

N321 Care Plan # 1
Lakeview College of Nursing
Toni Andres

Demographics (3 points)

Date of Admission 09/24	Client Initials C.G	Age 49	Gender M
Race/Ethnicity Caucasian	Occupation NA	Marital Status Single	Allergies NKA
Code Status Full	Height 158.5cm	Weight 90.1kg	

Medical History (5 Points)**Past Medical History:**

Obsessive compulsive disorder
 COVID
 Hypotension
 Down syndrome
 Partial hearing loss
 Hallucinations
 Psychosis
 Gout
 Diabetes
 Chronic heart failure
 Unstable angina
 Urinary retention
 Depression

Past Surgical History:

Cyst removal on left side
 Bunion removal on right hallux

Family History:

Heart disease on paternal side. Father's deceased, age 48 from myocardial infarction.

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

None- Asked and denies
 None- Asked and denies
 None- Asked and denies

Assistive Devices:

None

Living Situation:

Lives with his sister

Education Level:

Graduated High School, Special Education

Admission Assessment**Chief Complaint (2 points):**

Short of breath x 2 months
Weight gain of 25 pounds in less than a month

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

The patient is a very pleasant 49 year old male admitted to the hospital for being short of breath and a weight gain of 25 pounds in a month. Having just been to his primary care provider in the previous month and noticing the weight gain and some swelling in the lower extremities he did not have. This had become more noticeable within the past month. The patient also had significant loss of appetite, loss of motivation for activity, and short of breath upon activities of daily living. The patient had begun to spend more time sleeping when he was usually a very active individual.

Primary Diagnosis**Primary Diagnosis on Admission (2 points):**

Chronic heart failure

Secondary Diagnosis (if applicable):

Pericardial effusion

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

The pathophysiology of heart failure is very complex. It is a progressive disorder usually resulting from an event that culminates in a clinical syndrome impaired by cardiac function and circulatory congestion. Heart failure is a syndrome characterized initially by left ventricular dysfunction leading to a fall in cardiac output. This is a compensatory reaction at first but eventually becomes part of the disease process leading to further worsening cardiac functioning. It is a medical condition characterized by reduced cardiac output and increased venous pressure. It is associated with underlying molecular changes and subsequent damage to end death of cardiac muscle cells. The heart changes size and shape in response to a number of mechanical, biochemical, and ultimately molecular signals. Excessive sympathetic drive and activation of the renin angiotensin system promote preferential efferent glomerular arteriolar constriction in the kidney. there is increased sodium reabsorption in the proximal tubule of the kidney leading to reduced free water clearance as the heart progressively enlarges and blood flow is limited. Heart failure is a progressive disorder of the left ventricular remodeling that occurs after an event. It's a structural problem. It is ultimately accompanied by signs and symptoms of breathlessness and fatigue, fluid collection and arrhythmogenesis (Francis, 2021). Any form of heart disease can lead to heart failure and abnormalities of diastolic and systolic function frequently coexist. Heart failure is a complex syndrome and the autonomic imbalance with the activation of the sympathetic nervous system and the reduction of vagal activity should be treated (Nicholson, 2017). Pericardial effusions are not uncommon in patients with congestive heart failure. Patients with congestive heart failure, elevated right sided filling pressures are less common than elevated left sided filling pressures, explaining a lower prevalence of pericardial than pleural effusions. Although in echocardiogram is the standard and most available testing method for the evaluation of pericardial effusion an MRI can also offer advantages these are some imaging techniques that

can allow assessment of the entire chest and detect abnormalities in the media stadium, lungs, and adjacent structures (Sagristà-Sauleda, 2021).

Pathophysiology References (2) (APA):

Francis, G. S. (2021). Pathophysiology of chronic heart failure. *The American Journal of Medicine*, 110(7), 37–46. [https://doi.org/10.1016/s0002-9323\(98\)00385-4](https://doi.org/10.1016/s0002-9323(98)00385-4)

Nicholson, C. (2017). Chronic heart failure: Pathophysiology, diagnosis and treatment. *Nursing Older People*, 26(7), 29–38. <https://doi.org/10.7748/nop.26.7.29.e584>

Sagristà-Sauleda, J. (2021). Diagnosis and management of pericardial effusion. *World Journal of Cardiology*, 3(5), 135. <https://doi.org/10.4330/wjc.v3.i5.135>

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	4.28-5.56		3.2	Red blood cells help carry adequate oxygen to the body tissues. Having a low red blood cell count is a sign of being anemic
Hgb	13-17		10.0	If your body does not get enough oxygen rich blood the lack of oxygen can make you feel tired and you may have shortness of breath.
Hct	38.1- 48.9		30.4	The hematocrit test can tell if someone is anemic and can determine how many red blood cells someone has it can also indicate certain nutritional deficiencies.
Platelets	149 - 393		234	
WBC	4.0 - 11.7		5.9	

