N431 Care Plan #1

Lakeview College of Nursing

Beatriz Amaya

Demographics (3 points)

Date of Admission 2/11/23	**Client Initials** M.L	**Age** 72 years old	**Gender** Female
Race/Ethnicity Hispanic	**Occupation** Retired	**Marital Status** Widowed	**Allergies** Bananas, Shellfish, Cyclobenzaprine
Code Status Full Code	**Height** 157.48cm (5’ 2”in)	**Weight** 48 kg (106 lbs.)	

Medical History (5 Points)

Past Medical History: Hypertension, Atrial fibrillation, Hyperlipidemia, Chronic Heart Failure

CHF exacerbation in October 2017, New onset atrial fibrillation in

May 2018, UTI in January 2020, Cellulitis in December 2020, Pneumonia in July 2021

Past Surgical History: Cholecystectomy in 1995, Total Knee Replacement in 2009

Family History: Mother – diabetes, Brother – diabetes, Father – MI

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

Denies use of tobacco and drugs. Alcohol occasionally 1-2x per month socially and has

for 10 years.

Assistive Devices: Denies use of assistive device.

Living Situation: Lives at the Oaks Manor Assisted Living Facility

Education Level: GED

Admission Assessment

Chief Complaint (2 points): Weight gain, swelling of the ankles

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

Patient presents to the emergency department with complaints of a 12-pound weight gain within the last four days. Edema peripherally presenting bilaterally on the ankles and pedal areas. As stated, before duration has been noticed within the last four days. Characteristically she has noted weight gain as she weighs herself daily. Patient states "Ambulating aggravates my edema causing pain." Patient states "Rest and elevating my extremities relieve my pain." Patient did not mention taking anything to treat her symptoms at the time but her medications from home are as listed due to past medical history Lisinopril 40 mg PO daily, Amiodarone 200 mg PO daily, Aspirin 81 mg PO daily, Atorvastatin 40 mg PO daily at HS, Metoprolol 50 mg PO BID, Furosemide 40 mg PO daily. Severity at the time patient stated 0/10 pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Chronic heart failure exacerbation

Secondary Diagnosis (if applicable): N/A

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

The patient presenting issues are concurrent with heart failure. Heart failure can present itself in several ways. There is a difference between right and left-sided heart failure. According to Hinkle & Cheever (2022, p.794), this cardiac disorder cannot pump enough blood to meet the body's metabolic demands or needs. This process can be chronic to where if the not lifestyle is not changed, the patient will be more prone to having hospital visits often and have complications present more often than wanted. Capriotti (2020, p.399) states that a low ejection of blood volume into the arterial circulation is known as systolic dysfunction in heart failure.

In contrast, heart failure is caused by the ventricle's inability to relax, expand, and fill with adequate blood volume, known as diastolic dysfunction. The heart is not working as

efficiently as it used to. Capriotti (2020, p.404) states that edema occurs because of high hydrostatic pressure in capillary blood into interstitial and intracellular spaces. Overall, this can affect the body in different manifestations, which in this case was edema in the lower extremities and the hands, and pulmonary edema, not enough oxygen being perfused into the blood since the heart does not eject as efficiently as it should.

Various complications can arise from heart failure right side, especially with insufficient blood filling into the pulmonary circulation. Left-sided heart failure coincides with the inability of the left ventricle to as left-sided heart failure cannot supply or eject sufficient blood into the systemic circulation. A patient with chronic heart failure can present with left and right-sided heart failure and cause pulmonary edema. According to Hinkle & Cheever (2022, p.797), pulmonary edema occurs when the left ventricle fails, and increased fluid pressure is transferred back through the lungs, leading to damage to the right side of the heart. According to Hinkle & Cheever (2022, p.795), signs and symptoms of left-side heart failure include dyspnea, orthopnea, cough, pulmonary crackles, weight gain (rapid), and dependent edema. Capriotti (2020, p.420) states that right-sided heart failure has jugular vein distention, ascites, and ankle or sacral edema. Many patients can go undiagnosed until they present with edema. My patient presented with a significant 12-pound weight gain within four days and peripheral edema of the bilateral ankles and pedal areas.

In heart failure, the recommended test to be done to diagnose is an echocardiogram. An echocardiogram will show the function and size of the heart. According to Capriotti (2020, p.422), it is commonly used to evaluate the size and function of the ventricles, valve structure, and valve function. According to Capriotti (2020, p.422), other diagnostics include cardiac catheterization and angiography, multiple-gated, brain natriuretic peptide, acquisition scan,

electrocardiogram, brain natriuretic peptide, and a Chest X-Ray. A BNP can be obtained; if it is above 500, it indicates heart failure. My patient had a chest x-ray, finding consistency with an enlarged heart and pulmonary vascular congestion. My patient also had an electrocardiogram showing atrial fibrillation with a rate of 88 bpm.

