N431 Care Plan # 2

Lakeview College of Nursing

Abraham Eugenio

Demographics (3 points)

Date of Admission 10/29/2022	Client Initials DA	Age 59	Gender Female
Race/Ethnicity Caucasian	Occupation Not employed	Marital Status Single	Allergies Lamictal, house dust, cat hair
Code Status Full	Height 4'9	Weight 167lbs	

Medical History (5 Points)

Past Medical History: asthma, depression, affective schizophrenia, bipolar disorder,

COPD, myalgia, chronic rib fracture

Past Surgical History: total knee arthroplasty of right knee, hysterectomy,

cholecystectomy, upper GI endoscopy, colonoscopy

Family History: UTA, no information in chart, and patient's coherence is unstable to assess

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

tobacco use for 30 years, 0.25 packs per day, quit on 5/1/2019, pack years of 7.5; no

significant alcohol or drug use

Assistive Devices: N/A

Living Situation: The patient lives at home with her daughter at home.

Education Level: Associate's degree

Admission Assessment

Chief Complaint (2 points): right rib area pain

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

The patient is a 59-year-old Caucasian female who checked in at Convenient Care to

be seen for right sided rib pain after an injury on 10/25/2022. An X-Ray of the chest was

done, which revealed chronic fractures of the rib, and opacities in the lungs. The patient

came to the ED on 10/29/2022 due to shortness of breath and chest pain. Upon assessment, her oxygen saturation was recorded at 85%, and aggravating factors were unable to be assessed. To relieve her symptoms, pain medications were administered and she was given 10L of oxygen via nasal cannula. The patient was finally admitted on 10/29/2022 4 days after her initial visit on 10/25/2022.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Community-acquired pneumonia

Secondary Diagnosis (if applicable): acute respiratory failure with hypoxia

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

Infection of the respiratory tract happens when an organism or pathogen is able to enter the host and overwhelm the host's immune system (Capriotti & Frizzell, 2020). Upon invasion, pathogens cause tissue inflammation and possible tissue damage. The local inflammation results in a systemic reaction such as fever, chills, and fatigue. Community-acquired pneumonia (CAP) is a type of lung infection caused by viruses and bacteria and is contracted from the community without recent exposure from healthcare settings (Rider & Frazee, 2018). Pneumonia involves fluid infiltration into the alveolar regions of the lungs as a result of inflammation (Capriotti & Frizzell, 2020). Imaging studies such as CT scan and chest X-ray reveal opacities in the lungs. Radiographs and physical examination are used to diagnose pneumonia (Rider & Frazee, 2018). Additionally, a respiratory pathogens panel can be utilized to identify an infection. As fluid builds up in the lungs, patients such as DA may experience shortness of breath, dyspnea, cough, and chest pain. DA initially came into Convenient Care due to chest trauma where it revealed a rib fracture and opacities in the lungs. Her oxygen saturation was 85% with shortness of breath.

Trauma can make infections more likely due to a more accessible portal of entry. At the hospital, the patient was officially admitted for CAP. She is being treated with pain medication for rib pain and oxygen therapy to aid in her respiratory workload. Usually, patients are also treated with antibiotics for the infection, but if the agent is viral, antibiotics are contraindicated. Pneumonia can be life-threatening due to the risk of developing sepsis, which can overwhelm the body, resulting in death.

Pathophysiology References (2) (APA):

Capriotti, T. & Frizzell, J.P. (2020). *Pathophysiology: Introductory concepts and clinical perspectives.* (2nd ed.). F.A. Davis Company

Rider, A. C., & Frazee, B. W. (2018). Community-acquired pneumonia. *Emergency Medicine Clinics of North America, 36*(4), 665–683. https://doi.org/10.1016/j.emc.2018.07.001

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	3.5 – 5.20 10:6/uL	3.86	3.85	
Hgb	11.0 – 16.0 g/dL	12.6	12.2	
Hct	34.0 – 47.0 %	35.7	36.5	
Platelets	140 – 400 10:3/uL	161	191	
WBC	4.00 – 11.00 10:3/uL	11.00	10.88	
Neutrophils	%	N/A	N/A	
Lymphocytes	%	N/A	N/A	

