Samjhana Rai

Lakeview College of Nursing

N321: Adult Health I

Professor Henry

29th September 2025

Demographics

Date of Admission 9/24/2025	Client Initials PO	Age 76 (9/29/1949	Biological Gender Female
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Divorced	Allergies -codeine -Enoxaparin -Enoxaparin Sodium
Code Status Full code	Height 152.4 cm	Weight 96.9kg	

Medical History

Past Medical History:

Hepatocellular carcinoma (HCC), Arthritis, Asthma, Atrial fibrillation, Bilateral pneumonia, Breast cancer, Congestive heart failure (CHF), Chronic obstructive pulmonary disease (COPD), Hypertension, Skin cancer (basal cell carcinoma), Stroke.

Past Surgical History:

Diagnostic endoscopy, Diagnostic colonoscopy, Simple mastectomy, Complete bilateral hernia repair (laparoscopic), Initial inguinal hernia repair, Cholecystectomy, Bilateral cardiac catheterization, breast surgery, pacemaker insertion, Upper GI endoscopy, incisional lesion mass removal, Mohs surgery.

Family History:

Father: Colon cancer (Died at 62)

Maternal aunt: Kidney cancer (died at 58)

Son/Daughter: Unknown medical problems

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

Smoking: Former smoker, one pack per day for 27 years.

Alcohol: Denies use

Drugs: Denies use

Education: The patient completed high school and two years of college in a general education program.

Living Situation: Currently resides at Labelle Nursing Home, Danville, IL.

Assistive devices: Uses a walker, wheelchair, and gait belt as needed for mobility.

Chief Complaint: Shortness of breath.

Admission History

History of Present Illness (HPI)– OLD CARTS

PO is a 76-year-old Caucasian female who states, “I have been having trouble breathing for the past few hours.” The dyspnea is constant and occurs both at rest and with activity. The patient reports that movement worsens the shortness of breath, while supplemental oxygen provides some relief. The symptom has persisted since onset, is moderate in severity, and has limited the patient’s ability to perform daily activities, causing fatigue and anxiety. Contributing factors include a history of Takotsubo syndrome with dilated cardiomyopathy, reduced ejection fraction, previous respiratory issues, and low oxygen saturation at the nursing home, which prompted transport via EMS. The patient denies chest pain, palpitations, cough, sputum production, fever, or gastrointestinal or genitourinary complaints.

Admission Diagnosis

Primary Diagnosis: Acute on chronic systolic (CHF)

Secondary Diagnosis (if applicable): COPD

Pathophysiology

Heart failure arises when sustained stress on the myocardium triggers maladaptive cellular changes that lower contractility and relaxation. The injury to myocytes triggers neurohormonal pathways, including the renin-angiotensin-aldosterone system and the sympathetic axis, which elevate preload and afterload, stimulate fibrosis and apoptosis, and make the ventricle stiffer and the chamber larger over time, thereby decreasing stroke volume and cardiac output (Hinkle & Cheever, 2022). With increased filling pressure, the pulmonary capillary hydrostatic pressure rises, and fluid moves into the interstitial and alveoli, leading to dyspnea and crackles. Decreased forward flow restricts perfusion to the kidneys and brain, causing fatigue, oliguria, and confusion in end-stage disease.

Typical findings include exertional dyspnea, orthopnea, nocturnal paroxysmal dyspnea, edema, jugular venous distension, and a S3 gallop in cases of volume overload (Hinkle & Cheever, 2022). Vital signs are expected to include tachycardia, which attempts to maintain output, potentially accompanied by

tachypnea and hypoxemia during congestion, and blood pressure, which may be normal initially but may drop in decompensation along with low stroke volume (Heidenreich et al., 2022). When the plateau wall is stressed and untreated, the laboratory patterns may include high levels of natriuretic peptides, indicating pressure on the walls. They may also include hyponatremia and mild renal impairment (McDonagh et al., 2023).

The process of diagnosis is based on clinical examination, with the assistance of chest radiographs (pulmonary congestion and cardiomegaly), electrocardiograms (rhythm and ischemia), and transthoracic echocardiography (ejection fraction and structural disease) to determine a specific therapeutic approach in both diminished and preserved phenotypes (Hinkle & Cheever, 2022). A high NT-proBNP level, bilateral interstitial edema on chest radiograph, and an echocardiogram with a low ejection fraction assist in diagnosing and understanding the pathophysiology of dyspnea in this patient (McDonagh et al., 2023).

