N431 Care Plan #2

Lakeview College of Nursing

Airelle Mitchell

Demographics (3 points)

Date of Admission 02/19/2022	**Client Initials** K.D.	**Age** 67 years old	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Married	**Allergies** Sulfa drugs – Hives Codeine – doesn't like the feeling. Penicillin – syncope
Code Status Full code	**Height** 165.1 cm / 5'5" in	**Weight** 70.40 kg / 155.2 lbs.	

Medical History (5 Points)

Past Medical History: Diabetes mellitus, hepatitis C, Kidney stones, acute heart failure, asthma, and tobacco abuse.

Past Surgical History: Colonoscopy (07/17/2018), breast augmentation, partial hysterectomy, and sling procedure of the bladder neck.

Family History: Mother: Chronic pulmonary obstructive disease, diabetes mellitus, and heart failure.

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

Tobacco: The client is a former smoker. She smoked a pack of cigarettes per day for 30 years. The client has a history of tobacco abuse.

Alcohol: The client does not drink alcohol anymore but did drink it for about 30 plus years. She would have 1-3 cans of beer a night.

Drugs: Denies use.

Assistive Devices: None.

Living Situation: Lives at home with her husband.

Education Level: The client completed some college.

Admission Assessment

Chief Complaint (2 points): Shortness of breath, orthopnea, and tachycardia.

History of Present Illness – OLD CARTS (10 points): The client is a 67-year-old female who first presented to the walk-in clinic due to a fast heart rate, difficulty breathing lying down, low oxygen level 83%, and shortness of breath. She stated she went to the walk-in clinic due to being previously treated there for lung issues. She thought her asthma was worsening so she went to get a refill for prednisone. The doctor at the clinic told the client as a recommendation to go to the emergency room on Friday 02/19/2022. The client decided to go home since she had already been dealing with these symptoms for a week. The client took prednisone in hopes of it helping, but when it did not help, she decided to go to the emergency room later Saturday afternoon 02/19/2022. The client was not in any pian. When arriving her breathing was improving, but her pulse was still very high.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): N/A

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

Heart failure occurs when the heart muscles can't adequality pump blood through ventricles causing decreased cardiac output. The blood can back up causing congestion in the lungs (Hinkle and Cheever, 2018). When pulmonary and peripheral congestion occurs, this can lead to congestive heart failure. Signs and symptoms of heart failure are dyspnea, orthopnea, cough, pulmonary crackles, edema, decreased exercise tolerance, wheezing, confusion, pallor, lightheaded, and fatigue (Capriotti, 2020). The client experienced signs and symptoms of shortness of breath, dyspnea, orthopnea, wheezing, and fatigue on admission. Expected findings

for a client wit heart failure are tachycardia, dysthymias, tachypnea, and elevated blood pressure (Hinkle and Cheever, 2018). The client upon admission had tachycardia, tachypnea, and dyspnea. Risk factors for heart failure is diabetes, coronary artery disease, obesity, smoking, and other heart issues (Hinkle and Cheever, 2018). The client has type II diabetes which is a common risk factor for developing heart failure especially if it is not controlled. The client is a former smoker which can contribute to heart disease. Laboratory tests that can be done are serum electrolytes, BUN, creatinine, liver function tests, complete blood count, BNP, and a urinalysis (Hinkle and Cheever, 2018). These can establish a baseline for when creating a plan for treatment. The client had a low sodium, increased glucose, a decreased e-GFR, an increased cholesterol, triglycerides, and high LDL.

