

N311 Care Plan 1

Cheyenne Wilken

Lakeview College of Nursing

N311: Foundations of Professional Practice

Instructor Jami Dowell

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Demographics

Date of Admission 9/10/2025	Client Initials CS	Age 75 years old	Biological Gender Female
Race/Ethnicity White	Occupation Other	Marital Status Single	Allergies Cephalexin Clindamycin Doxycycline Penicillins Septra (Sulfamethoxazole trimethoprim) Cefuroxime
Code Status Full code	Height 147.3 cm	Weight 160 lb. 14.4 oz	

Medical History

Past Medical History: Anemia, Arthritis, Asthma, Bipolar 1 disorder (HCC), CHF (Congestive heart failure) (HCC), Diabetes Mellitus (HCC), Gerd (gastroesophageal reflux disease), Hyperlipidemia, Hypertension, Pancreatits, Respiratory failure (HCC), and UTI (Urinary tract infection).

Past Surgical History: Cholecystectomy, Bladder surgery, Hernia repair, and Upper gastrointestinal endoscopy

Family History: No family history on file

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

There is no use of tobacco, smokeless tobacco, vaping, alcohol or drug use.

Education: There is no education on file

Living Situation: local assisted living

Assistive devices: walker, wheelchair (for long distances), glasses (for reading) and oxygen

Admission Assessment

Chief Complaint: General illness

History of Present Illness (HPI)– OLD CARTS:

Patient presented with chills, generalized weakness, dyspnea (difficult breathing) that started one day ago from 9/10/2025. These onset symptoms lasted for one day and there was little to no relief with home albuterol treatment. Primary location shortness of breath. No aggravating factors, relieving factors or severity stated.

Primary Diagnosis

Primary Diagnosis on Admission: Congestive heart failure (CHF)

Secondary Diagnosis (if applicable): No secondary diagnosis

Pathophysiology

Pathophysiology of the Disease, APA format:

The abbreviation CHF stands for congestive heart failure. According to the pathophysiology introductory concepts and clinical perspectives “Heart failure is defined as a syndrome characterized by elevated cardiac filling pressure and/or inadequate peripheral oxygen delivery, at rest or during stress, caused by cardiac dysfunction” (Capriotti, 2024) It can also be described in different ways including acute or chronic. Acute CHF is the rapid and sudden development of heart failure whereas chronic is more common because it is when the heart weakens over time. It is a progressive condition that affects the hearts ability to pump correctly due to the ejection fraction not being at a healthy percent. The ejection fraction of a healthy adult

is 50% to 70%. When it comes to CHF there are 2 categories. The first one is called Heart failure with reduced ejection fraction. This is when the ejection fraction is less than or equal to 40%. The second category is when the ejection fraction is either normal or close to normal, but it is greater than or equal to 50%. These two categories are the most common but there is a third category some consider, and it is heart failure with mildly reduced or borderline ejection fraction. This is when the ejection fraction is 41% to 49%. Congestive heart failure has many causes including ischemic heart disease (most common), chronic hypertension, chronic pulmonary disease, cardiomyopathies, dysrhythmias, heart valve abnormalities and cardiac infections. The signs and symptoms can include dyspnea, cough, orthopnea, weak peripheral pulses, JVD, and edema. (Capriotti, 2024) Heart failure most times starts with a injury to the heart which could be ischemia or even hypertension that is induced from stress this then leads to the weakening of the heart muscle over time. This can also affect different systems throughout by causing pulmonary congestion, renal dysfunction, hepatic congestion, and cognitive decline.

My 75-year-old female was experiencing generalized weakness, dyspnea, and chills when she came into the emergency room and it had started one day ago from her day of admission on 09/10/2025 and only lasted a day. The patient has a history of CHF. According to Nursing Diagnosis Reference Manual “Monitor for dyspnea or shortness of breath every 2 to 4 hours and report deviation from baseline.” (Phelps, 2023) So the patient would need to be monitored due to her already having dyspnea prior to coming to the emergency department. With heart failure there is a decreased cardiac output which is what causes a lot of the symptoms like dyspnea, fatigue and irregular heart rhythms.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Phelps, L. L. (2023). *Nursing diagnosis reference manual*. Wolters Kluwer.

Vital Signs, 1 set – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen SAT	Oxygen Delivery Method
2301	72	140/73	20	97.6 F	93%	Nasal cannula 3 l/min

Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
0840	0-10	N/A	0	N/A	N/A