Monocytes	%	N/A	N/A	
Eosinophils	%	N/A	N/A	
Bands	%	N/A	N/A	

Chemistry <mark>Highlight All Abnormal Labs</mark>—**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 mmol/L	143	<mark>147</mark>	
K+	3.5 -5.1 mmol/L	<mark>3.1</mark>	4.1	
Cl-	98 – 107 mmol/L	100	<mark>108</mark>	
CO2	22.0 -29.0 mmol/L	26.0	27.0	
Glucose	74 – 100 mg/dL	98	158	
BUN	10 – 20 mg/dL	<mark>35</mark>	<mark>32</mark>	Elevated creatinine level and BUN indicate renal damage.
Creatinine	0.55 – 1.02 mg/dL	<mark>3.02</mark>	<mark>1.56</mark>	Elevated creatinine level and BUN indicate renal damage.
Albumin	3.5 – 5.0 g/dL	<mark>3.1</mark>	<mark>3.0</mark>	Low blood serum albumin level suggest poor nutrition.
Calcium	8.9 – 10.6 mg/dL	9.9	9.4	
Mag	1.6 – 2.6 mg/dL	1.7	2.0	
Phosphate	2.3 -4.7 mg/dL	N/A	N/A	
Bilirubin	0.2 -12 mg/dL	1.1	0.6	
Alk Phos	40 -150 U/L	<mark>153</mark>	118	
AST	5-34 U/L	<mark>62</mark>	<mark>68</mark>	Elevated liver enzymes may suggest liver damage or inflammation.
ALT	0 – 55 U/L	16	27	

Amylase	N/A	N/A	N/A	
Lipase	N/A	N/A	N/A	
Lactic Acid	0.5 – 2.0 mmol/L	1.0	N/A	
Troponin	0.00 – 0.03 ng/mL	0.02	<mark>2.97 as of 11/1/2022</mark>	
CK-MB	N/A	N/A	N/A	
Total CK	N/A	N/A	N/A	

Other Tests <mark>Highlight All Abnormal Labs</mark>—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	0.9 – 1.1 ratio	<mark>1.2</mark>	<mark>1.2 as of 11/1/2022</mark>	Elevated INRs and PT can be due to the action of the Heparin drip which the patient is receiving.
PT	11.7 – 13.8 sec	<mark>14.7</mark>	<mark>15.2 of 11/1/2022</mark>	Elevated INRs and PT can be due to the action of the Heparin drip which the patient is receiving.
PTT	22.4 - 35.9 sec	30	<mark>139.8</mark>	Elevated PTT can be due to the action of the Heparin drip which the patient is receiving.
D-Dimer	<0.50 ug/mL	N/A	<mark>3.92 of 11/1/2022</mark>	
BNP	0.0 – 100.0 pg/mL	33.0	1282.0	
HDL	N/A	N/A	N/A	
LDL	N/A	N/A	N/A	
Cholesterol	N/A	N/A	N/A	
Triglycerides	N/A	N/A	N/A	
Hgb A1c	N/A	N/A	N/A	
TSH	N/A	N/A	N/A	

Urinalysis <mark>Highlight All Abnormal Labs</mark>—**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	Colorless-yellow	Yellow, clear	N/A	
pH	pH	5.5	N/A	
Specific Gravity	1.000 – 1.030 arbitrary unit	1.015	N/A	
Glucose	Negative mg/dL	negative	N/A	
Protein	Negative mg/dL	<mark>30</mark>	N/A	
Ketones	Negative mg/dL	negative	N/A	
WBC	0-25/uL	<mark>40</mark>	N/A	
RBC	0-20/uL	10	N/A	
Leukoesterase	Negative	negative	N/A	

Arterial Blood Gas <mark>Highlight All Abnormal Labs</mark>—**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	7.350 – 7.450	7.417	7.347	
PaO2	80 – 100 mmHg	<mark>35.4</mark>	84.3	

PaCO2	35.0 - 45.0 mmHg	42.6	45.6	
HCO3	22.0 – 26.0 mmol/L	26.8	24.4	
SaO2	%	69.9	95.9	

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	No growth	N/A	No growth	
Blood Culture	No growth	N/A	No growth	
Sputum Culture	No growth	N/A	No growth	
Stool Culture	No growth	N/A	N/A	

Lab Correlations Reference (1) (APA):

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Coronavirus-19 PCR	Normal value is not detected. The patient's test result is not detected as of 10/30/2022.
Chest X-Ray	Physician interpretation: chronic rib fracture, infiltrates may be indicative of pneumonitis
Lower extremity venous duplex of both legs	No evidence of superficial or deep vein thrombosis
MRSA screening by PCR	negative

Diagnostic Test Correlation (5 points):

Infiltrates result in opacities in the lungs, which is used as a diagnostic evidence for pneumonia

(Rider & Frazee, 2018). Additionally, the patient's chronic rib fracture indicates repeated rib

cage trauma.