Diagnostic tests often done are stress test, echocardiogram, electrocardiogram, computes tomography of the chest, stress test, and a chest x-ray. The client's CT scan showed pericardial effusion and mild congestive heart failure. The chest x-ray revealed mild edema and fluid overload. Treatment for the client would include the relieve of symptoms and improves the client's quality of life due to the irreversible affects (Capriotti, 2020). The client was prescribed diuretics to decrease fluid volume overload. The client was also prescribed albuterol to help her dyspnea and shortness of breath upon admission. The client should be educated on lifestyle changes such as a heart healthy diet, fluid and sodium restrictions, weight reduction, and controlling her diabetes.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology* (2nd ed.). 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	3.80-5.41	4.55	4.43	
Hgb	11.3-15.2	13.5	13.5	
Hct	33.2-45.3	40.7	39.3	
Platelets	149-393	271	265	
WBC	4.0-11.7	7.4	7.1	
Neutrophils	45.3-79.0	63.5	58.5	
Lymphocytes	11.8-45.9	24.8	28.5	
Monocytes	4.4-12.0	0.7	0.8	Low monocytes could be caused by drug therapy of prednisone. The client took 4 tablets of prednisone before coming into the emergency room (Pagana et al, 2021).
Eosinophils	0.0-6.3	N/A	N/A	
Bands	0.2-1.6	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-	136-145	133	132	Since the client has congestive heart failure, she is on a fluid and sodium restriction diet. The client is also taking furosemide which is help remove excess salt and water. This can lower sodium levels (Pagana et al, 2021).
K+	3.5-5.1	4.0	4.2	

Cl-	98-107	98	98	
CO2	21-31	25	25	
Glucose	74-109	152	152	Hyperglycemia can cause increased blood glucose. This is caused by the clients type 2 diabetes mellitus diagnosis (Pagana et al, 2021).
BUN	7-25	12	18	
Creatinine	0.84-1.21	0.99	1.06	
Albumin	3.5-5.2	4.3	N/A	
Calcium	8.6-10.3	9.4	9.3	
Mag	1.6-2.1	N/A	N/A	
Phosphate	45-117	N/A	N/A	
Bilirubin	0.3-1.0	0.8	N/A	
Alk Phos	30-120	64	N/A	
AST	0.3-1.0	20	N/A	
ALT	13-39	31	N/A	
Amylase	30-110	N/A	N/A	
Lipase	11-82	N/A	N/A	
Lactic Acid	0.5-1.0	N/A	N/A	
Troponin	0.0-0.030	0.028	N/A	
CK-MB	0.60-6.30	N/A	N/A	
Total CK	30-223	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	Normal: 1 Therapeutic 2-3	N/A	N/A	
PT	10-12 seconds	N/A	N/A	
PTT	30-45 seconds	N/A	N/A	
D-Dimer	<200	N/A	N/A	
BNP	0-100	N/A	N/A	
HDL	23-92	N/A	40	
LDL	<100	N/A	120	The client's chronic hepatitis C can cause increased levels of LDL (Pagana et al, 2021).
Cholesterol	<199	N/A	200	Slightly increased levels could be due to poorly controlled diabetes, atherosclerosis, or a high cholesterol diet (Pagana et al, 2021).
Triglycerides	0-149	N/A	201	Increased levels can be due to poorly controlled diabetes or risk of atherosclerosis. The clients CT – scan showed aortic and coronary artery atherosclerotic calcification (Pagana et al, 2021).
Hgb A1c	<6.4	N/A	N/A	
TSH	0.45-5.33	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	
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	

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	7.32 - 7.41	N/A	N/A	
PaO2	40-50	N/A	N/A	
PaCO2	40 -50	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	92-100%	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	
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):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). *Mosby's diagnostic & laboratory test reference* (15th ed.) Elsevier.

Sarah bush reference information: Cerner 2022

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The client had an echocardiography ordered (02/21/2022) and was supposed to have that done later that day. The client had a stress test to look at her heart, but the results were pending (02/21/2022). The client had a chest x-ray (02/19/2022) that showed bilateral thickening of the lungs suggesting mild edema and fluid overload. The test also showed mild to moderate heart enlargement persists with no significant change in bilateral interstitial thickening. The Echocardiogram done upon admission (02/19/2022) showed sinus tachycardia. The client received a CT Angio – chest – pulmonary with contract on (02/19/2022) which showed tachycardia, new onset of mild congestive heart failure, moderate heart enlargement, trace pericardial effusion and aortic / coronary atherosclerotic calcification.