Treatments can vary to the extent of heart failure but changing the patients to a healthy lifestyle is beneficial. According to Hinkle & Cheever (2022, p.803), treatments include oxygen, a low-sodium diet, diuretics, smoking cessation, and increasing physical activity. My patient's pharmacological treatment is Furosemide 40 mg IV BID Potassium Chloride 40 mEq PO once. Diuretics were prescribed to eliminate the excess fluids and potassium due to the Furosemide being a potassium-wasting medication. Oxygen is supplied at a 2 L nasal cannula. The non-pharmacological treatments include daily weight checks, fluid restriction of 1,000 mL per day, and strict intake and output. Assessing the patients' lungs and edema needs to **be monitored closely to ensure the interventions and medications in place are effective.**

Pathophysiology References (2) (APA):

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

Hinkle, J.L., & Cheever, K. H. (2022). *Brunner & Suddarth's textbook of medical-surgical Nursing* (15th:h ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

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	4.0-5.8x10^6/mcL	**N/A**	**N/A**	**N/A**
Hgb	12.0-15.8g/dL	**N/A**	**N/A**	**N/A**

Hct	36.0-47.0%	**N/A**	**N/A**	**N/A**
Platelets	140-440K/ mcL	**N/A**	**N/A**	**N/A**
WBC	4.0-11.0 K/mcL	9.4 K/mcL	**N/A**	**N/A**
Neutrophils	40-60%	**N/A**	**N/A**	**N/A**
Lymphocytes	19-49%	**N/A**	**N/A**	**N/A**
Monocytes	3.0-13.0%	**N/A**	**N/A**	**N/A**
Eosinophils	0.0-8.0%	**N/A**	**N/A**	**N/A**
Bands	0.0-10.0%	**N/A**	**N/A**	**N/A**

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145mmol/L	138 mmol/L	**N/A**	**N/A**
K+	3.5-5.2mmol/L	**3.1** mmol/L	**N/A**	According to Capriotti (2020, p.129) diuretics commonly cause urinary loss of potassium, leading to hypokalemia. My patient is taking furosemide which is a potassium wasting diuretic causing her to have hypokalemia.
Cl-	98-107mmol/L	**N/A**	**N/A**	**N/A**
CO2	21-31mmol/L	**N/A**	**N/A**	**N/A**
Glucose	70-99 mg/dL	**94** mg/dL	**N/A**	**N/A**
BUN	5-20 mg/dL	24 mg/dL	**N/A**	Blood urea nitrogen is elevated according to Capriotti (2020, p.341) due to possible indication of renal damage. As well as my patient being hypertensive can cause injuries to the kidneys and heart failure.

Creatinine	0.50-1.50mg/dL	2.8 mg/dL	**N/A**	My patient's creatinine is elevated according to Capriotti (2020, p.341) due to renal insufficiency. As my patient's chronic heart failure progresses the cardio output decreases which leads to a renal decline function.
Albumin	3.5-5.7 g/dL	**N/A**	**N/A**	**N/A**
Calcium	8.6-10.3 mg/dL	**N/A**	**N/A**	**N/A**
Mag	1.6-2.6 mg/dL	**N/A**	**N/A**	N/A
Phosphate	2.4-4.5 units/L	**N/A**	**N/A**	**N/A**
Bilirubin	Less than 1.0 mg/dL	**N/A**	**N/A**	**N/A**
Alk Phos	35-150 units/L	**N/A**	**N/A**	**N/A**
AST	5 to 40 Units/mL	**N/A**	**N/A**	**N/A**
ALT	5 to 35 Units/mL	**N/A**	**N/A**	**N/A**
Amylase	**30-220 U/L**	**N/A**	**N/A**	**N/A**
Lipase	**0-160 U/L**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.5-1 mmol/L**	**N/A**	**N/A**	**N/A**
Troponin	**0-0.04 ng/mL**	**N/A**	**N/A**	**N/A**
CK-MB	**5-25 µg/L**	**N/A**	**N/A**	**N/A**
Total CK	**22-198 U/L**	**N/A**	**N/A**	**N/A**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.8-1.1	**N/A**	**N/A**	**N/A**
PT	11-12.5 seconds	**N/A**	**N/A**	**N/A**
PTT	30-40 seconds	**N/A**	**N/A**	**N/A**
D-Dimer	<0.4	**N/A**	**N/A**	**N/A**
BNP	< 100	**4,923 pg/mL**	**N/A**	My patients B-type natriuretic peptide (BNP) is elevated due to my patient's fluid overload caused by heart failure. According Capriotti (2020, p.474) BNP is excreted in response to fluid volume overload. My patient is in fluid volume overload s due to chronic heart failure showing edema, pulmonary congestion, and need of oxygen causing elevated BNP.
HDL	>60 mg/dL	**N/A**	**N/A**	**N/A**
LDL	<130 mg/dL	**N/A**	**N/A**	**N/A**
Cholesterol	<200 mmol/L	**N/A**	**N/A**	**N/A**
Triglycerides	<150 mg/dL	**N/A**	**N/A**	**N/A**
Hgb A1c	4-5.9%	**N/A**	**N/A**	**N/A**
TSH	0.4-4.0 mU/L	**N/A**	**N/A**	**N/A**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	yellow, clear	**N/A**	**N/A**	**N/A**
pH	5.0-9.0	**N/A**	**N/A**	**N/A**

