

N321 CARE PLAN #2

Bailey McMasters

Lakeview College of Nursing

N321: Adult Health I

Kristal Henry

March 28, 2025

Demographics

Date of Admission 03/14/25	Client Initials RC	Age 72	Biological Gender Male
Race/Ethnicity White/Caucasian	Occupation Retired on disability	Marital Status Married	Allergies Augmentin (Amoxicillin-pot Clavulanate), Trazodone
Code Status Full Code	Height 5' 10"	Weight 113.1 Kg	

Medical History

Past Medical History: Atrial fibrillation (HCC), Gout, Hyperlipidemia, Hypertension, and Sleep apnea

Past Surgical History: Appendectomy, back surgery, shoulder surgery, sinus surgery, cyst removal (09/09/2019), colonoscopy (06/14/2018), colonoscopy (03/03/2022), cataract removal with implant (right, 04/16/2024), and cataract removal with implant (left, 04/30/2024)

Family History: There is a family history of colon cancer in his maternal grandmother and mother.

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

The patient has never vaped or used alcohol. The patient has also never used drugs and is not currently sexually active. The patient is a former cigarette smoker (2 packs a day, 15 years, 30 packs/year, quit in 2000, 25 years since quitting). The patient has never used smokeless tobacco.

Education: The patient's highest level of education is 2 ½ years of junior college.

Living Situation: The patient lives at home with his wife.

Assistive devices: The patient does not use any assistive devices.

Admission History

Chief Complaint: Worsening shortness of breath and leg swelling.

History of Present Illness (HPI)– OLD CARTS

The patient presented to his primary care provider after feeling “more out of breath than normal”. The patient stated, “I had been noticing I was getting tired and more out of breath easier when doing my day-to-day activities”. The patient was able to recall feeling a worsening of shortness of breath “about a week before going to the doctor”. The patient mentioned, “my doctor's first idea was that I had a sinus infection”. Upon assessment at the patient's primary care office, he was found to be hypoxic, and he was transferred to the OSF emergency department via ambulance. The patient was admitted to OSF hospital March 14, 2025. When asking further about symptoms experienced, the patient stated, “I had this cough. It felt like I needed to cough something up, but nothing ever came up”. The patient was also found to have edema on his lower extremities. The patient stated, “I tried to keep my legs elevated, but the swelling never went away”. When patient was asked about when he first noticed the edema, he stated, “I don't really remember, this was about two weeks ago”. When asked about relieving and aggravating factors to his shortness of breath, he stated, “I would become out of breath when I would do my daily activities. The only thing I did to help me catch my breath was sit down for a few minutes”. The patient's provider at OSF hospital put the patient on oxygen via nasal cannula at 4L. The patient stated, “I kept putting off getting oxygen, I thought I would be fine without it”.

Admission Diagnosis

Primary Diagnosis: Acute on chronic diastolic congestive heart failure

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

Pathophysiology

When determining heart failure, there are many different distinctions that can describe the specific issue of the heart. It is also important to determine whether heart failure is classified as acute or chronic, as these result from different complications. In this particular patient, he was diagnosed with acute on chronic diastolic congestive heart failure. Acute heart failure is the sudden or rapid onset of heart failure (Capriotti, 2024). Chronic heart failure is described as when the heart is slowly weakened over a continuous period of time (Capriotti, 2024). The patient was diagnosed as “acute on chronic” due to the primary diagnosis being added on top of his past diagnosis of atrial fibrillation. Diastolic dysfunction of the left ventricle often occurs as a result of ventricle experiencing an increase in stiffness or a decrease in relaxation (Capriotti, 2024). Diastolic dysfunction is mainly caused by hypertension, as this increased the resistance of blood within the left ventricle (Capriotti, 2024). Furthermore, the causes hypertrophy of the left ventricle since it is trying to keep up with the increased blood flow (Capriotti, 2024). Enlargement of the left ventricle leads to less blood flow into the ventricle, resulting in decreased cardiac output into the aorta (Capriotti, 2024).

The resulting decreased cardiac output stimulates the activation of the renin-angiotensin-aldosterone system, or RAAS (Malik & Chhabra, 2023). This activation of the RAAS increases vasoconstriction, retention of salt and water, and the release of angiotensin II (Malik & Chhabra, 2023). Angiotensin II is known to increase cellular hypertrophy of the cardiac cells, leading to

further cardiomegaly (Malik & Chhabra, 2023). As the patient has been previously diagnosed with hypertension, increased vasoconstriction is a severe complication caused by congestive heart failure.