Neutrophils	45.3 - 79.0%		44.9%	Neutropenia symptoms may include fatigue and shortness of breath.
Lymphocytes	11.8 - 45.9%		42.4%	
Monocytes	4.4 - 12.0%		8.8%	
Eosinophils	0.0 - 6.3 %		1.6%	
Bands	0 - 6.0		NA	

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		142	
K+	3.5 - 5.1		4.4	
Cl-	98 - 107		106	
CO2	21 - 31		31	
Glucose	74 - 109		79	
BUN	7 - 25		15	
Creatinine	0.70 - 1.30		1.11	
Albumin	3.5 - 5.2		3.5	
Calcium	8.6-10.3		8.4	A symptom of hypocalcemia can be shortness of breath.
Mag	1.6 - 2.4		2.0	
Phosphate	2.5 - 5.0		4.1	
Bilirubin	0.3- 1.0		NA	
Alk Phos	34- 104		NA	
AST	13- 39		NA	

ALT	7 - 52		NA	
Amylase	29- 103		NA	
Lipase	11- 82		NA	
Lactic Acid	< 2.5		NA	

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.86- 1.4		NA	
PT	11.9- 15		NA	
PTT	22.6 - 35.3		NA	
D-Dimer	0.00 - 0.62		NA	
BNP	0-100		NA	
HDL	23-92		NA	
LDL	75 -193		NA	
Cholesterol	<199		NA	
Triglycerides	<150		NA	
Hgb A1c	<5.7%		NA	
TSH	0. 45 -5.33		NA	

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 and clear		NA	

pH	5.0 -8.0		NA	
Specific Gravity	1.005 - 1.034		NA	
Glucose	70-100		84	
Protein	negative		NA	
Ketones	negative		NA	
WBC	4.0 -11.7		NA	
RBC	4.28 - 5.56		NA	
Leukoesterase	negative		NA	

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		NA	
Blood Culture	negative		NA	
Sputum Culture	negative		NA	
Stool Culture	negative		NA	

Lab Correlations Reference (1) (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest X-Ray

The findings on a chest X-ray depends on the size of the effusion and comorbidities. Smaller effusions may not show significant findings on the chest radiograph, while larger effusions can present with an enlarged cardiac silhouette with clear images in the lung fields. However, and enlarged cardiac silhouette and chest X-ray cannot be considered diagnostic for

the presence of a pericardial effusion. Further diagnostic image testing would be needed (West, 2019).

Echocardiogram

An echocardiogram is specific and sensitive for the detection of pericardial effusion. It can provide information regarding the significance of the effusion. The pericardial fluid appears on the diagnostic image as a space between the pericardium in the epicardium. An echocardiogram should be done to document the presence of a fusion and confirm the location and size of the effusion and determine if and should be evaluated for the diagnosis of cardiac tamponade (West, 2019).

CTA- Chest

A coronary computed tomographic angiography Is it noninvasive test that assesses for coronary artery disease in patients with suspected or acute or chronic coronary syndromes. It is a way to determine, specifically exclude significant coronary stenosis. It is an alternative to an invasive coronary angiography in patients with stress test results with a diagnosis of coronary artery disease that his son certain. certain patients as an alternative to a stress test (Thakur, 2017).

Diagnostic Test Correlation (5 points):

Chest X-ray finding resulted in pulmonary edema with bilateral pleural effusion. To further diagnose the patients situation a coronary computed tomography angiography was ordered of the chest that showed moderate pericardial effusion negative for pulmonary embolism. Upon those findings and echocardiogram had been ordered that showed an ejection fracture of 50 to 55% with no tamponade.

Diagnostic Test Reference (1) (APA):

Thakur, D. V. (2017). Non-invasive computed tomographic coronary angiography for patients with suspected coronary artery disease. *Journal of Medical Science and Clinical Research*, 5(8). <https://doi.org/10.18535/jmscr/v5i8.72>

West, S. (2019). Pericardial effusion: Its diagnosis and treatment. *The Lancet*, 175(4513), 560–564. [https://doi.org/10.1016/s0140-6736\(01\)74839-8](https://doi.org/10.1016/s0140-6736(01)74839-8)

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

Home Medications (5 required)