Specific Gravity	1.003-1.013	**N/A**	**N/A**	**N/A**
Glucose	Negative	**N/A**	**N/A**	**N/A**
Protein	Negative	**N/A**	**N/A**	**N/A**
Ketones	Negative	**N/A**	**N/A**	**N/A**
WBC	0.0-0.5	**N/A**	**N/A**	**N/A**
RBC	0.0-3.0	**N/A**	**N/A**	**N/A**
Leukoesterase	Negative	**N/A**	**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	**7.35-7.45**	**N/A**	**N/A**	**N/A**
PaO2	90-100 mm Hg	**N/A**	**N/A**	**N/A**
PaCO2	**35-45 mEq/L**	**N/A**	**N/A**	**N/A**
HCO3	22-26 mEq/L	**N/A**	**N/A**	**N/A**
SaO2	95%-100%	**N/A**	**N/A**	**N/A**

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	**N/A**	**N/A**	**N/A**
Blood Culture	Negative	**N/A**	**N/A**	**N/A**
Sputum Culture	Negative	**N/A**	**N/A**	**N/A**
Stool Culture	Negative	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Patient had a chest x-ray with a finding of an enlarged heart and pulmonary vascular congestion patient also had an electrocardiogram done showing atrial fibrillation at a rate of 88 bpm.

Diagnostic Test Correlation (5 points):

Chest X-Ray:

My patient had a chest x-ray done upon admission. According to Capriotti (2020, p.421) a chest x-ray is done to delineate the cardiac shadow and pulmonary fields. My patient diagnosis was chronic heart failure exacerbation which an x-ray was essential to show any cardiac and or pulmonary findings. The chest x-ray found consistency with an enlarged heart and pulmonary vascular congestion. According to Capriotti (2020, p.421) in heart failure, cardiomegaly, and pulmonary congestion is commonly seen in heart failure. Which in this scenario is what my patients x-ray identified!

EKG = shows A fib at a rate of 88 bpm

My patient upon admission also had an electrocardiogram done. An electrocardiogram is done to show the patient heart rhythm and the heart electrical activity. My patient came in diagnosed with chronic heart failure and a history of new on set atrial fibrillation. Due to her history and current diagnosis, it was essential to perform an electrocardiogram According to Capriotti (2020, p.422) an electrocardiogram may demonstrate various abnormalities in heart failure.

The electrocardiogram showed a-fib at a rate of 88 bpm. The data provided by the electrocardiogram was concurrent with studies showing patients in heart failure will show abnormal findings in an electrocardiogram.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	Zestril/ Lisinopril	Cardamone / Amiodarone	Ancasal/ Aspirin	Lipitor/ Atorvastatin	Lopressor/ Metoprolol
Dose	40 mg	200 mg	81 mg	40 mg	50 mg
Frequency	Daily	Daily	Daily	Daily, HS	BID
Route	PO	PO	PO	PO	PO
Classification	**Pharmacological:** Angiotensin-converting enzyme	Pharmacological: Benzofuran derivative Therapeutic: Class III	**Pharmacological:** Salicylate **Therapeutic:** NSAID	**Pharmacological:** HMG-CoA reductase inhibitor **Therapeutic:**	**Pharmacological:** Beta-adrenergic blocker **Therapeutic:** Anti

