N431 Care Plan # 1

Lakeview College of Nursing

Shana Stanley

Demographics (3 points)

Date of Admission 2-23-23	Client Initials RD	Age 84	Gender M
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Widowed	Allergies None
Code Status DNR	Height 5'10"	Weight 236lb	

Medical History (5 Points)

Past Medical History: The patient has a history of CHF, atrial fibrillation, and frequent urinary tract infections due to urinary retention.

Past Surgical History: The patient has no surgical history noted in the chart or described by the patient.

Family History: The patient can't remember any family history, but could tell me that his father had a bad heart.

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): The patient informed me that he used to be a smoker for over 40 years with the use of at least one pack a day. He has since stopped and has been smoke-free for over 20 years now.

Assistive Devices:

The patient uses a walker for ambulation.

Living Situation:

The patient currently lives in an assisted living facility.

Education Level:

The patient graduated from high school and had trade training. He did not want to be specific about his trade.

Admission Assessment

Chief Complaint (2 points): Shortness of breath

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

The patient presented to the emergency department on 2-23-23 complaining of shortness of breath. The patient denies any extensive physical activity and said he was having a normal day. The patient indicated that his breathing issues started the evening before and was not elevated with rest. The patient denies pain while breathing and just finds it difficult to catch his breath.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): Atrial fibrillation

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

Congestive heart failure (CHF) is a condition in which the heart cannot pump enough blood to meet the body's needs. This results in a buildup of fluid in the lungs and other parts of the body. Congestive heart failure can lead to several conditions such as heart arrhythmias pulmonary congestion, and peripheral edema. Arrhythmias are abnormal heart rhythms that can be caused by various factors, including damage to the heart muscle or electrical conduction system. As the heart fails to pump properly peripheral edema can occur causing fluid retention in the extremities. Along with that fluid can start to build up in the lungs and cause shortness of breath(Capriotti, 2020). Heart arrhythmias are common in patients with CHF due to the constant need to supply blood to the body from a damaged heart(Hsu, n.d.).

This patient is currently experiencing shortness of breath, +2 edema, and is currently in atrial fibrillation. These are all signs of his current diagnosis of congestive heart failure.

Pathophysiology References (2) (APA):

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

Hsu, L.-F. (n.d.). Developments in the Management of Atrial Arrhythmias in Congestive Heart Failure. *Www.radcliffecardiology.com*. Retrieved March 2, 2023, from https://www.radcliffecardiology.com/articles/developments-management-atrial-arrhythmias-congestive-heart-failure#:~:text=Atrial%20arrhythmias%20and%20congestive%20heart

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	4.0-4.9 10^6/uL	**4.34 10^6/uL**	NA	**Normal range**
Hgb	12.0-16.0 g/dL	**13.9 g/dL**	NA	**Normal range**
Hct	37.0-48.0%	**43.1%**	NA	**Normal range**
Platelets	150-400 10^3/uL	**203 10^3/uL**	NA	**Normal range**
WBC	4.1-10.9 10^3/uL	**10.81 10^3/uL**	NA	**Normal range**
Neutrophils	1.50-7.70 10^3/uL	**8.60 10^3/uL**	NA	**Urinary tract infection can lead to an increase in neutrophil levels due to the infection process, this patient**

				has a history of chronic UTI's (Pagana et al., 2018).
Lymphocytes	1.00-4.90 10^3/uL	**10.3 10^3/uL**	NA	**Urinary tract infection can lead to an increase in lymphocytes levels due to the infection process, this patient has a history of chronic UTI's (Pagana et al., 2018).**
Monocytes	0.00-0.80 10^3/uL	**0.8 10^3/uL**	NA	**Normal range**
Eosinophils	0.00-0.50 10^3/uL	**1.0 10^3/uL**	NA	**Urinary tract infection can lead to an increase in eosinophils levels due to the infection process, this patient has a history of chronic UTI's (Pagana et al., 2018).**
Bands	**0.0-10.0%**	**NA**	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 mmol/L	**142 mmol/L**	NA	**Normal range**
K+	3.5-5.1 mmol/L	**3.8 mmol/L**	NA	**Normal range**
Cl-	98-107 mmol/L	**107 mmol/L**	NA	**Normal range**
CO2	21.0-32.0 mmol/L	**23 mmol/L**	NA	**Normal range**
Glucose	60-99 mg/dL	**89 mg/dL**	NA	**Normal range**
BUN	5-20 mg/dL	**19 mg/dL**	NA	**Normal range**
Creatinine	0.5-1.5 mg/dL	**0.86 mg/dL**	NA	**Normal range**
Albumin	3.4-5.4 g/dL	**3.2 g/dL**	NA	**This patient has chronic CHF, due to the lack of blood flow to the body the liver may not be functioning properly thus producing lower levels of albumin (Pagana et al., 2018).**