Clinical manifestations of congestive heart failure include chest pain, dyspnea, exertional fatigue, ascites, and lower extremity edema (Malik & Chhabra, 2023). Chest pain and dyspnea are due to developed pulmonary edema. Pulmonary edema is caused by hydrostatic pressure forcing fluid extravasation within interstitial spaces (Capriotti, 2024). This can also result in the patient experiencing a cough and crackles to be heard in the lower lobes of the lungs (Capriotti, 2024). Due to the difficulty in breathing these manifestations cause, this leads to exertional fatigue due to the lack of oxygen intake. Ascites and lower extremity edema are caused by the body's retention of water and sodium due to the activation of the RAAS. The signs and symptoms that relate to my patient are dyspnea, exertional fatigue, ascites, lower extremity edema, cough, and crackles in the lungs. Although ascites was not found upon my assessment of the client, he reported that swelling within his abdomen is what resulted in the hernia that appears on the lower right quadrant of his abdomen. My patient presented to the ER with shortness of breath and lower extremity swelling. The patient expressed that he would experience dyspnea upon exertion and that he developed a nonproductive cough. Lastly, the patient was found to have crackles within the lower lobes of the bilateral lungs upon auscultation.

The diagnosis was made for my client based on his B-type Natriuretic peptide lab, hyponatremia, chest x-ray, and chest computed tomography. The B-type Natriuretic peptide lab shows when the myocardium has secreted B-type Natriuretic peptide, or BNP, in response to an excessive blood volume that stretches the ventricle (Capriotti, 2024). Hyponatremia is caused by serum sodium being diluted by increased water due to retention (Capriotti, 2024). The chest x-

ray was able to find cardiomegaly caused by left ventricular hypertrophy, as well as pulmonary edema from fluid retention (Capriotti, 2024). The chest computed tomography was used to find signs that suggested fluid overload within the patient.

Treatment for this heart failure includes diet changes, beta blockers, and ACE inhibitors (Capriotti, 2024). My patient's treatment included a cardiac diet, as well as several medications pertaining to his cardiovascular complications. My patient was prescribed carvedilol (Coreg) and empagliflozin (Jardiance). These medications are the help improve the symptoms of heart failure and decrease the risk of cardiac mortality. Also prescribed was acetazolamide (Diamox) and budesonide-formoterol fumarate (Symbicort). Diamox is a diuretic to help relieve the patient's fluid overload and Symbicort is to help the patient breathe easier, both resulting from the complications of congestive heart failure.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Pathophysiology Introductory Concepts and Clinical Perspectives* (3rd ed.).

F.A. Davis.

Malik, A., & Chhabra, L. (2023). *Congestive Heart Failure*. StatPearls.

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
Sodium	131 mmol/L	137 mmol/L	136-145 mmol/L	Hyponatremia is most likely caused by the patient's primary diagnosis of congestive heart failure. Other

				<p>possibly causes could be ascites or peripheral edema caused by the patient's fluid overload. Hyponatremia could also be caused by the use of diuretics. The increasing trend could be due to the patient's ascites and peripheral edema improving. It could also be because of the provider holding the patient's diuretics due to his kidney function (Pagana et al., 2023).</p>
Potassium	5.4 mmol/L	4.0 mmol/L	3.5-5.1 mmol/L	<p>Hyperkalemia could possibly be from the patient's home medication, spironolactone. This is because spironolactone is an aldosterone-</p>

				<p>inhibiting diuretic that can increase potassium levels. The trend decreases most likely because the provider issued a hold on the patient's diuretics due to the patient's kidney function (Pagana et al., 2023).</p>
Chloride	96 mmol/L	93 mmol/L	98-107 mmol/L	<p>Hypochloremia is most likely due to the client's primary diagnosis of congestive heart failure. Other possibilities could be the patient's diuretic therapy, metabolic alkalosis, or fluid overload. The trend decreases most likely because of the worsening of one of the client's conditions (Pagana et al.,</p>

				2023).
CO2, venous	23 mmol/L	33 mmol/L	22-30 mmol/L	Increased CO2, venous levels are possibly due to metabolic alkalosis as this can be caused by dehydration. The trend increases mostly likely from the fluid restriction that was placed on the patient in the hospital causing the patient to become dehydrated (Pagana et al., 2023).
BUN	53 mg/dL	38 mg/dL	8-26 mg/dL	Elevated BUN levels are most likely caused by the patient's primary diagnosis of congestive heart failure. Another possible cause could be that the patient is dehydrated due to fluid restriction the provider has ordered. Also, the

				<p>levels may be increased due to the patient's home medications. These include allopurinol, furosemide, and spironolactone. The trend could be decreasing due to the patient experiencing fluid overload. It could also be decreasing because the patient's provider held the patient diuretics due to the patient's kidney function (Pagana et al., 2023).</p>
Creatine, blood	1.70 mg/dL	1.01 mg/dL	0.70-1.30 mg/dL	<p>Elevated Creatine, blood levels could be caused by the patient's primary diagnosis of congestive heart failure. The trend decreases most likely from the patient's</p>

				condition improving (Pagana et al., 2023).
GFR, Estimated	42	>60	>=60	Decreased GFR, estimated could be caused by the patient's primary diagnosis of congestive heart failure. This is due to the diagnosis affecting the function of the kidneys. The trend increases most likely due to the patient's condition improving (Pagana et al., 2023).
BUN/Creatine ratio	31 ratio	38 ratio	12-20 ratio	The BUN/Creatine ratio is elevated most likely due to the patient's primary diagnosis of congestive heart failure. This can also cause fluid overload which can influence BUN/Creatine

				ratios. The trend decreases most likely due to the patient experiencing dehydration due to being placed on a fluid restriction (Pagana et al., 2023).
GFR, Est. Nonafrikan	40	>60	>=60	Decreased GFR, estimated could be caused by the patient's primary diagnosis of congestive heart failure. This is due to the diagnosis affecting the function of the kidneys. The trend increases most likely due to the patient's condition improving (Pagana et al., 2023).
GFR, Est. African	48	>60	>=60	Decreased GFR, estimated could be