	inhibitor **Therapeutic:** Antihypertensive	antiarrhythmic		Antihyperlipidemic	anginal
Mechanism of Action	"Reduce blood pressure by inhibiting conversion of angiotensin 1 to angiotensin II" (Jones, 2021, p.659).	"To treat life threatening, recurrent ventricular fibrillation and hemodynamically unstable ventricular tachycardia when these arrythmias don't respond to other drugs" (Jones, 2021, p. 52)	"Blocks the activity of cyclooxygenases, the enzyme needed for prostaglandin synthesis" (Jones, 2021 p.87)	Reduce plasma cholesterol and lipoprotein (Jones, 2021, 96).	Decreased cardiac excitability, cardiac output. And myocardial oxygen demand, Helps reduce blood pressure by decreasing renal release renin (Jones, 2021, p.726)
Reason Client Taking	Patient has a history of hypertension, also treats heart failure.	Patient has new onset atrial fibrillation helps convert the patient back to sinus rhythm.	Patient is taking it to prevent an acute myocardial infarction from occurring and reduce risk of death due to my patient having a history of chronic heart failure	Patient takes it due to her history of hyperlipidemia.	Patient takes it due to her history of hypertension, new onset a-fib and heart failure.
Contraindications (2)	Hypersensitivity to ACE inhibitor, Hypersensitivity to lisinopril	Bradycardia, Hypersensitivity to Amiodarone	Active bleeding., hypersensitivity to aspirin	Hypersensitivity to atorvastatin, active liver disease (Jones, 2021, p.96)	Hypersensitivity to metoprolol, Heart rate less than 45 bpm (Jones. 2021, p.796).

Side Effects/Adverse Reactions (2)	Arrythmias, hypotension	Abnormal gait, dizziness	Prolonged bleeding time, Central nervous system depression	Arrythmias, hepatic failure	Arrythmias, heart failure
Nursing Considerations (2)	Advise patient to change position slowly to minimize orthostatic hypotension, urge patient if a nonproductive cough occurs notify provider (Jones, 2021, p.661)	Monitor vital signs ad oxygen levels, Check patients heart rate before administration.	Ask patient if tinnitus occurs when tsking this medication, do not crush time released capsules unless instructed to do so (Jones 2021, p.89).	Use in caution with patients who consume alcohol, Instruct patient if hyperbilirubinemia symptoms occur inform provider (Jones, 2021, p.97).	Assess ECG of patient because they may be at risk for an AV block, if patient with heart failure experience's brady cardia expect to decrease dosage (Jones, 2021, p.726).
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Reviewing clients blood pressure before administration, Monitor patients' potassium	Monitor serum amiodarone levels, Monitor continuous ECG (Jones, 2021, p.55).	Check if patient is taking ibuprofen as it may reduce the cardioprotective effects Instruct patient to stop taking medication if symptoms of intestinal bleeding occur (Jones, 2020, p.89).	Liver functions tests, measuring lipid levels 2 to 4 weeks after therapy starts (Jones, 2021 p.97).	Check patients heart rate before administration, Checks patients' blood pressure before administration
Client Teaching Needs (2)	Notify provider if they feel like there dizzy when	"Explain that patient will need frequent monitoring	Take with food, avoid alcohol to reduce risk of ulcers	Teach patient Atorvastatin is not a substitute for a low	Take with food at the same time each day, caution

	standing up due to hypotension, “Advise patient to take lisinopril at the same time every day” (Jones, 2021, p.661)	and lab tests during treatments, patient to report abnormal bleeding or bruising” (Jones, 2021, p.55).	(Jones, 2021, p.89)	cholesterol diet, if a dose is missed take it as soon as possible (Jones, 2021, p.97)	patient to not stop drug abruptly.

Hospital Medications (5 required)

Brand/Generic	Lasix/ Furosemide	Apo-K/ Potassium Chloride	Tylenol/ Acetaminophen	Doxidan /Docusate	Statex/ Morphine
Dose	40mg	40 mEq	650 mg	100 mg	1mg
Frequency	BID	Once	q6h PRN	BID, PRN	q4h, PRN
Route	IV	PO	PO	PO	IV
Classification	**Pharmacological:** Loop Diuretic **Therapeutic:** Antihypertensive, diuretic	**Pharmacological:** Electrolyte cation **Therapeutic:** Electrolyte Imbalance	**Pharmacological: Non-salicylate Therapeutic:** Non opioid analgesic	**Pharmacological:** Surfactant **Therapeutic:** Laxative	**Pharmacological:** Opioid **Therapeutic:** Opioid analgesic
Mechanism of Action	Reducing extracellular and intracellular fluid volume, drug reduces blood pressure and cardiac	Maintain electroneutrality in cells by controlling exchange of extracellular and intracellular	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain	Softens stools by decreasing surface tension between oil and water in feces (Jones, 2021, p.332).	Binds with active opioid receptors in brain and spinal cord to reduce analgesia (Jones,2021, p.753)