Diagnostic Test Reference (1) (APA):

Rider, A. C., & Frazee, B. W. (2018). Community-acquired pneumonia. *Emergency Medicine*

Clinics of North America, 36(4), 665–683. https://doi.org/10.1016/j.emc.2018.07.001

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

Hospital Medications (5 required)

Brand/Generic	Fluoxetine (Prozac)	Ipratropium-albuterol (0.5-2.5mg/ 3mL)	Methocarbamol (Robaxin)	Vortioxetine (Trintellix)	Hydrocodone-acetaminophen (NORCO)
Dose	10mg	3mL	1500mg	20mg	5-325mg 1 tablet
Frequency	Daily	4x daily	Q 6 hours	Daily	TID
Route	Oral	Inhalation	Oral	Oral	oral
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					
Key Nursing Assessment(s)/Lab					

(s) Prior to Administration					
Client Teaching Needs (2)					

Home Medications (5 required)

Brand/Generic	Singulair (Montelukast)	Furosemide (Lasix)	Albuterol HFA 90mcg inhaler (Ventolin HFA)	Baclofen (Robaxin)	Tizanidine (Zanaflex)
Dose	10mg	40mg	1-2 puffs	10mg	2mg
Frequency	Every evening	Daily	Q 4-6 hours PRN	2x daily	At bedtime, PRN
Route	Oral	Oral	inhalation	Oral	oral
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					
Key Nursing Assessment(s)/Lab(s) Prior to Administration					
Client Teaching Needs (2)					

Medications Reference (1) (APA):

Assessment

Physical Exam (18 points) – <mark>HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS</mark>

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient appears to be clean and neat. She is alert to self, and person x4. <mark>The patient is alert and oriented to place, time, and situation x1</mark>. She does not appear to be in distress at this time.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 14** **Drains present: Y☐ N ☒** **Type:**	the patient's skin color is white and appropriate for race; her skin is cool and dry; her skin turgor is decreased; no wounds, rashes or lacerations noted; <mark>bruise on right elbow noted</mark>; no spots of redness, bumps or warmth noted during general survey
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	the patient's head is normocephalic and atraumatic; no JVD identified; her ears, eyes and nose are clear and no exudate noted; her teeth are mostly complete and oral mucosa is intact; unable to visualize the uvula because of the tongue; sclera is white; no cuts, lesions, or drainage noted in the eyes, ears and throat; throat is centered; <mark>white film in patient's mouth</mark>
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐**	S1 and S2 heard upon auscultation; no murmurs, gallops, rubs or bruits auscultated; no s3 or s4 sounds auscultated; peripheral pulses are present in upper and lower extremities bilaterally +2, capillary refill in all extremities are brisk and less than 3 seconds; no neck vein distension noted; no edema upon palpation; cardiac rhythm by ECG is

Edema Y ☐ N ☐ **Location of Edema:**	normal
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No accessory muscle use; patient's respiratory rate and rhythm are regular and nonlabored; <mark>course crackles in all lobes of the lungs auscultated; right lower lobe is diminished</mark>

GASTROINTESTINAL:
Diet at home: regular
Current Diet: clear liquid
Height: 4'9
Weight: 167 lbs
Auscultation Bowel sounds:
Last BM: 11/1/2022
Palpation: Pain, Mass etc.:
Inspection:
    Distention:
    Incisions:
    Scars:
    Drains:
    Wounds:
Ostomy: Y ☐   N ☒
Nasogastric: Y ☐   N ☒
    Size:
Feeding tubes/PEG tube   Y ☐   N ☒
    Type:
	Bowel sounds are normoactive in all quadrants; no pain upon palpation in the abdomen; no incisions, scares, drains, wound, or distension noted; no organomegaly noted

GENITOURINARY:
Color: yellow
Character: clear
Quantity of urine: 1030 mL collected from catheter
Pain with urination: Y ☐   N ☒
Dialysis: Y ☐   N ☒
Inspection of genitals: unable to assess
Catheter: Y ☒   N ☐
    Type: urethral foley
    Size: not indicated in chart and foley itself does not have a label	