				<p>caused by the patient's primary diagnosis of congestive heart failure. This is due to the diagnosis affecting the function of the kidneys. The trend increases most likely due to the patient's condition improving (Pagana et al., 2023).</p>
B Type Natriuretic Peptide	1427 pg/mL	N/A	<100 pg/mL	<p>Increased B Type Natriuretic Peptides are most likely due to the client's primary diagnosis of congestive heart failure. This is caused by the stretching of the ventricle due to increased fluid volume (Pagana et al., 2023).</p>
Hemoglobin (HGB)	17.2 g/dL	N/A	13.0-16.5 g/dL	<p>Elevated hemoglobin levels could possibly be</p>

				caused by the patient's primary diagnosis of congestive heart failure or if the patient is dehydrated (Pagana et al., 2023).
Hematocrit	52.4%	N/A	38.0-50.0%	Elevated hematocrit levels are most likely caused by the patient being dehydrated (Pagana et al., 2023).
MCV	96.5 fL	N/A	82.0-96.0 fL	Elevated MCV, mean corpuscular volume, can be caused by the patient experiencing vitamin B12 or folic acid deficiency (Pagana et al., 2023).
RDW	16.0%	N/A	11.8-15.5%	Elevated RDW, red blood cell distribution width, can be caused by the patient experiencing vitamin B12 or folic acid

				deficiency (Pagana et al., 2023).
Neutrophils	74.4%	N/A	40.0-68.0%	Neutrophilia could most likely be caused by the patient's past medical history of gout (Pagana et al., 2023).
Lymphocytes	7.4%	N/A	19.0-49.0%	Lymphocytopenia could possibly be caused by the patient's use of diuretics, as this can decrease lymphocyte levels (Pagana et al., 2023).
Monocytes	16.2%	N/A	3.0-13.0%	Monocytosis could possibly be caused by the patient's use of the medication, allopurinol, as this can increase monocyte levels (Pagana et al., 2023).
Absolute neutrophils	5.40 10(3)/mCL	N/A	1.40-5.30 10(3)/mCL	Increased absolute neutrophils could most

				likely be caused by the patient's past medical history of gout (Pagana et al., 2023).
Absolute lymphocytes	0.50 10(3)/mCL	N/A	0.90-3.30 10(3)/mCL	Decreased absolute lymphocytes could possibly be caused by the patient's use of diuretics, as this can decrease lymphocyte levels (Pagana et al., 2023).
Absolute monocytes	1.20 10(3)/mCL	N/A	0.10-0.90 10(3)/mCL	Increased absolute monocytes could possibly be caused by the patient's use of the medication, allopurinol, as this can increase monocyte levels (Pagana et al., 2023).

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
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<p>Chest X-Ray: This test was to determine the status of the patient’s cardiac and pulmonary systems. It helped determine if the patient was experiencing pleural effusion or pericardial effusion (Pagana et al., 2023).</p>	<p>The client was experiencing a worsening of shortness of breath and lower extremity swelling upon presenting to the ER.</p>	<p>Findings include blood flow issues in the bilateral lungs, suggesting pleural edema or an infection of the lungs. Findings also include severe heart enlargement.</p>
<p>Chest Computed Tomography: This test was to determine if the patient had pleural effusion (Pagana et al., 2023).</p>	<p>The patient was experiencing a worsening of shortness of breath and lower extremity swelling upon presenting to the ER.</p>	<p>Findings suggested fluid overload within the body.</p>
<p>Chest X-Ray: This test was to determine the status of the patient’s cardiac and pulmonary systems. It helped determine if the client’s pleural edema had worsened or improved (Pagana et al., 2023).</p>	<p>The patient’s previous diagnostic tests had revealed the patient’s had pleural edema.</p>	<p>There was no significant change in the findings showing improvement or worsening of the plural edema compared to the tests taken six days prior.</p>

N/A	N/A	N/A
N/A	N/A	N/A

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's Diagnostic & Laboratory Test Reference* (16th ed.). Elsevier.

Active Orders

Active Orders	Rationale
Diet Cardiac	This order is placed because of the client's diagnosed congestive heart failure.
IP Consult to Nephrology	This order was placed to have a specialist in nephrology assess the patient's kidney function to see if diuretics could still be used in the client's care.
BMP am x1	This order was placed to have BMP taken once in the morning so the patient's provider can see the patient's labs.
CBC w diff am x1	This order was placed to have CBC w differential taken once in the morning so the provider can see the patient's complete blood count levels.
Mag am	This order was placed to have the patient's magnesium levels taken for the provider.

