Comerford, 2021).	Potassium chloride is contraindicated with concurrent use with amiloride or triamterene (Comerford, 2021).	As acetaminophen is metabolized in the liver, the primary contraindication associated with this medication is any population at risk of liver failure (Comerford, 2021).	Colace has reduced therapeutic efficacy and an increased risk/severity related to adverse effects of drugs such as Acetazolamide and Aclidinium (Drugbank, 2021).	Contraindications to morphine include significant respiratory depression and gastrointestinal obstruction (Comerford, 2021).
Side Effects/Adverse Reactions (2)	Side effects related to furosemide often relate to hypokalemia, a serious potential complication of loop diuretics, including arrhythmias and thromboemb	Side effects include arrythmias, asystole, cardiac arrest, GI bleeding, and hyperkalemia (Comerford, 2021).	Side effects may include hepatotoxicity, headache, fatigue, dyspnea, and anxiety (Comerford, 2021).	No substantial toxic effects have been recorded - however Colace has been known to entirely fail to treat constipation in some clients (Drugbank, 2021).	Adverse reactiond may include increased intracranial pressure, seizures, bradycardia, coma, and toxic megacolon (Comerford, 2021).

	olisms (Comerford, 2021).				
Nursing Considerations (2)	Use furosemide with great caution in patients with advanced hepatic cirrhosis, as furosemide may lead to lethal hepatic comas in such patients. Also, intake and output values should be strictly monitored (Comerford, 2021).	Oral potassium chloride should be taken with or immediately after meals, and potassium labs should be regularly drawn to monitor effectiveness (Comerford, 2021).	The hepatotoxic effects indicate that liver function much be closely monitored, and alcohol interacts dangerously with acetaminophen (Comerford, 2021).	Long term usage of docusate may cause dependence on laxatives for the body to produce bowel movements, and patient stool output should be closely monitored (Comerford, 2021).	Morphine is a schedule II substance. In the event of serious reaction, naloxone is the antidote for morphine. Respiratory status must be carefully evaluated following administration (Comerford, 2021).

Medications Reference (1) (APA):

Comerford, K. C., & Durkin, M. T. (2021). *Nursing 2021 drug handbook.* 41st edition. Philadelphia: Wolters Kluwer.

Drugbank. (2021, October 12). *Docusate*. DrugBank Online. Retrieved October 12, 2021.from https://go.drugbank.com/drugs/DB11089.

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient was alert and oriented to the person, place, time, and situation. Patient showed no signs of distress. Patient's overall physical appearance was clean and proper.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Patient had dry, cool skin with loose skin turgor alongside edema noted in the lower extremities. No drains were present, and the patient's skin was intact. 3+ pitting edema was noted in both lower extremities. A Braden Score was not assessed for this patient, though projections based on available information may result in a score as low as 15.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient is normocephalic. Patient had a normal rise and fall of uvula. Patient showed no sign of dental caries, gums were intact, and the patient did not complain of ear pain. Patient's ears were free from cerumen and symmetrical. Patient's nostrils were patent, and did not demonstrate a deviated septum, polyps, or epistaxis.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐** **Edema Y ☐ N ☐** **Location of Edema:**	Patient's heart sounds were standard, demonstrating a normal S1 and S2 without presence of an S3 or S4. Pulses were palpable at a +2 strength Patient's EKG demonstrated atrial fibrilation. Capillary refill was assessed and found to be normal is upper extremities without edema, with 3+ pitting edema in the lower extremities.
RESPIRATORY:	Auscultation of the lungs indicated crackles are

Accessory muscle use: Y☐ N ☐ **Breath Sounds: Location, character**	the base of both lungs. No accessory muscles were used with respiration. Respirations were even, calm, and regular.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Patient was auscultated in all 4 quadrants with no gastrointestinal abnormalities noted. Patient's abdomen was soft and non-tender, with no masses noted. Bowel sounds were audible and standard. Patient has no ostomy, nasogastric tube, or feeding tube. Patient has no distention, incisions, scars, drains, or wounds. Patient's height is 62 in. Patient's weight is 102 lbs. Patient described regular bowel movements, with two regular movements noted over a course of four hours.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Patient output was assessed to be 1750 mL voided over the course of four hours, and the character of the urine was otherwise not assessed with this physical examination.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	Patient is alert and oriented and ambulates independently and requires no assistance with ADLs. Patient does not utilize any supportive devices. Patient displays functional musculoskeletal strength and range of motion regarding upper and lower extremities, demonstrating a strength of 3 on a scale of 0-5. Lower extremity edema places the patient at increased risk for falls compared to their normal ambulation, however the Morse fall score still places this patient at low risk at <50.

NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient exhibits PERLA signs, and moves all extremities well. Loss of consciousness was not evaluated. Patient displayed clear, regular speech. Patient exhibits no sensory deficits.
PSYCHOSOCIAL/CULTURAL: **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's psychosocial and cultural status were not assessed with this assessment.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	88	152/68	24	36.5 C	98 W/ 2L 02 via NC
1100	68	138/62	24	36.8	97 W/ 2L 02 via NC

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	numerical	n/a	0/10	n/a	n/a
1100	numerical	n/a	1/10	n/a	tylenol administered

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:**	A 20G IV was inserted today on the left antecubital fossa. The IV is patent, showing no signs of erythema or drainage. The dressing is clean, dry, and intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360 mL with breakfast (240 mL tea, 120 mL apple juice)	1750 mL total voided in 4 hrs

Nursing Care

Summary of Care (2 points)

Overview of care:

Pharmaceutical interventions have been administered for management of the patient's CHF and its associated symptoms.