Treatment is a combination of decongestion and disease-modifying therapy. IV loop diuretics relieve the congestion and enhance gas exchange during exacerbation. In contrast, long-term guideline-informed therapy incorporates angiotensin receptor neprilysin inhibitor or ACE inhibitor, evidence beta-blocker, mineralocorticoid receptor antagonist, and an SGLT2 inhibitor to reduce mortality and hospitalizations across the correct phenotype, fits the plan of furosemide in this client with initiation of sacubitril–valsartan and

carvedilol once euvolemic (Heidenreich et al., 2022). Continuous education about the limitations of sodium intake, daily weight, and compliance promotes stability and lessens relapse.

References

Heidenreich, P. A., Bozkurt, B., Aguilar, D., et al. (2022). 2022 AHA/ACC/HFSA guideline for the management of heart failure. *Journal of the American College of Cardiology*, *79*(17), e263–e421. https://doi.org/10.1016/j.jacc.2021.12.011

Hinkle, J. L., & Cheever, K. H. (2022). *Brunner and Suddarth's textbook of medical-surgical nursing* 15th ed. Wolters Kluwer.

McDonagh, T. A., Metra, M., Adamo, M., et al. (2023). 2023 focused update of the 2021 ESC guidelines for the diagnosis and treatment of acute and chronic heart failure. *European Heart Journal*, *44*(37), 3627–3639. https://doi.org/10.1093/eurheartj/ehad195

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
BUN	**26mg/dl**	**62mg/dl**	**10-20mg/dl**	Increased BUN suggests reduced renal perfusion from CHF. Reduced cardiac output causes reduced kidney filtration and urea accumulation (Kosiorek et al.,

				2022).
Creatinine, Blood	**1.57mg/dl**	**1.29mg/dl**	**0.6-1.0mg/dl**	Increasing slightly with renal hypoperfusion due to CHF and diuresis. Suggests partial recovery of AKI.
GFR, estimated	**34**	**47**	**Greater than 60**	Reduced GFR suggests smooth improvement reflects improved perfusion following treatment.
Glucose	**145mg/dl**	**101mg/dl**	**70-99mg/dl**	Mildly elevated due to stress response and steroid medication use during hospitalization. Common in CHF patients receiving corticosteroids or with physiologic stress**.**
Albumin	**3.2g/dl**	**N/A**	**3.5-5g/dl**	Slightly low due to poor nutritional intake and chronic illness (CHF). Low albumin reduces oncotic pressure,

				worsening edema and fluid retention.
Alkaline phosphate	**36U/L**	**N/A**	**40-150 U/L**	Mild elevation may result from congestive hepatopathy liver congestion caused by right-sided heart failure reducing hepatic blood flow.
GFR-non-African	**32**	**44**	**Greater than 60**	Below normal, indicating reduced renal filtration capacity caused by decreased cardiac output in CHF and coexisting AKI.
GFR African	**39**	**53**	**Greater than 60**	Also, below normal for expected range; reflects moderate kidney impairment secondary to CHF-related renal hypoperfusion.
NT Bro BNP	**64pg/ml**	**N/A**	**85-105pg/ml**	Ongoing management and better fluid balance.
Neutrophils	**79.4%**	**83.6%**	**47-73%**	An elevated neutrophil count may be a

				sign of stress response or subclinical infection that accompanies chronic disease or hospital stay.
lymphocytes	**13.9%**	**10%**	**18-42%**	Low lymphocyte count (lymphopenia) may occur due to physiologic stress or corticosteroid therapy during hospitalization. Common in acutely ill CHF patients.
Absolute Neutrophils	**8%**	**12.90%**	**47-73%**	Low absolute neutrophil indicates neutropenia, which can increase infection risk. Causes may include bone marrow suppression, acute illness, or medication effects (Huether & McCance, 2020)
Protein random urine	**4+ negative**	**N/A**	**N/A**	Severe proteinuria indicates renal damage and decreased filtration from

				acute kidney injury and chronic CHF-related renal hypoperfusion (Gallo et al., 2023).
Urine Glucose	**1+ negative**	**N/A**	**N/A**	Trace glucose in urine likely due to transient hyperglycemia from physiologic stress or medication effect; kidneys are excreting small amounts due to reduced threshold.
Chloride	**104mmol/L**	**95mmol/L**	**98-107 mmol/L**	Slightly low chloride (hypochloremia) results from loop diuretic use (Furosemide), which increases chloride loss in urine, and contributes to metabolic alkalosis risk.
BUN/Creatinine Ration	**17 ratio**	**52 ratio**	**12-20 ratio**	Increase in pre-renal azotemia secondary to dehydration and decreased

				cardiac output in CHF.