Acapella- Initial	This order is to help exercise the lungs and help loosen secretions.
Aerosol Nebulizer- Subsequent	This order is placed to help treat the patient's difficulty breathing.
Incentive Spirometry Rt- Initial	This order is placed to help with the client's difficulty breathing.
MDI Treatment Rt- Subsequent	This order is placed for the patient's multidose inhaler. This helps with the patient's difficulty breathing because of their fluid retention affecting the lungs.
Oxygen therapy	This order is placed to keep the patient's oxygen saturation levels in the appropriate ranges.
Pulse oximetry	This order is placed to allow the nurses to monitor the patient's oxygen saturation levels.
Rt Assessment for Albuterol and Ipratropium treatment plan	This order is placed for respiratory therapy to assess if treatments like Albuterol and Ipratropium will be effective in helping with the patient's breathing.
Admission weight	This order is placed to be able to calculate drug dosages, as well as to provide a baseline weight so it can be monitored for

	changes.
No VTE Prophylaxis	This order is placed because the patient is already on antithrombotic medication.
Ambulate patient	This order is placed so the nurses know to allow the patient to walk and make sure he is active.
Daily weight	This order is placed because the client is on a fluid restriction. It helps to determine how much fluid the client has lost compared to the previous day. This is also placed due to the client being on a fluid restriction.
Elevate extremity	This order is to help decrease the patient's lower extremity swelling through gravity.
Fluid restriction	This order is placed due to the excessive amount of fluid that the patient's body is retaining. It is important that he begins losing that fluid, rather than increasing the fluid retention.
Incentive spirometry nursing	This order is placed so the nurses educate the patients on how to use the incentive spirometry. It can also be so the nurse reminds the patient to continue to use the

	device.
Insert/Maintain Peripheral IV	This order is placed to keep the patient's IVs intact for when solutions or medications need to be administered. This is also to ensure the IV remains patent.
Maintain IV while on Telemetry	This order is to keep the patient's IV intact while he is being monitored on telemetry.
Notify physician- Symptomatic Bradycardia and Ventricular Arrhythmias	This order is placed so the nurse knows to notify the physician if the patient shows signs of symptomatic bradycardia or if telemetry notices any ventricular arrhythmias.
Nursing nightly calls	This order is placed so nurses can call the provider during the night if the patient has an emergency or if the nurse has questions about the provider's notes.
Place Sequential Compression Device (HUC orders equip)	This order is placed so the nurses can apply compression devices to help blood circulation in the patient's lower extremities. This will help prevent the development of deep vein thrombosis and air embolisms due to the patient's lack of activity.

Place Ted Hose, HUC orders equip	This order is for the patient to wear the Ted hose to help circulate the patient's blood in their lower extremities. This helps prevent deep vein thrombosis and air embolisms caused by the patient's lack of activity.
Rt therapy assessment score	This order is placed for respiratory therapy to complete an assessment of the patient's respiratory status due to his shortness of breath.
Saline lock IV	This order was placed to keep the patient's IV saline locked. This allows it to stay available to when the patient needs medication or solutions.
Strict Intake and Output	This order is to evaluate and keep track of how much the patient consumes and excretes. This is a strict order because the patient has fluid overload. Their intake and output need to be monitored constantly so it does not worsen.
Up with assistance	This order is placed because the patient should have a nurse's supervision when getting out of bed due to his fall score of 95.

Vital signs per unit routine	This order is placed to allow the nurses to take and monitor the vital signs of their patient's per the hospitals floor regulations.
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Medications

Home Medications (Must List ALL)

Medications	Reason for taking
acetaminophen (Tylenol)	This medication is to help treat the patient's mild to moderate pain as needed.
allopurinol (Zyloprim)	This medication is being used to help treat the client's past medical diagnosis of gout.
amlodipine (Norvasc)	This medication is to help treat the patient's past medical diagnosis of hypertension.
apixaban (Eliquis)	This medication is for the patient's past

	diagnosis of Atrial Fibrillation.
carvedilol (Coreg)	This medication is to treat the patient's past medical diagnosis of hypertension, as well as to treat his primary diagnosis of congestive heart failure.
Cholecalciferol (Vitamin D)	The patient is taking this to increase his vitamin D levels.
empagliflozin (Jardiance)	This medication is being taken to prevent further complications caused by the patient's primary diagnosis of congestive heart failure.
furosemide (Lasix)	This medication is being taken to help with the client's fluid retention.
gabapentin (Neurontin)	This medication is to help treat the patient's past medical diagnosis of hypertension as it can help lower blood pressure.
Multiple Vitamins- Minerals	These vitamins and minerals are being taken to increase the patient's intake of minerals.
oxycodone- acetaminophen (Percocet)	This medication is to help treat the patient's pain of his lower back and right knee.

pramipexole (Mirapex)	This medication is being taken to help with the patient's restless leg syndrome.
simvastatin (Zocar)	This medication is to treat the patient's past medical diagnosis of hyperlipidemia.
spironolactone (Aldactone)	This medication is used to treat the patient's past medical diagnosis of hypertension, as well as to treat his primary diagnosis of congestive heart failure.
telmisartan (Micardis)	This medication is being used to treat the patient's past medical diagnosis of hypertension, as well as to treat his primary diagnosis of congestive heart failure.

