Medications

Furosemide - 40mg (4mL) IV BID with meals
Reason:
Carvedilol - 6.25mg x 1 tabs P.O BID with meals
Reason:
Potassium chloride SA - 10mEq x 1 tabs P.O BID with meals
Reason:
Aspirin Chewable - 81mg tab P.O. daily
Reason:
Isosorbide Dinitrate - 30mg x 3 tabs BID after meals
Reason:
Allopurinol - 100mg x 1 tab daily
Reason:
Ferrous Sulfate - 325mg x 1 tab oral BID
Reason:
Finasteride - 5mg x 1 tab Daily
Reason:

Demographic Data

Date of Admission: 08-28-22
Admission Diagnosis/Chief Complaint: Acute on Chronic Combined Systolic/Diastolic Congestive Heart Failure
Age: 84
Gender: Male
Race/Ethnicity: Caucasian
Allergies: Penicillin V
Code Status: FULL CODE
Height in cm: 178cm
Weight in kg: 93kg
Psychosocial Developmental Stage: Ego Integrity vs. Despair
Cognitive Developmental Stage: Patient is able to read and write with fully formed sentence structure. Patient is fully capable of making informed decisions.
Braden Score: 16
Morse Fall Score: 85 (High Risk) [Hospitals documents score of 10]
Infection Control Precautions: None

N321 Concept Map

Student Name:

Medical History

Previous Medical History:

Congestive Heart Failure, Stroke, Diabetes Mellitus, Hypertension, Myocardial Infarction, COPD on Exacerbation, Gout, Benign prostate hypertrophy, generalized arthritis.

Prior Hospitalizations:

Hospitalized on July 17 for the same chief complaint.

Previous Surgical History:

Pacemaker insertion - x2, endoscopy - Colon, Cholecystectomy - exploratory of abdomen, Heart catheterization, Abdominal Surgery - exploratory - laparotomy - lysis of adhesion.

Social History:

Tobacoo: No never

Alcohol: No

Drugs: None

Sexual Activity: Not currently

Admission History

O: First week of August
L: Abdominal
D: More than 2 weeks
C: Bloating, cramping, and abdominal pain
A: None
R: None
T: Been hospitalized since

Chief Complaint: Blocked Bowel
S/S chief complaint: Pressure, pain, bloating, alot of bowel movement which led to abdominal surgery.

Lab Values/Diagnostics

Glucose: 183 mg/dL

Normal Value: 70 - 100 mg/dL

Pathophysiology

Disease process:

Physical Exam/Assessment

General:

Patient is alert and oriented X3 to person, place, and time. No distress appearance at the moment and was resting/ laying in bed with HOB elevated at 40 degrees. Patient is alert and responsive to verbal and painful stimuli.

Integument:

Skin color was a tan olive along with normal wrinkles. Skin was also dry and warm to the touch. Rashes are present in the front forearms bilaterally (about 3 inches width with some purple tint). Bruising were also present in front forearms bilaterally. (about 4 inches in width with pale yellow purple tint). Turgor was slow at retractability with tenting present. Open Wound is present on rt skin of lower extremity, clear liquid secretions from open wound, wound has a pink color in the middle and the edges are slightly red color.

HEENT:

Skull and face are symmetrical has a normal mole behind the ear (it is round, raised, even borders, and brown), Trachea is midline with no deviations and Upon palpation trachea movement is present when patient swallows. Carotid artery is palpable and is +2 left and right. all lymph nodes are nonpalpable. Eyelids have no visible discoloration, lesions, or swelling bilaterally. Sclera is white and clear bilaterally. Conjunctiva is pink and moist bilaterally. Pupils (PERRLA) are round and equal, reactive to light, and are able to accommodate bilaterally. 6 Extraocular movements are present in both eyes with no deviations bilaterally. No present ear tenderness upon palpation bilaterally with no visible drainage or discoloration bilaterally. No visible impaction in ears bilaterally. Nose septum is midline. Turbinates are moist and pink in nose bilaterally and have no visible signs of bleeding. Frontal sinuses are nontender to palpation bilaterally. Uvula is midline bilaterally. Soft palate and hard palate are present. Swallow reflex is present with a soft palate able to move upward. Buccal mucosa is moist. Teeth are present and are a yellow tint has spaces between the top front and bottom front section of teeth. An unknown black spot is present in the right top side inner molars of teeth (physician is notified of the finding).

Cardiovascular:

Sinus Rhythm is present along with S1 and S2 sound present. No signs of S3, S4, or murmurs. Heart rhythm is regular. upper peripheral pulses were +3 and lower peripheral pulses were +2 bilaterally. Mitral valve is palpable with a grade of +2. No signs of neck vein distention. Cap refill is less than 5 secs. Edema is present in both lower legs bilaterally +2 (From the middle of calf muscles to the ankles).

Respiratory:

Normal rate and regular pattern of respirations. Respirations are symmetrical and non-labored. Lung sounds clear throughout anterior/posterior bilaterally but had slight crackle/congestion sounds in the lower lobes bilaterally. No wheezes or rhonchi noted. No use of accessory muscle or signs of breathing distress. Lung aeration is equal bilaterally.

Genitourinary

Urine is yellow with slight foam and clear distinction. Urine voided was about 325mL and patient denies pain with urination. Genitals are clean. Patient is not on dialysis. Foley catheter is present 16 french. CAUTI Precautions included aseptic technique, hand hygiene, and routine genital hygiene check.

Gastrointestinal:

No signs of distention upon inspection. Incision scar is present on left lower quadrant and left upper quadrant with redness and scabby. Bowel sounds were audible within normal limits in all 4 quadrants. No pain, mass, or tenderness upon palpation in all 4 quadrants. No present ostomy or nasogastric tube. Last bowel movement was the day before at 8pm. Current diet at home/facility is mechanical soft. Height is 5’20’’ (177.8cm) and weight is 205 lbs (93kg).

Musculoskeletal

Neurovascular is intact. Patient is able to perform All ROM actively in the upper extremities but lower extremities is done passively. Muscle strength is 5/5 bilaterally in right upper/lower extremity. Muscle strength is 2/5 in left side of upper and lower extremity. Client is dependent with 2 person assistance of walking or support devices. Fall Risk score is 10 (high fall risk).

Neurological

MAEW is intact and PERRLA is equal, round and reactive. Mental status is normal with behavior appropriate to their responses. speech and sensory is normal. LOC is 15 with patient alert and awake to question and answers appropriately.

Most recent VS (include date/time and highlight if abnormal):

09/01/22 @1030am

Blood Pressure: 115/57 - **Temperature**: 97.5F - **HR**: 78

Respiratory Rate: 74 - **O2**: 99%

Pain and pain scale used:

0/10 - verbalized/number scale

Nursing Diagnosis 1	Nursing Diagnosis 2	Nursing Diagnosis 3
Rationale	**Rationale**	**Rationale**
Interventions **Intervention 1:** **Intervention 2:**	**Interventions** **Intervention 1:** **Intervention 2:**	**Interventions** **Intervention 1:** **Intervention 2:**
Evaluation of Interventions	**Evaluation of Interventions**	**Evaluation of Interventions**

References (3) (APA):