	output.	ions (Jones, 2021, p.880)	impulse generational in the peripheral nervous system (Jones, 2021, p.9)		
Reason Client Taking	Patient is having excess fluid causing edema due to chronic heart failure she is taking this diuretic to reduce edema and get rid of the excess fluids.	Patient is taking a diuretic that depletes potassium and, upon admission, a patient presented with hypokalemia of 3.1 mmol/L. To replenish electrolyte imbalance.	Patient takes it for her pain, specifically her headache.	Patient takes it in case of constipation.	Patient takes it in case they have severe pain.
Contraindications (2)	Anuria, hypokalemia	Hypersensitivity to potassium salts, acute dehydration	Hypersensitivity to acetaminophen, hepatic impairment	Fecal impaction, concomitant use of mineral oil (Jones, 2021, p,332)	Respiratory depression, Bronchial Asthma
Side Effects/Adverse Reactions (2)	Arrythmia, Hypokalemia	Arrythmias, pulmonary edema	Hypotension, hypokalemia	Dizziness, muscle weakness	Respiratory depression, Hypotension
Nursing Considerations (2)	Obtain patients weight before and periodically during furosemide therapy, try to give dosing early in the day so patient sleep	Administer meals, Mix oral solutions with water (Jones, 2021,882).	Monitor for symptoms of hepatoxicity, use in caution with patients who drink alcohol (Jones, 2021, p.11).	Excessive use of this medication will cause dependence on laxatives for bowel movements, Monitor for diarrhea (sign of toxicity).	Can lead to addiction and misuse, continuously monitor the patients carbon dioxide and oxygen saturation

	is not interrupted by needing to urinate (Jones, 2021, p.500).				
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor sodium, Monitor potassium.	Check potassium, Monitor heart rhythm	Monitor renal functions. (creatinine), Monitor liver functions (AST, ALT)	DO not administer if patient feels nauseous and is committing, assess for laxative abuse (Jones, 2021, p.332)	Check respiratory rate, Assess patient drug use before administration (Jones, 2021, p.755).
Client Teaching Needs (2)	Empathize importance of monitoring weight, emphasize importance of monitoring a low sodium diet (Jones, 2021, p.501).	Notify provider of stool color changes, (black, tarry), teach patient to check radial pulse and notify provider if patient notices significant changes in heart rate and rhythm (Jones,2021, p. 882)	Teach patient about hepatotoxicity symptoms such as easily bruising bleeding, and malaise (Jones, 2021 p.10). Educate to only take as prescribed as well as cold medicine over the counter contains acetaminophen	Encourage patient to increase their fiber intake, advise patient to take it with a full glass of milk (Jones, 2021, p.332).	Advise patients to move positions slowly due to possibility of orthostatic hypotension, urge patients to avoid alcohol when taking this medication (Jones, 2021, p.757).

Medications Reference (1) (APA):

Jones, D.W. 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 patient was alert and oriented to person, place, time, and situation. Alert and Oriented times four. (A&O x4) The patient showed no signs of distress. Overall physical hygiene was well maintained and cared for.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	The patient's skin color is an even tone throughout the skin and a light tan color. Skin is moist and warm to the touch. Skin turgor is loose with no lesions, bruises, or wounds present. Patient Braden's score is 20. No drains present.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normal cephalic and symmetrical. Ears are symmetrical with no serum or epistaxis. The patient's eye represented PERLA. The nose showed no polyps, nor deviated septum. The patient teeth are intact and self-care hygiene was provided during visit.
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:**	Patients' heart sounds S1 and S2 were auscultated. No present murmurs heard. Cardiac rhythm was atrial fibrillation reading 88 bpm. Peripheral pulses demonstrating a rating of +2. Capillary refill less than three seconds. No neck vein distention. Pitting edema present showing 3+.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No accessory muscles were used. The patient's breath sounds were auscultated anterior and posterior noted sounds of crackles in the bases of the lungs bilaterally.
GASTROINTESTINAL: **Diet at home:** **Current Diet**	The patient's diet at home is regular, avoiding bananas and shellfish, due to her allergies. The current diet is recommended to be low sodium

Height: **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	with a fluid restriction of 1,000 mL per day. Patient height is 157.48 cm. and weight 48kg. Bowel sounds were active in all four quadrants. Last bowel movement 2/13/2023 with two stools documented during shift. Upon palpation of abdomen no pain or masses present. No distension, incision, scars, or drains present. Patient does not ostomy or nasogastric tube. No feeding tubes either.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient urine was yellow and clear. Total urine voided in four hours was 1,750 mL. Patient did not express any pain with urination. Patient does not have dialysis. Genitals were not inspected. The catheter was not needed or ordered by the physician.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 75** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk: ☐Yes**	Patients' neurovascular status is intact. Active range of motion present and demonstrated. Patient does not use any assistive device. Patient showed 5/5 strength on upper extremities bilaterally. Patient showed 4/5 strength bilaterally on lower extremities. Patients' fall score was 75 (High risk). Mobility status patient requires one personal assistance for completion of activity of daily livings. Patient does need help with use and set up of equipment other than gait belt application. Patient also needs additional support to stand and walk due to patient mentioning her edema being aggravated by ambulation.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -**	The patient can move all extremities well with some weakness in the legs. Eyes were examined and exhibited PERLA. The patient has equal strength of 5/5 for the upper extremities. Equal