Hospital Medications (Must List ALL)

Brand/ Generic	acetazola mide	allopurin ol	apixaban (Eliquis),	budesonid e-	carvedilol (Coreg), 1	empagliflozi n
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	(Diamox), 1 tablet, 500 mg, once, 1 dose, oral	(Zyloprim), 1 tablet, 100 mg, oral, daily	1 tablet, 5 mg, oral, 2 times daily	formotero l fumarate (Symbico rt), 80-4.5 MCG/AC T, inhalation , 2 puff, 2 times daily	tablet, 6.25 mg, oral, 2 times daily with meals	(Jardiance), 1 tablet, 10 mg, oral, daily
Classifica tion	Pharmacologic: Carbonic anhydras e inhibitor Therapeu tic: Diuretic	Pharmacologic: Xanthine Therapeu tic: Antigout	Pharmacologic: Factor Xa inhibitor Therapeut ic: Anticoagu lant	Pharmacologic: Corticoste roid Therapeu tic: Antiasth matic, anti- inflamma tory	Pharmacologic: Nonselectiv e betablocke r and alpha-1 blocker Therapeuti c: Antihypert ensive,	Pharmacologic: Sodium glucose cotransporte r 2 inhibitor Therapeutic: Antidiabetic, cardiovascul ar mortality reduction agent

					heart failure treatment adjunct	
Reason	This	This	This	This	This	This
Client	medicatio	medicatio	medicatio	medicatio	medication	medication is
Taking	n is being	n is being	n is being	n is being	is being	being taken
	taken to	taken due	taken to	taken to	taken due	to prevent
	help with	to the	reduce the	help with	to the	further
	the	client's	risk of a	the	patient's	complication
	client's	past	stroke	patient's	past	s caused by
	fluid	medical	caused by	difficulty	medical	the patient's
	retention.	history of	the	breathing	diagnosis	primary
		gout.	patient's	from	of	diagnosis of
			past	pleural	hypertensi	congestive
			medical	edema.	on. It is	heart failure.
			diagnosis		also being	
			of atrial		taken due	
			fibrillatio		to his	
			n.		primary	
					diagnosis	
					of	

					congestive heart failure.	
Key nursing assessment(s) prior to administration	Determine the patient's potassium and sodium levels. Also, determine the client's renal and hepatic function.	Determine the patient's uric acid levels and CBC. Determine the patient's serum creatine and BUN levels.	Determine the function of the patient's liver and risk of bleeding.	Determine if the client is lactose intolerant. Also, determine the patient's blood pressure due to hypertension.	Determine the patient's blood glucose level and peripheral vascular efficiency.	Determine the patient's fluid volume and blood pressure. Also, determine the patient's renal function.
Brand/ Generic	gabapentin (Neurontin), 1 capsule,	guaifenesin (Mucinex), 1 SR tablet,	ipratropium-albuterol (DUO-Neb), 3	Multivitamin- Minerals tablet, 1 tablet,	pramipexole (Mirapex), 1 tablet, 0.5 mg, oral,	prednisone (Deltasone), 1 tablet, 20 mg, oral, daily, 3 doses

	300 mg, oral, 2 times daily, do not crush	600 mg, oral, 2 times daily, do not crush	ml, nebulizati on, 4 times daily	oral, daily	nightly	
Classifica tion	Pharmacologic: 1- amino- methyl cyclohexa ne acetic acid Therapeu tic: Anticonv ulsant	Pharmacologic: Adrenergic antagonist Therapeutic: Expectorant	Pharmacologic: Anticholinergic, adrenergic Therapeutic: Bronchodilator	N/A	Pharmacologic: Nonergoline dopamine agonist Therapeutic: Antiparkinsonian	Pharmacologic: Glucocorticoid Therapeutic: Immunosuppressant
Reason Client Taking	This medication is being taken to	This medication is being taken to	This medication is being taken to	These vitamins and minerals	This medication is being taken to	This medication is being taken to help treat

	help with the patient's nerve pain.	help clear excess mucus in the patient's chest in order for him to breathe better.	help open the patient's bronchi in order for him to breathe easier.	are being taken to increase the patient's intake of minerals.	help with the patient's nerve pain.	the patient's edema.
Key nursing assessment(s) prior to administration	Determine the patient's renal function.	Determine the patient's hepatic function.	Determine the patient's blood pressure, heart rhythm, and potassium levels.	N/A	Determine the patient's blood pressure and if the patient is experiencing any confusion, delusions, or disorientati	Determine the patient's blood pressure, fluid intake, output, and daily weight.