Diagnostic Test Correlation (5 points):

An echocardiography is an ultrasound that looks at the structure and function of the heart. This procedure is noninvasive and allows the heart to be studied while its moving on the ultrasound (Pagana et al, 2021). A cardiac stress test shows if the client can sustain a maximum heart rate of 85% with no cardiac symptoms or dysfunction of the cardiac muscles with the use of medication

(Pagana et al, 2021). The client's results were still pending but the client did complete the stress test. A chest x-ray can show cardiac enlargement, pericardial effusion, inflammation, lung tumors, and pulmonary edema (Pagana et al, 2021). An echocardiogram (ECG) shows the rhythm and rate of the client's heart. In the results it showed sinus tachycardia upon admission and while in the hospital it is being continuously monitored. A computed tomography can diagnose tumors, nodules, hematomas, pleural effusion, and the lungs (Pagana et al, 2021). The clients received this to reveal what has been going on with her heart or lungs. All of these are important for diagnosing heart failure.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana T. J., & Pagana T. N. (2021). *Mosby's diagnostic & laboratory test reference* (15th ed.) Elsevier.

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

Home Medications (5 required)

Brand/Generic	Alprazolam / Xanax	Sitagliptin / Januvia	Aspirin / acetylsalicylate acid	Cetirizine / Zyrtec	Albuterol / ProAir HFA
Dose	0.5 mg	50 mg	81mg	10 mg	2.5 mg – 3 mL
Frequency	Q8h PRN	Daily	Daily	Daily	2 puffs Q4h PRN
Route	PO	PO	PO	PO	Inhalation solution
Classification	<u>Pharmacological</u>:	<u>Pharmacological</u>:	<u>Pharmacological</u>:	<u>Pharmacological</u>:	<u>Pharmacological</u>:

	Benzodiazepine Therapeutic: Anxiolytic, antipanic controlled substance schedule IV.	Dipeptidyl peptidase – 4 (DPP-4) inhibitors Therapeutic: N/A	Salicylate Therapeutic: NSAID (anti-inflammatory, antiplatelet, antipyretic, nonopioid analgesic)	Histamine – 1 receptor antagonist Therapeutic: Antihistamine	Adrenergic Therapeutic: Bronchodilator
Mechanism of Action	Increases GABA and other inhibitory neurotransmitters to control behavior. The limbic system contains many benzodiazepine receptors which can help antianxiety effects.	When blood glucose level is normal or high hormones increase insulin secretion and release from pancreatic beta cells. Decreases blood glucose in type II diabetes.	Blocks prostaglandin synthesis to inhibit the inflammatory response with swelling and pain and inhibits platelet aggregation.	Selective inhibition of peripheral H1 receptors to alleviate hives (urticaria).	Albuterol attaches to the receptors to stimulate the adenylate cyclase into ATP/CAMP. This will relax the bronchial smooth muscles.
Reason Client Taking	Control anxiety	To control blood glucose levels in type II diabetes	To reduce risk of a stroke or heart attack.	To prevent seasonal allergies or hives.	Wheezing and past medical history of asthma.
Contraindications (2)	Acute angle closure glaucoma and hyposensitivity to its components.	Hypersensitivity to Januvia or its components.	Active bleeding and tartrazine dye or components of aspirin.	Hypersensitivity to Zyrtec or its components.	Hypersensitivity to albuterol or its components.
Side Effects/Adverse Reactions (2)	Hepatitis and Angioedema	Heart failure and acute renal failure	Prolonged bleeding time and bronchospasm	Dry mouth and headache	Bronchospasms and pulmonary edema