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	strength for lower extremities 4/5. The patient is alert and oriented times four (A&Ox4). Mental status is alertness. Speech is clear. Patient sensory is intact. No loss of consciousness.
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):**	Patients coping mechanism were expressing to God about life and stressful situations. Development of mental status is appropriate for age. Patients' religion is Catholic meaning "I belong to God." Patient current environment at the assisted living states she is content and happy in her living situation. Patient says she often turns to God and family members for support.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0700	88	152/68	24	36.5	98% 2L on nasal canula
1100	68	138/62	24	36.8	97% 2L on nasal canula

Vital Sign Trends: Pulse rate decreased, elevated blood pressure decreased but still considered elevated, Oxygen saturation decreased by one percent still needing 2L on nasal canula. Pulse and temperature remain within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric (0/10)	N/A	N/A	N/A	No interventions yet.

1100	Numeric (0/10)	headache	1	"My headache is consistent and dull"	Tylenol administered

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20G **Location of IV:** left AC **Date on IV:** 2/13/23 **Patency of IV:** patent **Signs of erythema, drainage, etc.:** No signs of erythema or drainage **IV dressing assessment:** Dressing clean/dry/intact.	No fluids administered. Saline locked.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Tea PO 240 mL with breakfast Apple juice 120 mL with breakfast	Urine 1750mL voided in 4hours Stool x2

Nursing Care

Summary of Care (2 points)

Overview of care: Patient presented to the emergency department with a twelve-pound weight gain in four days with peripheral edema bilaterally on the ankles and pedal areas. Voiding well throughout shift, 1750mL urine voided in 4 hours with two stools through shift. Notified physician of low potassium of 3.1 potassium chloride was ordered. BNP elevated to 4,923 pg/mL. Creatinine elevated showing 2.8 mg/dL. Physician notified and aware of diagnostics and lab results. Patients' needs met at the time patient does not voice any concerns currently.

Patient given acetaminophen once during shift, due to complaints of 1/10 pain for a headache. Patient in need of 2L of oxygen to stay within normal range for oxygen saturation.

Procedures/testing done: Patient had a chest x-ray as well as electrocardiogram done upon admission. Chest-Xray showed pulmonary congestion as well as cardiomegaly. Electrocardiogram showing atrial fibrillation with a rate of 88 bpm.

Complaints/Issues: Patient complained of 1/10 pain for headache acetaminophen administered to help decrease the pain. The patient needs 2L of oxygen to maintain within limits on oxygen saturation. Patient needed 2L of oxygen to maintain oxygen within normal limits. Upon admission it was also noted the patient was having trouble tolerating walking due to it aggravating her edema.

Vital signs (stable/unstable): Vital signs unstable presented hypertension of first blood pressure reading at 0700 reading of 152/68. At 1100 blood pressure decreased but still considered elevated reading at 138/62. Respiration counts elevated slightly at a reading of twenty-four breaths per minute both times vitals were assessed. The patient needs 2L of oxygen during her hospitalization.

Tolerating diet, activity, etc.: Patient diet is following as recommended of 1,000 mL fluid restriction per day. As well as to follow a heart failure diet with a limit of sodium intake. Patient had no problem tolerating the diet well she ate breakfast with tea and apple juice with fluids closely being monitored. Overall ambulating tolerance has improved since admission with the help of one assistant and a gait belt.

Physician notifications: Physician ordered a fluid restriction of 1,000 mL per day, daily weight checks, and strict intake and outputs.

Future for client: The patient will return to Oaks Manor Assisted Living Facility upon discharge. The plan is to follow a heart failure diet with low sodium and limit her fluid intake to 1,000 ml per day.

Discharge Planning (2 points)

Discharge location: Patient will return to Oaks Manor Assisted Living Facility upon discharge. As well as a visit from a care coach.

Home health needs (if applicable): Patient requesting a one-time visit from a care coach.

Equipment needs (if applicable): Patient may need oxygen depending on her status with her oxygen needs upon discharge.

Follow up plan: Patient will follow up with primary care provider one week upon discharge.

Education needs: Patient needs to be educated on the importance of watching her fluid intake to 1,000 mL per day. Components of a heart failure diet and low sodium diet and educating on why it is important to follow the diet plan. As well as recognizing symptoms earlier and knowing when to come to the hospital if edema, weight gain or any other heart failure symptoms occur such as shortness of breath.