Calcium	8.5-10.1 mg/dL	**9.8 mg/dL**	NA	**Normal range**
Mag	1.6-2.6 mg/dL	**1.6 mg/dl**	NA	**Normal range**
Phosphate	-	**NA**	NA	
Bilirubin	0.1 to 1.2 mg/dL	**0.7**	NA	**Normal range**
Alk Phos	44-147 U/L	**61 U/L**	NA	**Normal range**
AST	**8-48**	**21**	NA	**Normal range**
ALT	**7-55**	**30**	NA	**Normal range**
Amylase	40-140	NA	NA	
Lipase	0-160	NA	NA	
Lactic Acid	4.5-19.8	NA	NA	
Troponin	0- 0.04	0.03	NA	
CK-MB	5-25	NA	NA	
Total CK	20-30	NA	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	0.8-1.1	NA	NA	
PT	11-13.5	NA	NA	
PTT	25-35	NA	NA	
D-Dimer	< 1	NA	NA	
BNP	< 100	NA	NA	

HDL	< 40-50	NA	NA	
LDL	< 100	NA	NA	
Cholesterol	< 200	NA	NA	
Triglycerides	< 150	NA	NA	
-Hgb A1c	< 5.7%	NA	NA	
TSH	0.5-5.0	NA	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		NA	Pending	
pH	5.0-7.0	NA	Pending	
Specific Gravity	**1.003-1.030**	NA	Pending	
Glucose	**Negative**	NA	Pending	
Protein	**Negative**	NA	Pending	
Ketones	**Negative**	NA	Pending	
WBC	0-25/uL	NA	Pending	
RBC	0-20/uL	NA	Pending	
Leukoesterase	**Negative**	NA	Pending	

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

Test	Normal	Value on	Today's	Explanation of Findings

	Range	Admission	Value	
pH	-	NA	NA	
PaO2	-	NA	NA	
PaCO2	-	NA	NA	
HCO3	-	NA	NA	
SaO2	-	NA	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	-	NA	NA	
Blood Culture	-	NA	NA	
Sputum Culture	-	NA	NA	
Stool Culture	-	NA	NA	

Lab Correlations Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). ***Mosby's Diagnostic and Laboratory Test Reference*** **(14th ed.). Mosby.**

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

EKG- An EKG was performed on the patient and it was found that the patient was maintaining his atrial fabulation status.

ECHO: Left, ventricular systolic function is severely reduced, estimated ejection fraction is 25-30%. Compared to the prior echo from 4/20/22, EF is down from 40%, and severe global hypokinesis of the left ventricle is present.

Diagnostic Test Correlation (5 points): All this correlates with the lab work, vital signs, and past medical history. The EKG and the ECHO are in correlation with the findings in CHF manifestations.

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

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

Home Medications (5 required)

Brand/Generic	**Acetaminophen (Tylenol)**	**Lactobacillus**	**loratadine (Claritin)**	**furosemide (Lasix)**
Dose	**65mg**	**1 capsule**	**10 mg**	**40 mg**
Frequency	**Q6hr**	**Daily**	**Daily PRN**	**Daily AM**
Route	**Oral**	**Oral**	**Oral**	**Oral**
Classification	**Antipyretic**	**Gastrointestinal, Herbals**	**Pharmacologic: CNS H1-receptor Therapeutic: Antihistamine**	**Pharmacologic: Loop diuretic Therapeutic: Anti-hypertensive**

Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.**	**Inhibiting or decreasing the growth of harmful microorganisms in the gut by producing lactic acid.**	**Binds to H1 histamine receptors found on endothelial cells and vascular smooth muscle to prevent or reduce histamine mediated symptoms (Jones & Bartlett, 2020).**	**Inhibits sodium and water reabsorption and increases urine formation. By reducing intracellular and extracellular fluid, the drug decreases blood pressure and cardiac output (Jones & Bartlett, 2020).**
Reason Client Taking	**Pain management**	**Supplement**	**To manage symptoms of allergic rhinitis.**	**To reduce edema caused by heart failure.**
Contraindications (2)	**Hypersensitivity to acetaminophen, hepatic impairment**	**Hypersensitivity to lactose or milk.**	**Hyper-sensitivity to loratadine or its components.**	**Anuria and hyper-sensitivity to furosemide or its components.**
Side Effects/Adverse Reactions (2)	**Hypotension, Stridor**	**Tachycardia Hives, itching, or rash.**	**Irregular heartbeat and dizziness.**	**Arrhythmias and hemolytic anemia.**
Nursing Considerations (2)	**Monitor intake of APAP as other drugs may contain it also and monitor renal function.**	**Monitor for allergic reactions. Ask Dr. about possible side effects.**	**Monitor respiratory especially with asthmatic or chronic bronchitis patients. Be aware of medication interaction with CNS depressants.**	**Monitor patient's weight before and during furosemide treatment. Be aware that the drug can worsen left ventricular hypertrophy.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**AST and ALT, creatinine levels.**	**Monitor for allergic reactions, and keep records of bowl movements**	**Assess respiratory status for tightness or wheezing.**	**Monitor BP and hepatic/renal function. Labs: BUN, blood**

				glucose, creatinine, and electrolytes.
Client Teaching Needs (2)	**Educate on not exceeding recommended dose and S/S of hepatotoxicity.**	**Educate on not exceed recommended dose. If a dose is missed take as soon as possible, but not if it is time for the next dose.**	**Advise the patient about daytime drowsiness. Can be taken in the AM or PM.**	**Take at the same time every day and advise the patient to move slowly to prevent orthostatic hypotension.**

Hospital Medications (5 required)

Brand/Generic	**Nystatin**	**Amiodarone**	**Furosemide**	**Hydrocodone**	**Alum-mag hydroxide**
Dose	**Powder**	**200mg**	**40mg tab**	**325mg tab**	**30ml**
Frequency	**X2 Daily**	**daily**	**Once a day**	**prn**	**prn**
Route	**Topical**	**oral**	**oral**	**oral**	**oral**
Classification	**antifungal**	**Antiarrhythmic**	**Loop diuretic**	**opioid**	**Antacid**
Mechanism of Action	**Binds to sterols in fungal cell membranes impairing membrane integrity.**	**Acts on the cardiac cell membrane prolonging repolarization and the refractory period**	**Inhibits sodium and water reabsorption in the loop of Henle.**	**Bind to and activates opioid receptors to produce pain relief.**	**Neutralizes or reduces gastric acidity**
Reason Client Taking	**Fungal infection**	**Hist of A-fib**	**hypertension**	**Leg pain**	**GI upset**
Contraindications (2)	**Skin sensitivity**	**Bradycardia SA node dysfunction**	**Anuria Hypersensitivity to furosemide.**	**Bronchial asthma Hypersensitivity**	**Hypersensitivity to aluminum only one shown**

				to hydrocodone.	**in book**
Side Effects/Adverse Reactions (2)	**Irritation Oral form may cause vomiting**	**Anxiety Confusion Bradycardia**	**Dizziness Vertigo arrhythmias**	**Anxiety CNS depression**	**Encephalopathy Constipation**
Nursing Considerations (2)	**Keep area dry Keep away from eyes**	**Check for pacemaker and review settings Use inline filter during IV administration**	**Obtain pt weight before giving drug Should be given in the morning as to not interrupt pt sleep.**	**Hydrocodone increases the risk of addiction. Should not be given to a client with impaired consciousness.**	**Don't give within 1-2hrs of other oral drugs Monitor serum levels**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Asses the area of irritation for openings, be sure that the affected area is clean before applying**	**Monitor blood pressure and apical pulse prior to administration. Liver function should be checked.**	**Monitor BP and hepatic/renal function. Labs: BUN, blood glucose, creatinine, and electrolytes.**	**Asses pain levels before administering and check BP if the patient is known to have low BP.**	**Assess the patient for any signs of acid-base or electrolyte imbalance. Assess for gastrointestinal complaints, such as nausea, vomiting and constipation.**
Client Teaching Needs (2)	**Keep the affected area clean and dry, do not use on the face.**	**Monitor for signs of allergic reactions, and avoid prolonged exposure to sunlight.**	**Take at the same time every day and advise the patient to move slowly to prevent orthostatic hypotension.**	**Take as directed and do not exceed the daily amount. Watch for signs of allergic reaction.**	**Take between meals or at bed time, take with full 8oz glass of water.**