					ons.	
Brand/ Generic	simvastati n (Zocor), 1 tablet, 20 mg, oral, daily	sodium chloride (Ocean), 0.65% nasal spray, nasal, 3 times daily	Vitamin D3 tablet, 50 mcg, oral, daily	N/A	N/A	N/A
Classifica tion	Pharmaco logic: HMG- CoA reductase inhibitor (statin) Therapeu tic: Antilipem ic	N/A	N/A	N/A	N/A	N/A

Reason Client Taking	This medication is being taken to treat the patient's past medical diagnosis of hyperlipi demia.	This medication is being used to help replace electrolyt es that are lacking in the patient's body.	The patient is taking this to increase his vitamin D levels.	N/A	N/A	N/A
Key nursing assessment(s) prior to administration	Determine the patient's renal and hepatic function. Also, determine the patient's	N/A	N/A	N/A	N/A	N/A

	serum lipoprotein level.					
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Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. carvedilol (Coreg)	This medication was chosen because it is used to control the patient's hypertension which is important especially with his primary diagnosis.	1. This medication can cause peripheral vascular disorders. 2. This medication can cause hypotension.
2. acetazolamide (Diamox)	This medication was chosen because it is being used to help treat the patient's fluid retention. This is important to treat as it is causing	1. This medication can cause bleeding gums. This is an issue because the patient is on an anticoagulant, apixaban (Eliquis).

	pulmonary edema which will affect the patient's breathing.	2. This medication can cause trouble breathing which can further impact how easily the patient can breathe on top of his other pulmonary issues.
3. ipratropium- albuterol (DUO-Neb)	This medication was chosen because it helps the patient breathe easier while having pulmonary edema by dilating his bronchioles.	1. This medication can cause difficulty breathing, which can further impact how easily the patient can breathe. 2. This medication can cause issues with swallowing which puts the client at risk for aspiration.

Medications Reference (1) (APA)

2024 Nurse's Drug Handbook, (2023). Jones & Bartlett Learning. 691-693.

Mayo Clinic. (2025). *Acetazolamide (oral route)*. <https://www.mayoclinic.org/drugs-supplements/acetazolamide-oral-route/description/drg-20535236>

Mayo Clinic. (2025). *Guaiifenesin (oral route)*.

<https://www.mayoclinic.org/drugs-supplements/guaiifenesin-oral-route/description/drg-20068720>

Mayo Clinic. (2025). *Ipratropium and albuterol (inhalation route)*.

<https://www.mayoclinic.org/drugs-supplements/ipratropium-and-albuterol-inhalation-route/description/drg-20062048>

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

<p>GENERAL:</p> <p>Alertness:</p> <p>Orientation:</p> <p>Distress:</p> <p>Overall appearance:</p> <p>Infection Control precautions:</p> <p>Client Complaints or Concerns:</p>	<p>The patient was alert and oriented to time, place, person, and why he was admitted to the hospital. There were no signs of acute distress, and his overall appearance was appropriate to situation and age. The patient did not have any infection control precautions. The patient had no complaints or concerns.</p>
<p>VITAL SIGNS:</p> <p>Temp:</p> <p>Resp rate:</p> <p>Pulse:</p> <p>B/P:</p> <p>Oxygen:</p> <p>Delivery Method:</p>	<p>The patient's temperature was 97 F which was taken temporally. The patient's respiratory rate was 20 breaths per minute and his oxygen was 95%. The patient's oxygen was being delivered by nasal cannula at 4 L. The patient's pulse was 72 and his blood pressure was 119/ 83.</p>
<p>PAIN ASSESSMENT:</p> <p>Time:</p> <p>Scale:</p>	<p>During my shift, at 1425, the patient stated he was in pain. The patient was assessed on a numerical scale of 1-10 and he rated his pain a</p>

<p>Location:</p> <p>Severity:</p> <p>Characteristics:</p> <p>Interventions:</p>	<p>“6”. The location of my patient’s pain was in his lower back and right knee. He characterized the pain as “aching and constant”. The nurse gave him oxycodone for his pain.</p>
<p>IV ASSESSMENT:</p> <p>Size of IV:</p> <p>Location of IV:</p> <p>Date on IV:</p> <p>Patency of IV:</p> <p>Signs of erythema, drainage, etc.:</p> <p>IV dressing assessment:</p> <p>Fluid Type/Rate or Saline Lock:</p>	<p>During the assessment the patient had one IV in place. This IV was a 22 gauge in his left posterior hand and was dated 03/24/25 at 1245. The IV dressing was intact, clean, and dry. There were no signs of erythema, drainage, etc. There were no signs of coolness, phlebitis, or infiltration. This IV was on a furosemide 5mg/hr drip at 2.5ml/hr.</p>
<p>INTEGUMENTARY:</p> <p>Skin color:</p> <p>Character:</p> <p>Temperature:</p> <p>Turgor:</p> <p>Rashes:</p> <p>Bruises:</p> <p>Wounds: .</p> <p>Braden Score:</p> <p>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>The patient’s skin color was cream and appropriate for age. The temperature of his skin was warm, and his skin turgor was 3 seconds. There were no rashes noted on the patient. There were bruises on the patient’s left arm from previous IV insertions. The patient had scars on his right shoulder and lower back due to past surgeries. The patient also had a hernia on the lower right quadrant of his abdomen. The patient stated this</p>