Brand/Generic	Abilify/aripiprazole	Aleve/Naproxin	Desyrel/Trazadone
Dose	15mg tab	500mg tab	150mg tab
Frequency	daily	BID PRN	HS
Route	oral	oral	oral
Classification	Antipsychotic	Non steroidal anti-inflammatory drug	Antidepressant
Mechanism of Action	A quinolinone antipsychotic that is a partial agonist. It stabilizes dopamine and serotonin within the nucleus accumbens, ventral tegmental area, and frontal cortex resulting in the management of positive, negative, and cognitive symptoms in schizophrenia (StatPearls n.d.).	Reversibly inhibits cyclooxygenase-1 and 2 enzymes, which results in decreased formation of prostaglandin precursors; has antipyretic, analgesic, and anti-inflammatory properties (StatPearls n.d.).	Blocks arachidonate binding to competitively inhibit both cyclooxygenase (COX) isoenzymes, COX-1 and COX-2, resulting in analgesic and anti-inflammatory effects (StatPearls n.d.).
Reason Client Taking	Psychosis	Anti-inflammatory	Depression
Contraindications (2)	Hypersensitivity to the drug. Hypersensitivity to any component of the drug	Hypersensitivity to naproxen, history of asthma.	Hypersensitivity to trazadone. Hypersensitivity to any component of the formulation of trazadone
Side Effects/Adverse	Neuroleptic malignant	May cause drowsiness,	May cause a manic mixed

Reactions (2)		syndrome, liver function abnormalities and jaundice, seizures, and agranulocytosis.	dizziness, blurred vision and other neurologic effects.	episode and patients with bipolar disorder. May increase the risk of bleeding if used with an antiplatelet and or anticoagulant	
Nursing Considerations (2)		Monitor blood pressure (repeat every 3 months) Measure weight (at 4,8 and 12 weeks)	Monitor for pain relief Monitor significant changes in blood pressure and worsening kidney period	Monitor baseline liver function prior to and during therapy. Closely monitor patients for depression suicidal thoughts, and psychosis.	
Brand/Generic	Lasix/furosemide	Abilify/aripiprazole	Lovenox/enoxaparin	Colchicine	Amatine/midodrine
Dose	20mg 1 tablet	15mg tablet	40mg	0.6 1 tablet	10mg 2 tablets
Frequency	daily	daily	HS	BID	TID
Route	oral	oral	SQ injectable	oral	oral
Classification	Loop diuretic Anti-hypertensive	Antipsychotic	Low molecular weight heparin, anticoagulant	Alkaloid	Alpha-1 adrenergic agonist
Mechanism of Action	Inhibits reabsorption of sodium and chloride in the ascending loop of Henle and proximal and distal renal tubules, interfering with the chloride-binding cotransport system (StatPearls n.d.).	A quinolinone antipsychotic that is a partial agonist. It stabilizes dopamine and serotonin within the nucleus accumbens, ventral tegmental area, and frontal cortex resulting in the management of positive, negative, and cognitive symptoms in schizophrenia (StatPearls n.d.).	Acts as an anticoagulant by enhancing the inhibition rate of clotting proteases by antithrombin III impairing normal hemostasis and inhibition of factor Xa. Low-molecular-weight heparins have a small effect on the activated partial thromboplastin time and strongly inhibit factor Xa (StatPearls n.d.).	An alkaloid obtained from various species of Colchicum. Exerts anti-inflammatory effects by inhibiting chemotaxis possibly diminishing phagocytosis (StatPearls n.d.).	Increases arteriolar and venous tone resulting in a rise in standing, sitting, and supine systolic and diastolic blood pressure in patients with orthostatic hypotension (StatPearls n.d.).
Reason Client Taking	Hypertension	Psychosis	Diabetes	Gout flare	Orthostatic hypertension
Contraindication (2)	Hypersensitivity to furosemide. Anuria	Hypersensitivity to the drug. Hypersensitivity to any component of	Urticaria reactions. History of immune mediated heparin induced	Renal impairment Renal disease	Hold <135 SBP Severe organic heart disease Acute renal disease

		the drug.	thrombocytopenia.	Cardiac disease Hepatic impairment	Urinary retention
Side Effects/Adverse Reactions (2)	Acute kidney injury. Electrolyte loss and disturbances.	Neuroleptic malignant syndrome, liver function abnormalities and jaundice, seizures, and agranulocytosis.	Peripheral edema Nausea	Diarrhea Nausea	Supine hypertension Chills Skin rash
Nursing Considerations (2)	Monitor fluid status. Monitor kidney function.	Monitor blood pressure (repeat every 3 months). Measure weight (at 4,8 and 12 weeks).	Monitor the platelet count. Monitor signs and symptoms of bleeding.	Uric acid values Monitor renal and hepatic function	Monitor for signs and symptoms of bradycardia. Monitor for renal and hepatic function.