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). ***2021 Nurse's Drug Handbook*** **(19th ed.). Jones & Bartlett Learning**

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient appears alert and oriented to person, place, and time.** **The patient is well-groomed and seems to be in no acute distress unless ambulating.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 19** **Drains present: Y☐ N ☒** **Type:**	**Skin color was pink, warm, and dry upon palpation.** **No rash, lesions, and some ecchymosis visible. Nails show no clubbing or cyanosis. Skin turgor is slow.** **Capillary refill was 3 + second range.** **The patient had wounds on the left knee and shin as well as the right shin.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head & Neck: Are symmetrical, trachea is midline without deviation. Bilateral pulses are palpable and 2+. No note nodules.** **Ears: Are symmetrical. No lesions, deformities, or lumps. Patient's hearing was fairly decreased.** **Eyes: Bilateral sclera red, corneas clear, conjunctiva pink/dark pink, visible drainage bilaterally. PERRLA bilaterally, EOMs intact/slowed.** **Nose: Septum is midline, turbinates are pink and moist bilaterally. No visible bleeding. Frontal sinuses are non-tender.** **Teeth: Oral mucosa is pink and moist. Patient had dentures.**

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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:**	. **Clear S1 and S2 heard without gallops or rubs. Peripheral pulses are palpable but weak. Capillary refill is more than 3sec. Edema was noted in both lower legs. Pt is in Atrial fibrillation. ECG monitoring on Lead II, alarms are on.**
RESPIRATORY: **Accessory muscle use: Y☒ N ☐** **Breath Sounds: Location, character**	Normal rate and pattern of respirations. Respirations are not symmetrical and are labored. **Lung sounds are heard throughout with noted wheezing and crackles.**
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 ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	**Patient has a normal diet with a good appetite. Hypoactive bowel sounds, patient's last bowel movement was 2 days ago.** **No distention, incisions, scars, drains, or wounds.**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: indwelling** **Size: 20**	**Patient had cloudy/ dark yellow urine and produced 800ml during the clinical shift.**

MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment x☐** **Needs support to stand and walk x☐**	**Lower extremities have limited ROM due to generalized weakness and pain. Hand grips demonstrate equal and normal strength. Pedal pushes are weak but equal in strength. Gait is not well balanced. the patient requires assistance with ambulation. The patient is alert and oriented to person, place, and time. PERRLA intact. Cranial nerves are intact. The patient is currently a one assist with a walker gait belt when out of bed.**
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient is spontaneous to stimuli, obeys commands, and A&Ox4. Strength is normal and equal in the upper extremities but equal and weakened in lower extremities. Mental status, speech, sensory, and LOC are all intact.
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):**	Ego Integrity vs. Despair (65+) **The patient is calm and cooperative. He is religious. He has a daughter that stays with him during the day at the hospital, this helps him.**

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0915	**118**	**120/69**	**20**	**98.8 oral**	**93% on nasial canula**
1145	**120**	**128/64**	**20**	**98.7 oral**	**96 % on nasial canula**

Vital Sign Trends:

While the vital signs in my chart look like there are not any trends, the patient's blood pressure does tend to stay in the higher numbers. The patient required frequent BP reassessment.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0915	**1-10**	**NA**	**0**	**NA**	**NA**
1145	**1-10**	**NA**	**0**	**NA**	**NA**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22G **Location of IV: Right, anterior forearm** **Date on IV: 2-25-23** **Patency of IV: good** **Signs of erythema, drainage, etc.: no** **IV dressing assessment: intact**	**Flushed and Saline locked**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
300ml	**800ml**

Nursing Care

Summary of Care (2 points)

Overview of care: I was able to provide medication, wound dressing, and ambulation with the nurse. We were able to walk around the room per the family's request and the patient allowed me to order his lunch before I left.

Procedures/testing done: No procedures or testing was done today while I was there.

Complaints/Issues: The patient had no complaints.

Vital signs (stable/unstable): Vital signs were stable except for his blood pressure. His BP was higher than normal throughout the day which required frequent BP checks.