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	**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

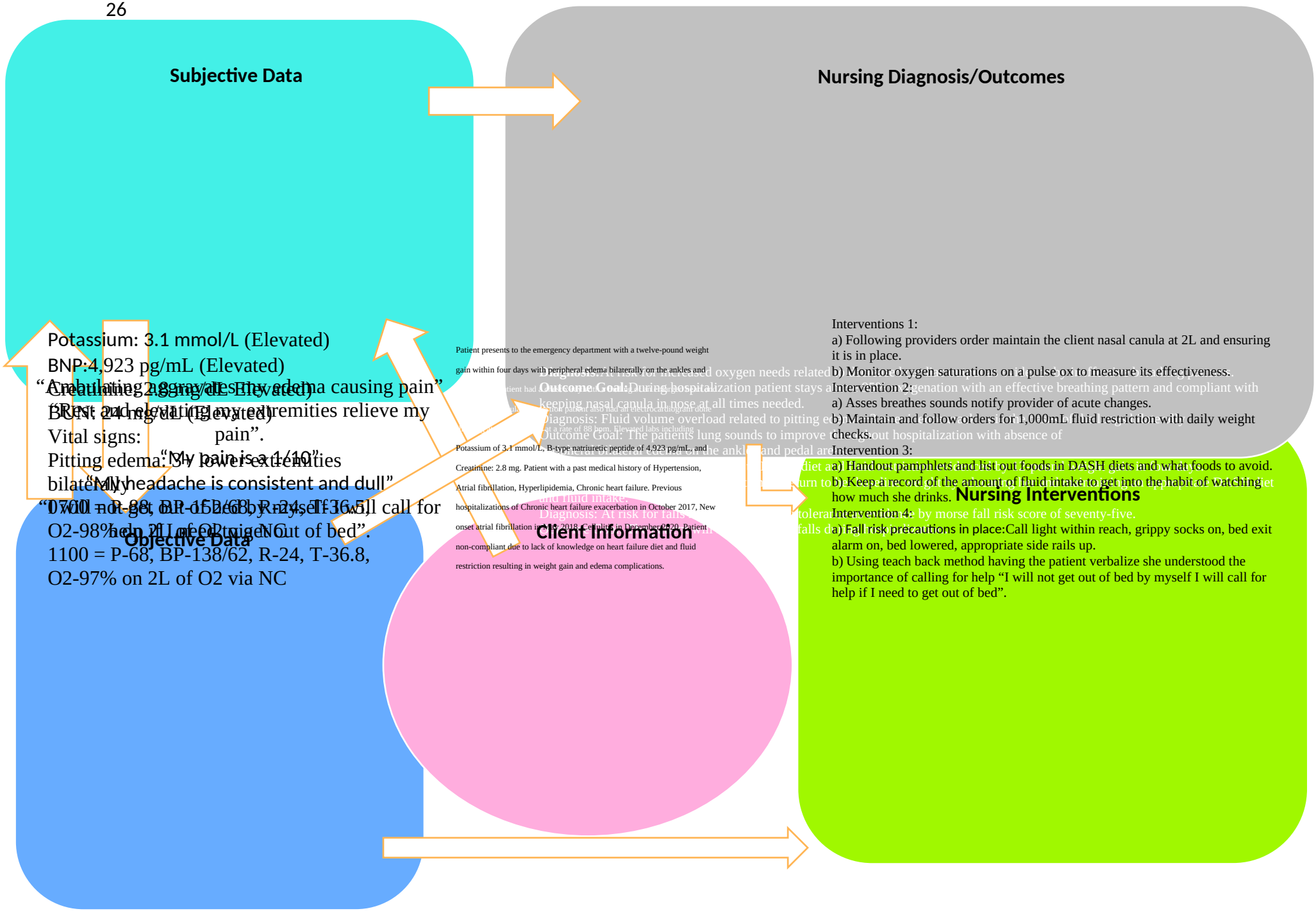
evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client				response, status of goals and outcomes, modifications to plan.
1. At risk for increased oxygen needs is related to decreased cardiac output as evidenced by ineffective breathing patterns.	This nursing diagnosis was chosen due to the patients' increased respiration of twenty-four breathes per minute causing ineffective breathing patterns. Also, no mention of prior use of oxygen needs at assisted living. Patient needing 2L nasal cannula to stay above 95% saturation reading.	**1.**Following providers order maintain the client nasal canula at 2L and ensuring it is in place. **2.**Monitor oxygen saturations on a pulse ox to measure its effectiveness.	**1. During** hospitalization, the patient stays above 95% oxygenation with an effective breathing pattern and compliant with keeping nasal canula in nose at all times needed.	The client agreed to wearing the nasal canula although at first, she seemed hesitant and seemed to think it was quite a hassle ambulating and getting used to wearing it all the time at the hospital. Expected outcome achieved as patient maintained 95% on nasal canula respiration decreased to twenty breaths per minute. The client responded eagerly hoping to soon be able to come off oxygen with improvement of her breathing patterns.
2. Fluid volume overload related to pitting edema +3 as evidence crackles in	This nursing diagnosis was chosen due to the patient presenting with +3 pitting edema,	**1.** Asses breathes sounds notify provider of acute changes. **2**.Maintain and follow orders for 1,000mL fluid restriction with daily weight	1.The patients lung sounds to improve throughout hospitalization with absence of peripheral bilateral edema on	The client was upset to find out she could not drink as many fluids as she would like she had a tough time adjusting to the fluid restriction but did eventually