<p>Type:</p>	<p>occurred when “fluid started building up in my stomach”. Ascites was not found upon assessment of the abdomen. However, the patient commented that it “had gone away”. The patient’s determined Braden score was 21.</p>
<p>HEENT:</p> <p>Head/Neck:</p> <p>Ears:</p> <p>Eyes:</p> <p>Nose:</p> <p>Teeth:</p>	<p>Head/Neck: The patient has no noted bumps, lumps or lesions. His head is normocephalic and his neck is midline. There are no lymph nodes palpable, and his neck is without jugular vein distention. The patient’s thyroid is non-palpable, and his trachea is midline.</p> <p>Ears: The patient’s ears are without deformities, lesions, or lumps. His bilateral canals are clear. There is no drainage noted.</p> <p>Eyes: The patient’s eyes are symmetrical with EOMs and PERRLA intact. The patient’s bilateral corneas are clear, bilateral sclera are white, and bilateral conjunctiva are pink. His bilateral lids are moist and pink without discharge or lesions. There is no overall discharge or drainage noted.</p>

	<p>Nose: The patient's nose is symmetrical, and his septum is midline. There is no drainage noted.</p> <p>Teeth/Mouth: The patient's teeth are intact, and his oral mucosa is pink and moist. There were no sores or lesions noted. The patient's tongue was midline.</p> <p>.</p>
<p>CARDIOVASCULAR:</p> <p>Heart sounds:</p> <p>S1, S2, S3, S4, murmur etc.</p> <p>Cardiac rhythm (if applicable):</p> <p>Peripheral Pulses:</p> <p>Capillary refill:</p> <p>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Location of Edema:</p>	<p>S1 and S2 heart sounds are present. There were no S3, S4 murmur, rubs or gallops heard upon auscultation. The patient had a normal cardiac rate and rhythm. The patient's bilateral pulses were palpable and 2+ throughout. His capillary refill was less than three seconds on his fingers and toes bilaterally. There was no neck vein distention noted. The patient did have edema on both his right and left leg. The edema on his right was non-pitting, while the edema on his left was pitting 2+.</p>
<p>RESPIRATORY:</p> <p>Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Breath Sounds: Location, character</p>	<p>The patient presented with crackles in the right lower lobe, as well as scattered and diminished crackles in the left. The upper bilateral lobes, as</p>

	<p>well as the middle lobe were clear throughout.</p> <p>There were no wheezes or rhonchi noted. The patient showed no signs of accessory muscle use, and his respirations were a normal rate and pattern. His respirations also appear at symmetrical and non-labored.</p>
<p>GASTROINTESTINAL:</p> <p>Diet at home:</p> <p>Current Diet:</p> <p style="padding-left: 40px;">Is Client Tolerating Diet?</p> <p>Height:</p> <p>Weight:</p> <p>Auscultation Bowel sounds:</p> <p>Last BM:</p> <p>Palpation: Pain, Mass etc.:</p> <p>Inspection:</p> <p style="padding-left: 40px;">Distention:</p> <p style="padding-left: 40px;">Incisions:</p> <p style="padding-left: 40px;">Scars:</p> <p style="padding-left: 40px;">Drains:</p> <p style="padding-left: 40px;">Wounds:</p> <p>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>The patient stated his diet at home was “regular with nothing special include”. He mentioned that his wife “started cooking more with the oven instead of frying foods”. The patient’s current diet is a cardiac diet while also being fluid restrictive. The patient is tolerating the diet well and is eating 100% of his meals. The client’s height is 5’ 10” and his weight is 113.1 Kg. The patient’s bowel sounds are present in all four quadrants and are normoactive. The patient states his last bowel movement was “yesterday”. There were no masses, pain, etc. felt upon palpation. The patient’s abdomen was soft and without distention. There were no incisions, scars, wounds, or drains noted upon inspection. The patient did have a hernia in his lower right</p>

<p>Size:</p> <p>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p>	<p>quadrant that was seen during inspection. The patient did not have an ostomy, nasogastric tube, or feeding tube.</p>
<p>GENITOURINARY:</p> <p>Color:</p> <p>Character:</p> <p>Quantity of urine:</p> <p>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Inspection of genitals:</p> <p>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p> <p>Size:</p>	<p>The patient's urine was dark yellow and clear.</p> <p>The patient denied any pain with urination. I collected 1,380 mL of urine during the shift. There was another 1,280 mL of urine that was collected by the nurse during my shift. The patient was not on dialysis and did not have a catheter. Inspection of genitals was not completed.</p>
<p>Intake (in mLs)</p> <p>Output (in mLs)</p>	<p>The patient's total intake during my shift was 1,200 mL. The patient's total output during my shift was 2,080 mL.</p>
<p>MUSCULOSKELETAL:</p> <p>Neurovascular status:</p> <p>ROM:</p> <p>Supportive devices:</p> <p>Strength:</p>	<p>The patient's neurovascular status is intact. The patient's nails were without clubbing or cyanosis. The patient's extremities are warm, dry, and symmetrical. There were bruises on the patient's left arm due to past IV insertions. The</p>