Nursing Considerations (2)	Expect to give a higher dose if panic attacks occur suddenly or during an activity like driving. If opioid use is used with this drug expect it to be a lower dose due to increased possible symptoms of respiratory depression, profound sedations, coma, or death.	Monitor blood glucose levels to determine therapeutic effectiveness. Monitor the patient for signs and symptoms of heart failure due to other drugs in this class have caused heart failure.	Monitor the client for signs of tinnitus which occurs when blood aspirin level reaches maximum dosage. Do not crush times release or controlled release aspirin tablets.	Monitor the client for sedation or somnolence and implement safety precautions.	Administer medication in the second half of inhalation when the airways open wider. Use cautiously in patient with cardiac disorders and diabetes mellitus because albuterol can worsen these symptoms.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Neurological assessment baseline before administering to monitor mental status and confusion.	Check blood glucose levels. Assess renal function before starting due to possible side effects of acute renal failure.	Monitor hematocrit and hemoglobin levels.	Assess the skin before administering cetirizine.	Baseline lung assessment before and after administration to monitor for therapeutic effects.
Client Teaching Needs (2)	Teach the client to not abruptly stop taking thing medication due to withdrawal symptoms. Educate the client to not consume alcohol	Advise the client to carry an identification card stating that she has diabetes. Teach the client to follow a diet suitable for controlling	Take aspirin with food or after meals to prevent GI upset. Advise the client to not take ibuprofen or naproxen because it can reduce	Advise the client to avoid hazardous activities due to an increase in sedation (CNS affects). Instruct the silent to keep	Teach the client to shake the inhaler first prior to administration. Advise the client to wait at least 1 full minute before the next

	while taking Xanax due to severe respiratory depression.	diabetes.	the cardioprotective effects.	medication away from small children.	inhalation of the medication.

Hospital Medications (5 required)

Brand/Generic	Pantoprazole / Protonix	Enoxaparin / Lovenox	Furosemide / Lasix	Atorvastatin / Lipitor	Tylenol / Acetaminophen
Dose	40 mg	40 mg – 0.4 mL	40 mg – 0.4 mL	40 mg	650 mg
Frequency	BID	Daily	Q12h	Daily	Q6h PRN
Route	PO	SQ	IV push	PO	PO
Classification	Pharmacological: Proton pump inhibitor Therapeutic: Antiulcer	Pharmacological: low-molecular-weight heparin Therapeutic: anticoagulant	Pharmacological: Loop diuretic Therapeutic: antihypertensive, diuretic	Pharmacological: HMG – CoA reductase inhibitor Therapeutic: Antihyperlipidemic	Pharmacological: Nonsalicylate, para-aminophenol derivative Therapeutic: Antipyretic, nonopioid analgesic
Mechanism of Action	Proton pump inhibitors block gastric acid production to prevent more stomach acid from forming.	Enoxaparin binds to and potentiates antithrombin to form an irreversible complex that inactivates clotting factor XA.	Loop diuretics inhibit sodium and water reabsorption so they can be excreted through the urine.	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA to enhance LDL and LDL breakdown.	Inhibits cyclooxygenase by blocking prostaglandin production and interfering with pain impulse.
Reason Client	Prophylaxis	Prevention of	Fluid	High	To relieve

Taking	for GI ulcer formed in the hospital.	blood clots in the hospital.	overload related to CHF	cholesterol and triglycerides	mild to moderate pain.
Contraindications (2)	Hypersensitivity to pantoprazole or its components.	Allergy to pork products or history of immune-mediated heparin induced thrombocytopenia (HIT).	Anuria and hypersensitivity to this drug.	Active hepatic disease and unexplained increase in transaminase levels.	Hepatic impairment and hypersensitivity to the medication or its components.
Side Effects/Adverse Reactions (2)	Hyponatremia and hepatotoxicity	Hepatitis and deep vein thrombosis	Hyponatremia and arrhythmias	Hypoglycemia and hepatic failure	Fatigue and Hypokalemia
Nursing Considerations (2)	Administer 30 minutes before a meal. Monitor the client for clostridium difficile (diarrhea).	Do not expel the air bubble. Rotate the injection sites in the abdomen subcutaneous tissue 2 inches away from the umbilicus.	Monitor the client for a reaction because if clients are allergic to sulfa drugs, they could also be allergic to furosemide. Administer the loop diuretic in the morning rather than in the evening to prevent sleep disturbances.	Monitor liver function tests before and after the start of atorvastatin for liver dysfunction. Expect to hold atorvastatin of the client experienced myopathy or risk for predisposing renal failure.	Make sure dosing does not reach the maximum daily dosage due to causing hepatic impairment. Monitor liver and renal function tests during administration of acetaminophen.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor PT and INR during drug therapy.	Monitor platelet levels, aPTT, and PT/INR labs.	Monitor the clients blood pressure before administering. Monitor	Monitoring lipid panel before and after administering for	Pain assessment before and after administering Tylenol.