Tolerating diet, activity, etc.: the patient tolerated activity well and ate as much as he could.

Physician notifications: no notifications

Future plans for the client: the current plan for this client is to see physical therapy to maintain his existing mobility, and to be medication compliant.

Discharge Planning (2 points)

Discharge location: possible high acuity nursing facility

Home health needs (if applicable): NA

Equipment needs (if applicable): patient will need a walker and portable oxygen tanks.

Follow up plan: No follow-up plans put in place at this time.

Education needs: Patient needs education on self-care/health promotion and coping.

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

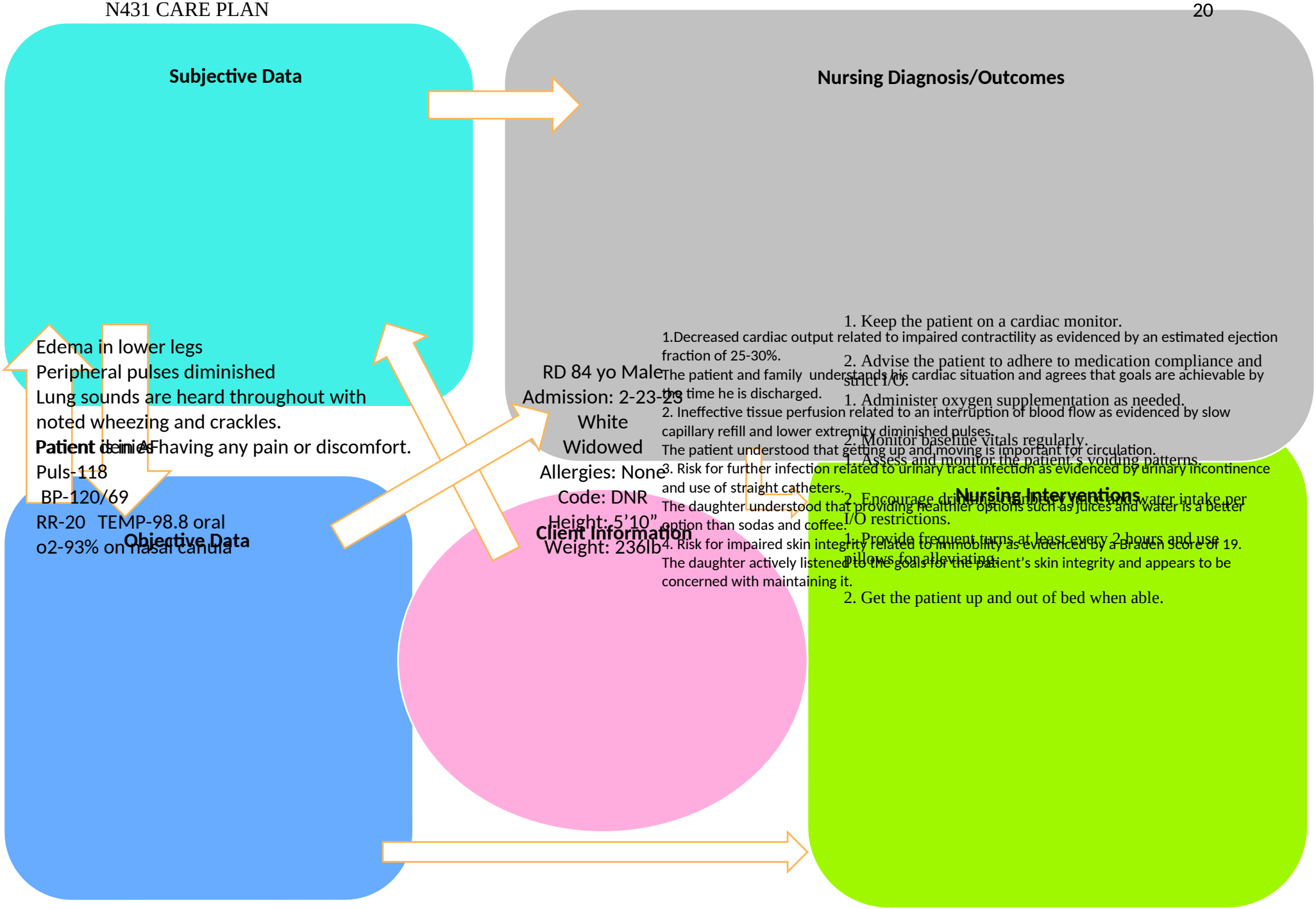
Nursing Diagnosis • Include full nursing diagnosis with "related to" and	**Rationale** • Explain why the nursing diagnosis	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's