<p>ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Fall Score:</p> <p>Activity/Mobility Status:</p> <p style="padding-left: 40px;">Activity Tolerance:</p> <p>Independent (up ad lib)</p> <p>Needs assistance with equipment</p> <p>Needs support to stand and walk</p>	<p>patient's ROM is intact. The patient had equal strength during upper extremity pushes and pulls, as well as pedal pushes and pulls. The patient showed good strength with hand grasps, could bend and straighten arms well, and could lift both legs at the knee with resistance. The patient does not use assistive devices. The patient does not need assistance with ADLs or equipment. The patient is at a fall risk with a fall score of 90. The patient's activity tolerance is limited due to his right knee and lower back pain. The patient does walk around and is still active. The patient is independent.</p>
<p>NEUROLOGICAL:</p> <p>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></p> <p>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -</p> <p>Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p>Orientation:</p> <p>Mental Status:</p> <p>Speech:</p> <p>Sensory:</p>	<p>The patient moves all extremities well and PERLA is intact. The patient's strength is equal as determined through ROM exercises. The patient is oriented to person, place, time, and why he was admitted to the hospital. The patient's speech is clear and controlled. The patient's mental status and sensory are appropriate for age. The patient is fully conscious and aware of his surroundings.</p>

LOC:	
PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	<p>The patient's coping method has been talking with family and friends on the phone, as well as watching television. The patient's developmental level is formal operational and integrity vs. despair. The patient is not religious. The patient has support from his wife, two children, and five grandchildren. His wife is unable to be at the hospital very often, as she cannot drive and relies on their son to drive her.</p>

Discharge Planning

Discharge location: The patient is planning to go back home after discharge.

Home health needs: The patient will need to have to be put on home oxygen. Due to his worsening condition, this patient will need to be on oxygen at all times to prevent any further declines in his health.

Equipment needs: The patient will need the equipment to provide him with oxygen in the home.

Follow up plan: The patient should follow up with his provider on how the home oxygen is working and have his oxygen saturation checked.

Education needs: The patient will need to be educated on the precautions to take with home oxygen and how to perform correct home oxygen care. He will need to understand

information such as he cannot turn up his oxygen if he feels out of breath, to keep the oxygen away from open flames, and to stay away from smoking while on oxygen.

Nursing Process

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

Nursing Diagnosis <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components • Listed in order by priority – highest priority to lowest priority pertinent to this client 	Rationale <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Outcome Goal (1 per dx)	Interventions (2 per goal)	Evaluation of interventions
1. Decreased cardiac output related to altered contractability as evidence by the patient’s primary diagnosis of acute on chronic diastolic	This nursing diagnosis was chosen due to the heart inability to pump the adequate amount of blood the patient’s body needs due to his diagnosis.	The patient will keep an adequate cardiac output, and his blood pressure will stay within the normal ranges throughout the patient’s hospitalization.	1. Assess and monitor the patient’s heart rhythm, rate, and blood pressure at least every four hours to watch for irregularities. 2. Monitor	The patient will be able to complete ADLs with his heart maintaining normal rate and rhythm. The patient’s blood pressure will stay within normal

<p>congestive heart failure.</p>			<p>patient's level of consciousness at least every four hours for changes resulting from hypoxia or decreased cardiac output.</p>	<p>limits. He will not experience any dyspnea, fatigue, or discomfort during the ADLs.</p>
<p>2. Excess fluid volume related to excessive fluid intake, as evidence by pleural edema.</p>	<p>This nursing diagnosis was chosen because the client is experiencing fluid retention from his acute on chronic diastolic congestive heart failure</p>	<p>The patient's urine specific gravity, BUN, creatine, sodium, and potassium levels will stay in the normal ranges throughout the patient's hospitalization.</p>	<p>1. Monitor and keep record of client's intake, output, and urine specific gravity. 2. Monitor the patient's</p>	<p>The patient's intake, output, and urine specific gravity will stay within expected ranges. The patient's daily weight will revert back to</p>

	which can lead to complications if left untreated.		BUN, sodium, potassium, and creatine levels for changes caused by the use of diuretics.	his baseline weight from improvement of excess fluid volume.
3. Risk for thrombosis related to impaired physical mobility as evidence by edema of the lower extremities.	This nursing diagnosis was chosen due to the client's lack of activity while in the hospital as a result of his edema.	The patient will remain without a thromboembolism and show signs of sufficient peripheral perfusion through his hospitalization.	1. Assess and monitor the patient's circulation in their extremities, as well as their pulses. 2 Encourage ROM exercises to the patient to	The patient will perform ROM exercises several times throughout the day if he does not feel like getting out of bed. The patient's extremities will remain

			increase their blood circulation while in bed.	normal temperature and pulses will remain 2+.
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Other References (APA):

Phelps, L. L. (2022). *Nursing Diagnosis Reference Manual: Twelfth Edition*. Wolters Kluwer.