			potassium levels before administering because furosemide depletes potassium.	therapeutic effects.	Monitor liver function tests (AST, ALT).
Client Teaching Needs (2)	Instruct the client to not chew or crush the pills and to just swallow. Instruct the client to notify the provider if diarrhea occurs and prolongs.	Teach the client signs and symptoms of bleeding and to report them right away if they occur. Teach the client that they might have some bruising from this injection.	Advise the client to change positions slowly as this drug can affect blood pressure. Teach the client that daily weight and diet control is important. Sodium and fluid restriction.	Advise the client that this medications of not a replacement and still should monitor diet (cholesterol). Teach the client that taking the drug at the same time each day will maintain its effects.	Teach the client to recognize signs and symptoms of hepatoxicity. When taking OTC or other drugs contain acetaminophen watch for the amounts in each drug to prevent overdose.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2021 Nurse's drug handbook* (20th ed.). Jones & Bartlett. Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The client is alert and oriented x4 to person, place, time, and situation. The client was not in any distress but did have anxiety about the new diagnosis and the stress test that she was having later that day. The client was well groomed.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 22 **Drains present: Y☐ N ☒** **Type:**	 Pink Dry, intact, and no moisture present. Warm to the touch on the clients anterior and posterior extremities bilaterally. Turgor less than three seconds and elastic. No rashes, bruises, or wounds present. 22
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 The client's head and neck are symmetrical with no abnormalities and within normal range of motion. The thyroid was able to rise and fall when swallowing. No inflammation or drainage noted in the ears. Both left and right eyes were equal, round, and reactive to light. 3mm when comparing to the penlight. The client wears glasses continuously. The sclera was white, and conjunctive was pink with no drainage noted. The nose was midline and symmetrical, with no drainage. The clints teeth were present with mild discoloration.
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:**	 Heart sounds S1 and S2 heard upon auscultation. No murmurs, gallops, or friction rubs present when auscultating the aortic, pulmonic, Erb's point, tricuspid, and mitral locations. The client's cardiac rhythm was normal sinus rhythm. Upon admission, the client was in sinus tachycardia. Capillary refill was less then 3 seconds. The peripheral pulses were left +3 in all arteries bilaterally in extremities and carotids arteries. All locations were easily palpable and brisk. No edema present.

RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The client had clear but diminished breath sounds in the anterior and posterior upper and lower lobes bilaterally. Respirations were 18 bpm, nonlabored, and were equal. The client was not using accessory muscles when breathing.
GASTROINTESTINAL: **Diet at home:** Low sodium **Current Diet:** Heart healthy **Height:** 165.1 cm **Weight:** 70.40 kg **Auscultation Bowel sounds:** Active in all 4 quadrants. **Last BM:** 02/20/2022 **Palpation: Pain, Mass etc.:** Patient denies any pian, tenderness, and no masses present. **Inspection:** **Distention:** No distention noted. **Incisions:** No incisions present. **Scars:** Abdominal scars. **Drains:** No drains present. **Wounds:** No wounds present. **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Pale yellow Clear and not concentrated. The client voided x 3 on my shift, but urine was not measured. Dry, clean, and pink.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** Active **Supportive devices:** None **Strength:** 5/5 **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** 20	The client had normal strength (5/5) in all extremities bilaterally. The client has active range of motion in all extremities. The client does not use any assistive / supportive devices and walks up ad lib. The client scored between 0-24 on the fall risk scale, so she is not considered a fall risk. 20.