Hospital Medications (5 required)

Medications Reference (1) (APA):

Aripiprazole - StatPearls - NCBI Bookshelf. (n.d.). Retrieved September 30, 2022, from

<https://www.ncbi.nlm.nih.gov/books/NBK547739/>

Colchicine - StatPearls - NCBI bookshelf. (n.d.). Retrieved October 1, 2022, from

<https://www.ncbi.nlm.nih.gov/books/NBK431102/>

Enoxaparin - StatPearls - NCBI Bookshelf. (n.d.). Retrieved October 1, 2022, from

<https://www.ncbi.nlm.nih.gov/books/NBK539865/>

Furosemide - StatPearls - NCBI Bookshelf. (n.d.). Retrieved October 1, 2022, from

<https://www.ncbi.nlm.nih.gov/books/NBK499921/>

Midodrine - StatPearls - NCBI Bookshelf. (n.d.). Retrieved October 1, 2022, from <https://www.ncbi.nlm.nih.gov/books/NBK473680/>

Naproxen - StatPearls - NCBI Bookshelf. (n.d.). Retrieved October 1, 2022, from <https://www.ncbi.nlm.nih.gov/books/NBK525965/>

Trazodone - StatPearls - NCBI Bookshelf. (n.d.). Retrieved October 1, 2022, from <https://www.ncbi.nlm.nih.gov/books/NBK470560/>

Assessment

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

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Patient was alert and responsive orientated to person place situation in time, in no obvious distress. The patient's overall appearance was appropriate for situation.</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Patients skin color as usual for ethnicity, skin character was dry and intact with no signs of abnormalities, no signs of rashes or bruises or wounds, no drains present.</p>
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck are symmetrical, trachea is midline without deviation, thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and two +. No visible deformities lumps or lesions on ears. Eyes are bilateral sclera are white, the bilateral cornea are clear bilateral conjunctive pink no visible drainage from eyes bilateral lids are moist and pink without lesions or discharge noted PERRLA bilaterally. EOMs intact bilaterally. Septum is midline. Posterior pharynx and tonsils are moist and pink. Uvula is midline</p>

	<p>soft palate rises and falls symmetrically hard palate is intact.</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>Clear cardiac sounds with no murmurs or rubs or gallops normal rate and rhythm. Normal capillary refill. All extremities are pink warm and dry and symmetrical. Pulse is 2 + bilaterally. No edema present at this time</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Normal rate and pattern of respirations unlabored. Respirations are symmetrical. Course crackles are noted in lower lobes.</p>
<p>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 <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Patient has a normal diet at home but is on a caffeine free heart healthy diet while admitted. Current height is 158.5 centimeters current weight is 90.1 kilograms bowel sounds are regular and active last bowel movement was yesterday morning (9/25). No pain or tenderness upon palpation no distention incision scars drains or wounds upon inspection.</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Patient had a urinary accident so out pet was unable to be recorded. When questioned about urination patient stated he had no pain when he urinated.</p>

<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>All extremities have full range of motion hand grips and pedal pushes and pulls demonstrate normal and equal strength a somewhat balanced end up right stance patient was alert and oriented with no supportive devices was able to be maneuvered to the restroom with no assistance is not considered a fall risk at home that was a fall risk and assist with one during his admission.</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Patient was oriented to person place situation in time cognition and mental status was normalled slightly impaired due to Down syndrome was able to follow commands did have effects of long term memories and obsessed with memories from the past his speech was a little garbled due to hearing impairment but was able to use sign language he was alert awake and could answer questions appropriately.</p>
<p>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):</p>	<p>Coping methods of communication where sign language and communicating with his sister if he had trouble communicating with others developmental level was high school/ special education.</p>

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:50	74	102/65	16	36.5C	93 RA
11:00	73	95/65	16	36.3	93 RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions

07:50	NUMBER	Right Hallux	3	“hurts”	Redirection from sister-patient was refereeing to a surgery that was preformed 10+ years ago and will focus on unnecessary things if brought to his attention
11:00	None	NONE- Patient having no pain	0	None	None

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:	Patient had 20 gauge IV established in left forearm. 9/24/2022 No phlebitis/infiltration present No IV assessment intervention necessary

Intake and Output (2 points)

	Output (in mL)
180mL juice, 240 mL water	Urinary accident- unmeasurable

Nursing Care

Summary of Care (2 points)

Overview of care:

Patient will remain admitted for one more day.

Procedures/testing done:

A stress test has been canceled but a chest X-ray has been ordered.

Complaints/Issues:

Patient was beginning to hallucinate slightly and has asked for Ambilify to alleviate the symptoms.