Procedures/testing done:

Patient has had a diagnostic chest x-ray and EKG performed to confirm CHF.

Complaints/Issues:

No patient complaints have been noted.

Vital signs (stable/unstable):

Vital signs are not yet stable, with blood pressure showing marked improvement though still outside normal ranges and with respiratory stable at an elevated 24 RR.

Tolerating diet, activity, etc.:

No activity has been noted, however the patient is currently tolerating fluids with breakfast and bowel movements show no abnormalities.

Physician notifications:

The physician has ordered nursing interventions related to improvement and monitoring of the client's fluid status, including: a fluid restriction of 1,000 mL per day, a daily weight, and strict I&Os.

Future plans for client:

Though not yet ordered by the physician, likely future interventions will include ambulatory measures to assess lower extremity strength/pain alongside stress tests to monitor patient vital response to activity.

Discharge Planning (2 points)

Discharge location:

Patient's assisted living facility: Oaks Manor Assisted Living Facility

Home health needs (if applicable):

N/A

Equipment needs (if applicable):

N/A

Follow up plan:

The patient will follow up with the PCP in 1 week following discharge.

Education needs:

Patient has requested a one-time visit from a Care Coach to assist with education following discharge.

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 ● Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** ● Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** ● How did the client/family respond to the nurse's actions? ● Client response, status of goals and outcomes, modifications to plan.
1. Decreased cardiac output related to symptoms of congestive heart failure as evidenced by chest x-ray results demonstrating enlarged heart .	Decreased cardiac output was prioritized due to the potential for cardiac deficiencies to lead to long term ischemia and acute cardiac events.	**1.** Patient education related to lifestyle changes associated with reduced risk for HTN and CHF **2.** Regular cardiac monitoring to evaluate presence of atrial fibrillation.	**1.** EKG / Cardiac monitoring will show regular sinus rhythms with no dysrhythmias.	Patient expresses an understanding of why they require cardiac monitoring and the role their medication plays in recovery.
2. Impaired gas exchange	Impaired gas exchange was prioritized as	**1.** Encourage incentive spirometry to promote lung	**1.** Patient will maintain an O2 of 95+% on room air by the time of	Patient participates in incentive spirometry following

related to crackles in the lungs as evidenced by chest x-ray results demonstrating pulmonary vascular congestion.	poor lung perfusion may interfere with the patient's ability to sufficiently breathe.	expansion despite pulmonary vascular congestion **2.** Fluid volume interventions, including those detailed for the 3rd nursing diagnosis, alongside strict I+Os to monitor effectiveness of diuretics.	discharge.	education and is cooperative with reporting fluid output.
3. Excess fluid volume related to renal perfusion associated with CHF as evidenced by edema in the lower extremities	Excessive fluid volume was prioritized as the edema in the patient's lower extremities interferes with ambulation.	**1.** Implement physician orders of a 1000 mL daily fluid restriction to discourage retention **2**. Evaluate patient progress through implementation of physician orders of taking a daily weight.	**1.** Patient will present with no edema upon discharge.	Patient understands the rationale behind the daily weights and is cooperative with the fluid restriction.

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

SUBJECTIVE DATA:
Patient describes pain with ambulation

Patient describes pain is alleviated by rest and elevation.

NURSING Dx AND OUTCOMES:
Dx: Decreased cardiac output related to symptoms of congestive heart failure as evidenced by chest x-ray results demonstrating enlarged heart
Outcome: Goal met as evidenced by the patient expresses an understanding of why they require cardiac monitoring and the role their medication plays in recovery.
Dx: Impaired gas exchange related to crackles in the lungs as evidenced by chest x-ray results demonstrating pulmonary vascular congestion.
Outcome: Goal met as evidenced by Patient participates in incentive spirometry following education and is cooperative with reporting fluid output.

Objective Data

ASSESSMENT RESULTS:
Laboratory results indicate hypokalemia, elevated creatinine and BUN levels, and elevated BNP.
Edema assessment indicated 3+ pitting edema on the lower extremities.
A chest x-ray indicates an enlarged heart and pulmonary congestion
An EKG indicates atrial fibrillation.
Vital sign assessment shows a RR of 24 and hypertension.
Auscultation of the lungs indicates crackles at the base of both lungs

Client Information

PATIENT INFORMATION:
Patient is a 72 year old woman with a history of CHF, hypertension, atrial fibrillation, and hyperlipidemia. Admitted due to acute weight gain and swelling of the ankles

Nursing Interventions

NURSING INTERVENTIONS:
Patient education related to lifestyle changes associated with reduced risk for HTN and CHF
Regular cardiac monitoring to evaluate presence of atrial fibrillation.
Encourage incentive spirometry to promote lung expansion despite pulmonary vascular congestion
Fluid volume interventions, including those detailed for the 3rd nursing diagnosis, alongside strict I+Os to monitor effectiveness of diuretics.
Implement physician orders of a 1000 mL daily fluid restriction to discourage