Activity/Mobility Status: **Independent (up ad lib)** ☒ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	
NEUROLOGICAL: **MAEW: Y** ☒ **N** ☐ **PERLA: Y** ☒ **N** ☐ **Strength Equal: Y** ☒ **N** ☐ **if no -** **Legs** ☐ **Arms** ☐ **Both** ☒ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient was alert and oriented x4. Thinking process fully intact. Speech is clear and understandable. Sensations was equal in all extremities bilaterally. The client's LOC is alert with no orientation difficulties.
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 client enjoys reading, gardening, and watching TV. The client's development level is appropriate for her age. The client does not have a religious preference. The client has a good family and friend support system.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0920	90	120/74	18	36 C	96% RA
1445	89	116/73	18	36.6 C	97% RA

Vital Sign Trends: The client's vital signs are stable and within normal ranges. The client should continue to be monitored for changes.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0920	Numeric scale 0-10	N/A	0 out of 10	N/A	N/A
1445	Numeric scale 0-10	N/A	0 out of 10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 gauge
Location of IV:	Left forearm peripheral IV
Date on IV:	02/19/2022
Patency of IV:	Flushes easily, patent, dry, clean, and intact
Signs of erythema, drainage, etc.:	No signs of erythema, drainage, or phlebitis.
IV dressing assessment:	No fluids running. Saline locked.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
(2) 8oz cups of water during my shift – 480 mL	Voided 3 times in my shift – unmeasured

Nursing Care

Summary of Care (2 points)

Overview of care: During my time with my patient, I was able to administer her medications, do a head-to-toe assessment, and teach the client about her new diagnosis.

Procedures/testing done: The client had a stress test done and an echocardiogram that was supposed to be later that day.

Complaints/Issues: The client had issues with the taking insulin and Januvia together. The client refused the insulin due to only wanting to take one or the other. The client did not want an injection, so we gave her Januvia.

Vital signs (stable/unstable): The client's vital signs are stable and should continue to be monitored.

Tolerating diet, activity, etc.: The client was tolerating the diet well, she just needed more information on her type of diet.

Physician notifications: N/A

Future plans for client: The client should be having an echocardiogram later that day and after the results, the client will be monitored until discharge.

Discharge Planning (2 points)

Discharge location:

Home health needs (if applicable): The client does not need any home health needs currently.

Equipment needs (if applicable): N/A

Follow up plan: The client should follow up with a dietician, a cardiologist, and her primary care provider.

Education needs: The client needed education on her new diagnosis of congestive heart failure.

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

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and	• Explain why the nursing diagnosis			• How did the client/family respond to the nurse's

"as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	was chosen			actions? • Client response, status of goals and outcomes, modifications to plan.
1. Excessive fluid volume related to congestive heart failure as evidenced by lower e-GFR, XR - chest, and CT – chest showed pulmonary edema.	The client's diagnostic imaging and laboratory results suggests pulmonary edema which relates to fluid volume excess.	1. Assess daily weight and monitor intake and output. 2. Administer a diuretic such as furosemide.	1. Goal for the client is to maintain fluid restriction throughout her stay in the hospital.	The client should maintain fluid restriction, and this can be monitored by daily weight. This can be monitored after discharge as well. During my shift I was able to monitor intake and output but was not able to assess weight. When doing my head-to-toe assessment, I was able to assess for edema in the client's extremities. The client will be administered a loop diuretic for excessive fluid volume.
2. Decreased cardiac output related to congestive heart failure as evidenced by CT –	An enlarged heart and atherosclerotic build up can decrease the client's cardiac output	1. Assess capillary refill and pulses. 2. Monitor restriction status for	1. The client will learn how to manage her sodium and	Upon discharge the client will be able to go home and reduce her fluid and sodium intake. During my head-to-toe