"as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	was chosen			actions? • Client response, status of goals and outcomes, modifications to plan.
1. Decreased cardiac output related to impaired contractility as evidenced by an estimated ejection fraction of 25-30%.	**I chose this for my priority because the heart is only pumping 25-30% of its capacity.**	**1. Keep the patient on a cardiac monitor.** **2. Advise the patient to adhere to medication compliance and strict I/O.**	**1. The patient demonstrates adequate fluid intake and medication compliance by discharge.**	**The patient and family understands his cardiac situation and agrees that goals are achievable by the time he is discharged.**
2. Ineffective tissue perfusion related to an interruption of blood flow as evidenced by slow capillary refill and lower extremity diminished pulses.	**I chose this as second priority because the heart is no longer able to provide the body with the needed blood supplies.**	**1. Administer oxygen supplementation as needed.** **2. Monitor baseline vitals regularly.**	**1. The patient will maintain his mobility in order to promote blood flow to the lower extremities.**	**The patient understood that getting up and moving is important for circulation.**
3. Risk for further infection related to urinary tract infection as evidenced by urinary incontinence	**I chose this as my third priority because this patient has a history of infection and is at risk for furthering**	**1. Assess and monitor the patient's voiding patterns.** **2. Encourage drinking cranberry juice and water**	**1. The client will achieve a normal urinary elimination pattern of 30 mL/hr.**	**The daughter understood that providing healthier options such as juices and water is a better option than sodas and coffee.**

and use of straight catheters.	**that infection with the practice of straight cathing.**	**intake per I/O restrictions.**		
4. Risk for impaired skin integrity related to immobility as evidenced by a Braden Score of 19.	**I chose this as my 4th priority because the patient has multiple sores and his mobility has declined.**	**1. Provide frequent turns at least every 2 hours and use pillows for alleviating.** **2. Get the patient up and out of bed when able.**	**1. The reduction of prolonged pressure on the skin for long periods of time will help prevent further sores from forming.**	**The daughter actively listened to the goals for the patient's skin integrity and appears to be concerned with maintaining it.**

Other References (APA): Linda Lee Phelps, & Sheila Sparks Ralph. (2018). *Sparks & Taylor's nursing diagnosis pocket guide*. Wolters Kluwer.

Concept Map (20 Points):


Subjective Data
Edema in lower legs
Peripheral pulses diminished
Lung sounds are heard throughout with noted wheezing and crackles.
Patient denies having any pain or discomfort.
Objective Data
Puls-118
BP-120/69
RR-20 TEMP-98.8 oral
o2-93% on nasal canula
Client Information
RD 84 yo Male
Admission: 2-23-23
White
Widowed
Allergies: None
Code: DNR
Height: 5'10"
Weight: 236lb
Nursing Diagnosis/Outcomes
1.Decreased cardiac output related to impaired contractility as evidenced by an estimated ejection fraction of 25-30%.
The patient and family understands his cardiac situation and agrees that goals are achievable by the time he is discharged.
2. Ineffective tissue perfusion related to an interruption of blood flow as evidenced by slow capillary refill and lower extremity diminished pulses.
The patient understood that getting up and moving is important for circulation.
3. Risk for further infection related to urinary tract infection as evidenced by urinary incontinence and use of straight catheters.
The daughter understood that providing healthier options such as juices and water is a better option than sodas and coffee.
4. Risk for impaired skin integrity related to immobility as evidenced by a Braden score of 19.
The daughter actively listened to the goals for the patient's skin integrity and appears to be concerned with maintaining it.
Nursing Interventions
1. Keep the patient on a cardiac monitor.
2. Advise the patient to adhere to medication compliance and strict I/O.
1. Administer oxygen supplementation as needed.
2. Monitor baseline vitals regularly.
1. Assess and monitor the patient's voiding patterns.
2. Encourage drinking fluids and water intake per I/O restrictions.
1. Provide frequent turns at least every 2 hours and use pillows for alleviating.
2. Get the patient up and out of bed when able.