MUSCULOSKELETAL: **Neurovascular status: no abnormality noted** **ROM: no limitation noted** **Supportive devices: leg compression devices on both legs** **Strength: equal in all extremities**	the patient is mobile but is on bedrest; pedal pushes and pulls +3; hand grips equal and +3

ADL Assistance: Y ⊠ N ☐ **Fall Risk: Y ⊠ N☐** **Fall Score: 100** **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 goes in and out of lucidity; speech is nongarbled, but sometimes repeated and monosyllabic==, the patient needs to be oriented every so often; she is alert and oriented to person x4; ==the patient is alert and oriented to place, time and situation x1,== no sensory deficits noted; and patient is conscious x3
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level: adult** **Religion & what it means to pt.: unable to assess** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient finds support from her daughter and sister; the patient is waiting for her sister to come to the hospital to support her regarding a possible heart failure diagnosis; the patient shared that she gardens at home and gets around the house by herself, ==but does not remember how she gets groceries==; the patient lives with her adult daughter

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
800	90	129/76, HOB at 30 degrees, supine	==24==	98.3 F, oral	97%, nasal cannula
1141	88	120/78 HOB at 30 degrees,	16	98.5 F, oral	95%, nasal cannula

		supine			

Vital Sign Trends: the patient's pulse, respiratory rate, BP and oxygen saturation have gone

down; her temperature has gone up, but is still within normal range

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
800	Verbal/numerical	The patient denies pain and does not show nonverbal signs of distress	The patient denies pain and does not show nonverbal signs of distress	The patient denies pain and does not show nonverbal signs of distress	The patient denies pain and does not show nonverbal signs of distress
1141	Verbal/numerical	The patient denies pain and does not show nonverbal signs of distress	The patient denies pain and does not show nonverbal signs of distress	The patient denies pain and does not show nonverbal signs of distress	The patient denies pain and does not show nonverbal signs of distress

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18G **Location of IV: right upper arm** **Date on IV: 10/31/2022** **Patency of IV: patent** **Signs of erythema, drainage, etc.: negative** **for erythema, drainage, or infiltration** **IV dressing assessment: dry and intact**	Heparin drip at 9.9ml/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

810.5 mL total
 	
   760.5 mL from IV
 	
   50 mL PO
	1030 mL total
	
	   1030 mL of urine from catheter

Nursing Care

Summary of Care (2 points)

Overview of care: the patient was meant to be discharged today (11/2/2022), but due to her BNP, the provider wants to investigate whether the patient may have heart failure

Procedures/testing done: continuous ECG, chest X-Ray, CT scan ordered, but was canceled tue to possible heart failure

Complaints/Issues:

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: patient able to tolerate diet, but put on liquid diet due to CT scan

Physician notifications: provider is to be notified of declining respiratory status

Future plans for client: patient will be kept in the hospital longer due to a possibility of heart failure

Discharge Planning (2 points)

Discharge location: home with daughter

Home health needs (if applicable): patient will need social work to determine needs for getting groceries

Equipment needs (if applicable): N/A

Follow up plan: the nurse should call the patient or the patient's support person to ensure that the patient has been followed up on by her PCP or social work

Education needs: the patient's support person needs to be educated that the patient may need a sitter at home due to her mental status

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. Risk for reduced cardiac output related to possible heart failure as evidenced by a BNP of 1282.0	The patient does not have any significant cardiac history prior to hospitalization. Her BNP is alarmingly high, which can suggest cardiac damage and possible heart failure. Her health status can change	1. The patient's input and output should be closely monitored and accurately recorded to identify possible decreased renal perfusion as a result of decreased cardiac output (Phelps, 2020).	The patient will not experience any dizziness, or incongruence in intake and output. The patient's support person will also report any signs of respiratory distress displayed by	The patient is receptive of instructions and she will report any changes in her health status. The support person will show understanding of the teaching and show involvement in the client's care.

