N311 Care Plan 1

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N311: Foundations of Professional Practice

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February 15, 2025

Demographics

Date of Admission	Client Initials	Age	Biological Gender
01/31/2025	DW	75 years old	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Married	-Metformin -Semaglutide -Empagliflozin
Code Status	**Height**	**Weight**	
Full Code	177.8cm (5:10”)	57.9 kg (127 lb)	

Medical History

Past Medical History: Afib (CMS-HCC), Anemia unspecified, Bilateral pleural effusion, chronic heart failure (CMS-HCC), Cognitive cardiac failure (CMS-HCC), Chronic anticoagulation, Diabetes mellitus (CMS-HCC), HTN, Hypoxia, NSTEMI (Non- ST elevated myocardial infraction) (CMS-HCC), Pneumonia unspecified organism, stage iii chronic kidney disease (CMS-HCC)

Past Surgical History: Coronary angiography, Coronary artery bypass graft, ERCP, Ilio-Femoral bypass graft left, IR cholecystostomy tube placement right, IR US Abdomen, left heart catheterization.

Family History: N/A

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

Never smoked, alcohol not currently drinking, drugs N/A

Education: High School Graduate

Living Situation: Lives with wife, has two daughters (one married with two grandchildren, one unmarried)

Assistive devices: Note Reported

Admission Assessment

Chief Complaint: Shortness of breath and weakness.

History of Present Illness (HPI)– OLD CARTS:

Onset: Progressive shortness of breath beginning after CABG procedure

Location: Pulmonary region with recurrent pleural effusions

Duration: Recurrent since CABG, with 5 documented pleural effusions

Characteristics: Dyspnea, weakness, and persistent pleural infiltrates

Aggravating Factors: Physical activity, fluid accumulation

Relieving Factors: Paracentesis (last performed 01/29 with removal of 1.2L)

Timing: Persistent with worsening over time

Severity: Described as uncomfortable but no pain reported

The patient was admitted on 01/31/2025 after experiencing persistent shortness of breath and weakness. He has a history of multiple pleural effusions following CABG surgery with left atrial appendage clip placement in October 2024. His most recent paracentesis removed 1.2L of fluid. He also has a history of pneumonia, chronic heart failure, and chronic kidney disease. He was previously treated for pneumonia and pulmonary edema in December 2024 with antibiotics and diuretics. On admission, he was initially on 4L nasal cannula, later switched to high-flow nasal cannula for oxygen support.

Primary Diagnosis

Primary Diagnosis on Admission: Recurrent pleural effusion with underlying congestive heart failure and pulmonary complications

Secondary Diagnosis (if applicable): Norovirus

Pathophysiology

Pathophysiology of the Disease, APA format:

Recurrent pleural effusion identified by a non-normal accumulation of fluid in the pleural space, the thin, fluid-filled cavity between the lungs and the chest wall. This condition is often associated with underlying cardiovascular and pulmonary diseases, such as congestive heart failure (CHF). In this patient, the pleural effusion is linked Recurrent pleural effusion is by an abnormal accumulation of fluid in the pleural space, which is the thin, fluid-filled cavity between the lungs and the chest wall. This condition is often associated with underlying cardiovascular and pulmonary diseases, such as congestive heart failure (CHF). In this patient, the pleural

effusion is linked to heart failure with preserved ejection fraction (HFpEF) and a history of coronary artery bypass graft (CABG) surgery (McCance & Huether, 2022).

The pathophysiology involves increased hydrostatic pressure within the pulmonary capillaries due to left ventricular diastolic dysfunction. This elevated pressure forces fluid into the pleural space, leading to symptoms such as dyspnea and impaired gas exchange. Additionally, recurrent pulmonary infections, like pneumonia, and the resulting inflammatory response can increase capillary permeability, further contributing to pleural fluid accumulation (McCance & Huether, 2022; American Heart Association, 2023).

Treatment focuses on addressing the underlying cause of the condition. In this patient's case, diuretic therapy (Lasix) was used to reduce fluid overload, along with antibiotics (Zosyn, doxycycline) to manage any infections. Paracentesis may also be conducted to drain excess fluid and relieve symptoms; however, the patient has experienced multiple recurrences. It is important to monitor oxygen levels and optimize cardiovascular function to prevent complications such as respiratory failure (McCance & Huether, 2022; American Heart Association, 2023).to heart failure with preserved ejection fraction (HFpEF) and a history of CABG surgery (McCance & Huether, 2022). The pathophysiology involves increased hydrostatic pressure within the pulmonary capillaries due to left ventricular diastolic dysfunction. This increased pressure forces fluid into the pleural space, causing dyspnea and impaired gas exchange. Additionally, recurrent pulmonary infections, such as pneumonia, and the inflammatory response contribute to increased capillary permeability and pleural fluid accumulation (McCance & Huether, 2022; American Heart Association, 2023).

Treatment involves addressing the underlying cause, as seen in this patient's case with diuretic therapy (Lasix) to reduce fluid overload and antibiotics (Zosyn, doxycycline) to manage

infection. Paracentesis is performed to drain excess fluid and alleviate symptoms, though the patient has experienced multiple recurrences. Monitoring oxygen levels and optimizing cardiovascular function are essential to prevent complications like respiratory failure (McCance & Huether, 2022; American Heart Association, 2023).

Pathophysiology References (2) (APA):

- McCance, K. L., & Huether, S. E. (2022). *Pathophysiology: The biologic basis for disease in adults and children* (9th ed.). Elsevier.
- American Heart Association. (2023, January 5). *Pleural effusion and heart failure*. https://www.heart.org

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen SAT	Oxygen Delivery Method
8: 00 AM	56 bpm	96/37	16 bpm	97.5 °F	91%	Nasal cannula

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
11: 00 AM	0/10	N/A	N/A	N/A	N/A