Vital signs (stable/unstable):

Vital signs were stable

Tolerating diet, activity, etc.:

Patient tolerated diet and activity well

Physician notifications:

Physician was notified for need of Ambilify, patient was beginning to hallucinate.

Future plans for client:

Patient was to be discharged the following day

Discharge Planning (2 points)

Discharge location:

Patient was to be discharged to his sister's care at home

Home health needs (if applicable):

No home health needs where necessary

Equipment needs (if applicable): No equipment needs where necessary

Follow up plan: Patient was to follow up with his primary care physician and his cardiologist

Education needs:

No specific education needs necessary

Nursing Diagnosis (15 points)

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

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components • Listed in order by priority – highest priority to lowest priority pertinent to this client 	<p>Rationale</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Interventions (2 per dx)</p>	<p>Outcome Goal (1 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the client/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Decreased Activity Tolerance related to generalized weakness evidenced by fatigue and dyspnea.</p>	<p>1. Patient had trouble breathing while performing activities of daily living and wanted to sleep all the time.</p>	<p>1. Monitor and evaluate the patient’s response to activities. Monitor vital signs and oxygen saturation levels before during and immediately after activity to determine whether they are within desired range.</p> <p>2. assist with self-</p>	<p>1. Participate in desired activities and achieve measurable increases in inactivity tolerance.</p>	<p>Include the patient as much as possible involving them and promoting a sense of control and reducing the feeling of helplessness.</p>

		<p>care activities as necessary encourage independence. Assist patient with activity of daily living making sure the patient's needs are met while reducing their cardiac workload.</p>		
<p>2. Decreased cardiac output related to edema of the lower extremities as evidenced by a 25 pound weight gain in one month.</p>	<p>1. Patient had a 25lb weigh gain in less than 1 month and +1 pitting edema in the lower extremities.</p>	<p>1. Provide a restful environment and encourage periods of rest and sleep. 2. Encourage active and passive exercises. Increase activity as tolerated.</p>	<p>1. Patient will demonstrate adequate cardiac output as evidenced by vital signs within acceptable limits 2. Patient will participate in activities that reduce cardiac workload</p>	<p>The patients sister is used to helping monitor vital signs and is used to helping the client participate in activities.</p>
<p>3. Excess fluid volume related to difficulty breathing as evidenced by abnormal/crackle breath sounds.</p>	<p>1. 2. Patient had pericardial effusion which as a result of CHF causing fluid buildup in the lungs</p>	<p>1. Weigh the patient daily and compare measurements to the previous measurement. 2. Follow a</p>	<p>1. Demonstrate stabilized fluid volume with balanced intake and output measures.</p>	

		low sodium diet and or fluid restrictions.	2. Verbalize understanding of dietary and fluid restriction.	
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Other References (APA):

Carpenito-Moyet, L. J. (2017). *Handbook of Nursing Diagnosis*. Wolters Kluwer Health/Lippincott Williams & Wilkins.

Concept Map (20 Points):

Subjective Data

He said he did not need to go home because he would be fine living at the hospital.
 Patient said he had toe pain that was 3/10 on a number scale and the foot from his surgery he had a long time ago was bothering him.

Nursing Diagnosis/Outcomes

Objective Data

Obsessive compulsive disorder
 COVID
 Hypotension
 Down syndrome
 Partial hearing loss
 Hallucinations
 Psychosis
 Gout
 Diabetes
 Chronic heart failure
 Unstable angina
 Urinary retention
 Depression
 Pulse 74, BP 102/65, Respirations 16,
 temp 36.5 C, o2 93 RA

Client Information

The patient is a very pleasant 49 year old male admitted to the hospital for being short of breath and a weight gain of 25 pounds in a month. Having just been to his primary care provider in the previous month and noticing the weight gain and some swelling in the lower extremities he did not have. This had become more noticeable within the past month. The patient also had significant loss of appetite, loss of motivation for activity, and short of breath upon activities of daily living. The patient had begun to spend more time sleeping when he was usually a very active individual.

Nursing Interventions

- 1. Monitor and evaluate the patient's response to activities. Monitor vital signs and oxygen saturation levels before during and immediately after activity to determine whether they are within desired range.**
- 2. Assist with self-care activities as necessary encourage independence. Assist patient with activity of daily living making sure the patient's needs are met while reducing their cardiac workload.**
- 1. Provide a restful environment and encourage periods of rest and sleep.**
- 2. Encourage active and passive exercises. Increase activity as tolerated.**
- 1. Weigh the patient daily and compare measurements to the previous measurement.**
- 2. Follow a low sodium diet and or fluid restrictions.**