	dramatically if this is not addressed appropriately.	2. Instruct the patient to report any dizziness, chest pain, or difficulty breathing, as these may suggest myocardial hypoxia (Phelps, 2020).	the patient.	
1. Impaired gas exchange related to pneumonia as evidenced by abnormal blood gases.	Currently, the patient is stable, however, her status can drastically change due to the effect of impaired gas exchange. Her abnormal ABGs upon admission can quickly return if her treatment is not followed properly.	1. Conduct respiratory and cardiac assessments on the patient every 4 hours (Phelps, 2020) 2. Monitor the patient's oxygen therapy and notify the provider if the patient needs any change in treatment regimen (Phelps, 2020)	1. The patient's oxygen saturation will stay within desired limits and any drastic change from baseline will be reported to the provider.	The patient's health status will remain stable, and the patient's health status should improve with the help of careful monitoring and appropriate adjustment of her oxygen therapy.
1. Anxiety related to a possible diagnosis of heart failure as evidenced by the patient crying and asking for student to hold her hand.	The patient has an extensive history of psychological and emotional problems, therefore, it is important for her well-being that her current emotional state due to recent news is addressed while in the	1. Use therapeutic communication and allow the patient to express herself. The student nurse or nurse should be attentive to the patient when she is expressing her concerns about the possibility	1. The patient's anxiety will be effectively controlled and the patient will be able to express her feelings and concern regarding heart failure and death. The student	The patient showed that she was comforted by the student holding her hand and by being present when the patient was showing fear. The patient showed understanding of the next steps related addressing the possibility of heart failure.

	hospital.	of heart failure (Phelps, 2020). 2. Provide the patient company when expressing anxiety. This can help relieve her feelings of being alone (Phelps, 2020).	and the nurse will listen and be present for the patient.	
1. Feeding self-care deficit related to schizophrenia and bipolar disorder as evidenced by the patient being unable to recall how she gets groceries and low albumin.	Outside of the hospital, the patient may not be able to adequately intake food and take care of herself. This is a great concern because nutrition is vital to maintaining and improving health status.	1. Refer the patient to outside resources to help the patient meet her nutritional needs (Phelps, 2020). 2. Assess the patient's functional and cognitive abilities related to feeding (Phelps, 2020). This helps the nurse identify the patient's specific needs and come up with a plan to address them.	1. The patient will be referred to outside resources and will be able to intake adequate nutrition. Social workers may be connected to the patient to ensure that the patient is being fed properly.	The patient's support person will help in acting as a liaison between the patient and social workers or community help groups to provide the patient with adequate feeding needs.

Other References (APA):

Phelps, L.L. (2020*). Sparks and Taylor's Nursing Diagnosis Reference Manual* (11th ed.).

 Wolters Kluwer

Concept Map (20 Points):

Subjective Data

The patient reported on 10/25/2022 that she had injured herself and crashed her right rib against the counter. She reported chest pain and difficulty breathing. She mentioned that upon discharge from Convenient Care, she took pain meds to alleviate the pain. On 10/29/2022, she was admitted due to shortness of breath.

Nursing Diagnosis/Outcomes

Risk for reduced cardiac output related to possible heart failure as evidenced by a BNP of 1282.0
The patient will not experience any dizziness, or incongruence in intake and output. The patient's support person will also report any signs of respiratory distress displayed by the patient.
Anxiety related to a possible diagnosis of heart failure as evidenced by the patient crying and asking for student to hold her hand.
The patient's anxiety will be effectively controlled and the patient will be able to express her feelings and concern regarding heart failure and death. The student and the nurse will listen and be present for the patient.

Objective Data

The patient's vital signs as of 11/2/2022 are as follows:
BP: 120/78
Pulse: 88
Resp: 16
Temp: 98.5 F, oral
Oxygen saturation: 95%, 2L nasal cannula
BNP: 1282
Venous duplex of lower extremities: negative for superficial or deep vein thrombosis

Client Information

The client is a 59-year-old Caucasian female and is 4'9'' tall. She has a history of schizophrenia and affective bipolar disorder. She lives with her daughter in a house. She has been admitted to the hospital of community-acquired pneumonia.

Nursing Interventions

The patient's input and output should be closely monitored and accurately recorded to identify possible decreased renal perfusion as a result of decreased cardiac output (Phelps, 2020).

Instruct the patient to report any dizziness, chest pain, or difficulty breathing, as these may suggest myocardial hypoxia (Phelps, 2020).
Use therapeutic communication and allow the patient to express herself. The student nurse or nurse should be attentive to the patient when she is expressing her concerns about the possibility of heart failure (Phelps, 2020).