scan showing an enlarged heart and atherosclerotic build up.	resulting in heart issues like CHF.	sodium and fluids.	fluids before discharge.	examination, the client had < 3 seconds capillary refill and palpable pulses in all extremities bilaterally.
3. Risk for impaired gas exchange related to congestive heart failure as evidenced by CT scan showed fluid in the lungs and mild heart enlargement.	The client was having difficulty breathing. The diagnostic results show heart enlargement, pleural effusion, and pulmonary edema in the lungs which can be a risk for impaired gas exchange.	1. Assess lung sounds for crackles, wheezing, or decreased breath sounds indication fluid volume overload. 2. Monitor the client's pulse oximetry, heart rate, and blood pressure.	1. The client will have stabilized fluid volume with balanced intake and output upon admission.	The client by the time she is discharged will have her fluid volume overload stabilized. When assessing the client's breath sounds, they were diminished but were clear upon all lobes. The client's pulse oximetry was staying above 92% during my shift.
4. Deficient knowledge related to new onset congestive heart failure as evidenced by the client stated she needed more information and diet education.	The client needed more information on the diagnosis of CHF, signs and symptoms, and a heart healthy diet.	1. Educate the client on fluid restrictions and sodium restrictions. 2. Ensure the client knows when to get help by	1. The client will teach back the specific signs and symptoms to watch out for by the end of teaching.	The client was able to use the teach back method on what she learned by answering my questions. I was able to educate the client on her disease process and fluid/sodium restrictions. During the teaching I was

		knowing specific signs and symptoms .		also able to educate the client on certain signs and symptoms to watch out for.

Other References (APA):

Concept Map (20 Points):

Subjective Data

The client's symptoms upon admission were SOB, difficulty breathing while lying down, and fast heart rate.
The client states she does not have any pain.
The client states she had deficient knowledge on her new diagnosis of congestive heart failure.

Nursing Diagnosis/Outcomes

Excessive fluid volume related to congestive heart failure as evidenced by lower e-GFR, XR -chest, and CT – chest showed pulmonary edema.
Goal for the client is to maintain fluid restriction throughout her stay in the hospital.
Decreased cardiac output related to congestive heart failure as evidenced by CT – scan showing an enlarged heart and atherosclerotic build up.
The client will learn how to manage her sodium and fluids before discharge.
Risk for impaired gas exchange related to congestive heart failure as evidenced by CT scan showed fluid in the lungs and mild heart enlargement.
The client will have stabilized fluid volume with balanced intake and output upon admission.
Deficient knowledge related to new onset congestive heart failure as evidenced by the client stated she needed more information and diet education.
The client will teach back the specific signs and symptoms to watch out for by the end of teaching.

Objective Data

CT scan/ Chest x-ray – pericardial effusion, congestive heart failure, mild pulmonary edema, fluid volume overload, and heart overload.
The client is taking furosemide for fluid volume overload.
The client has diminished but clear breath sounds in all lobes posteriorly and anteriorly.

Client Information

The client is a 67-year-old female with a history of acute heart failure presented to the ER on (02/19/2022). The client presented with tachycardia, SOB, and Orthopnea. The client had a CT / Chest x-ray showing pulmonary edema and pleural effusion. She was diagnosed with congestive heart failure.

Nursing Interventions

Assess daily weight and monitor intake and output.
Administer a diuretic such as furosemide.
Assess capillary refill and pulses.
Monitor restriction status for sodium and fluids.
Assess lung sounds for crackles, wheezing, or decreased breath sounds indication fluid volume overload.
Monitor the client's pulse oximetry, heart rate, and blood pressure.
Educate the client on fluid restrictions and sodium restrictions.
Ensure the client knows when to get help by knowing specific signs and symptoms.