the bases of the lungs bilaterally.	crackles in the bases of the lungs, and twelve-pound weight pain. These symptoms demonstrate fluid volume overload as well as the x-ray showing pulmonary vascular congestion.	checks.	the ankles and pedal areas.	understand the importance of following the providers' orders. Daily weight checks came easy to her as she does this at her assisted living facility. Outcomes were met as the patient learned to follow the providers orders, the edema slowly became absent and lung sounds cleared up with providers medications orders and attentive care provided.
3. Knowledge deficit related to DASH diet and fluid restriction as evidenced by 12-pound weight gain in four days.	This nursing diagnosis was chosen due to the patient showing a poor diet as evidenced by a twelve-pound weight gain and not knowing with chronic heart failure the importance on watching the intake of fluids.	1. Handout pamphlets and list out foods in DASH diets and what foods to avoid. **2.**Keep a record of the amount of fluid intake to get into the habit of watching how much she drinks.	**1.** The goal is for the patient to return to her baseline weight by educating her and maintaining an appropriate DASH diet and fluid intake.	The client was upset to learn she could not eat all the foods she wanted in the amounts that she would have liked. She had a challenging time coping with changing to a DASH diet with low sodium. Eventually the client communicated with the nurse and was given handouts for educational purposes. The client was content with the outcome as she returned to her baseline weight and kept a log of her fluid intake.

4. At risk for falls related to activity intolerance as evidence by morse fall risk score of seventy-five.	This nursing diagnosis was chosen due to the patient stating, “Ambulating aggravates my edema.” Potentially causing activity intolerance as she has 3+ pitting edema.	**1.** Fall risk precautions in place: Call light within reach, grippy socks on, bed exit alarm on, bed lowered, appropriate side rails up. **2.** Using teach back method having the patient verbalize she understood the importance of calling for help “I will not get out of bed by myself I will call for help if I need to get out of bed”.	**1.** The patient will remain free of falls during hospitalization**.**	The client understood why she needed assistance on ambulating she took the education very well. She pressed the call light each time she needed to get out of bed. The outcomes were met with no falls during the hospitalization.

Other References (APA): N/A

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Potassium: 3.1 mmol/L (Elevated)
BNP:4,923 pg/mL (Elevated)
Creatinine:2.8mg/dL (Elevated)
BUN: 24 mg/dL (Elevated)
Vital signs:
Pitting edema: 3+ lower extremities bilaterally
"0700 = P-88, BP-153/68, R-24, T-36.5, O2-98% on 2L of O2 via NC
1100 = P-68, BP-138/62, R-24, T-36.8, O2-97% on 2L of O2 via NC
"Ambulating makes my edema causing pain"
"Elevating my extremities relieve my pain".
"My pain is a 1/10"
"My headache is consistent and dull"
"I will not get out of bed by myself I will call for help if I need to get out of bed".
Objective Data
Patient presents to the emergency department with a twelve-pound weight gain within four days with peripheral edema bilaterally on the ankles and
Potassium of 3.1 mmol/L, B-type natriuretic peptide of 4,923 pg/mL, and Creatinine: 2.8 mg. Patient with a past medical history of Hypertension, Atrial fibrillation, Hyperlipidemia, Chronic heart failure. Previous hospitalizations of Chronic heart failure exacerbation in October 2017, New onset atrial fibrillation in May 2018, Cellulitis in December 2020. Patient non-compliant due to lack of knowledge on heart failure diet and fluid restriction resulting in weight gain and edema complications.
Client Information
Interventions 1:
a) Following providers order maintain the client nasal canula at 2L and ensuring it is in place.
b) Monitor oxygen saturations on a pulse ox to measure its effectiveness.
Intervention 2:
a) Asses breathes sounds notify provider of acute changes.
b) Maintain and follow orders for 1,000mL fluid restriction with daily weight checks.
Intervention 3:
a) Handout pamphlets and list out foods in DASH diets and what foods to avoid.
b) Keep a record of the amount of fluid intake to get into the habit of watching how much she drinks.
Intervention 4:
a) Fall risk precautions in place:Call light within reach, grippy socks on, bed exit alarm on, bed lowered, appropriate side rails up.
b) Using teach back method having the patient verbalize she understood the importance of calling for help "I will not get out of bed by myself I will call for help if I need to get out of bed".
Nursing Interventions