References APA:

Gallo, G., Lanza, O., & Savoia, C. (2023). New Insight in Cardiorenal Syndrome: From Biomarkers to Therapy. *International Journal of Molecular Sciences*, *24*(6), 5089. https://doi.org/10.3390/ijms24065089

Kosiorek, A., Biegus, J., Piotr Rozentryt, Hurkacz, M., & Zymliński, R. (2022). Cardiorenal syndrome: Decongestion in heart failure across wide spectrum of kidney pathophysiology. *Advances in Clinical and Experimental Medicine*, *31*(4), 445–455. https://doi.org/10.17219/acem/144327

Pagana, K., Pagana, T., Pagana, T. (2023). Mosby's Diagnostic & Laboratory Test Reference Sixteenth Edition. Elsevier.

Current Diagnostic Test & Purpose	**Clients Signs and Symptoms**	**Results and correlate to client diagnosis and condition**
XR chest single view portable.	Patient shows shortness of breath, pulmonary congestion, and history of	Enlarged but stable heart, device leads stable, pulmonary vascular congestion with mild edema, no

• **Purpose:** To evaluate heart size, cardiac device placement, and lung congestion in relation to heart failure (Huether & McCance, 2020). • **Date**: 9/24/2025	heart failure with cardiac device.	new effusion or pneumonia. Correlates with CHF**;** shows fluid overload but stable condition
Ultrasound Renal Complete • **Purpose** – To evaluate kidney size, structure, and rule out obstruction or acute changes in	Patient shows history of acute kidney injury, abnormal renal function, and possible flank discomfort.	Limited exam due to positioning; right kidney 10.7 cm, left kidney 10 cm; no acute abnormality; bilateral cystic lesions not well visualized. Correlates with AKI**;** no acute worsening, outpatient follow-up needed.

relation to acute kidney injury (Huether & McCance, 2020). • **Date**: 9/25/2025		

Diagnostic Test Reference (1) (APA):

Huether, S. E., & McCance, K. L. (2020). *Understanding pathophysiology* (7th ed.). Elsevier.

Active Orders

Active Orders	**Rationale**
Oxygen therapy via nasal cannula, 3 L initially, titrate down to 1 L by discharge	Assist in respiration function and maintain adequate oxygen saturation.
Furosemide 40 mg tablets, 80 mg PO in the morning	Loop diuretic reduces fluid overload, improves pulmonary congestion, and decreases dyspnea in CHF.
Strict I&O, Daily Weights	Detects early fluid retention or excessive diuresis; critical for CHF management.

Telemetry Monitoring	Monitors for arrhythmias related to CHF, atrial fibrillation, or electrolyte imbalance from diuresis.
Basic Metabolic Panel (BMP) daily	Monitors electrolytes, renal function, and response to diuretics.
Up as tolerated (routine, PRN)	Help maintain circulation and mobility
MRSA precautions (if patient is colonized or infected)	Prevent the spread of infection and ensure safety of staff and other patients
Vital signs per routine	Monitor changes in pulse, BP, respiration, and temperature for early detection of complications
Notify physician for critical lab values or abnormal vitals	Ensure prompt intervention for electrolyte imbalance, hypoxia, or abnormal heart rate/BP
Peripheral IV insertion/maintenance	Peripheral IV insertion/maintenance
Cardiac diet (low sodium, low fat)	Prevent fluid retention, reduce strain on the heart, and support management of CHF
Creatinine blood w/ GFR, routine daily	Assess kidney filtration rate and function in relation to AKI
CBC w/ diff, routine check daily	Monitor blood cell counts for infection or anemia that may affect CHF or kidney function

Brand/Generic	Dosage/ route/frequency	Classification	Reason for taking	Contraindications & Side Effects	Key nursing assessment(s) prior to administration
Advair/Fluticasone-salmeterol	1puff by inhalation in the morning	**Pharmacologic**: Corticosteroid + long acting beta2 agonist (Jones & Bartlett, 2024) (**Therapeutic**: bronchodilator (Jones & Bartlett, 2024)	Long-term management of COPD or asthma	Contraindications: Hypersensitivity, acute asthma attack. Side Effects: Oral thrush, headache (Jones & Bartlett, 2024)	Assess lung sounds, inhaler technique, rinse mouth after use (Jones & Bartlett, 2024)
Aldactone/ Spironolactone	25 mg, take 1 tablet by mouth daily	**Pharmacologic**: Potassium-sparing diuretic (Jones & Bartlett Learning, 2024) **Therapeutic**: Antihypertensive / diuretic (Pope., 2025)	Treat hypertension, edema, heart failure (Jones & Bartlett, 2024)	**Contraindications:** Hyperkalemia, anuria. **Side Effects:** Hyperkalemia, gynecomastia (Huether & McCance, 2020)	Assess potassium, BP, kidney function (Jones & Bartlett, 2024)
Bayer/Aspirin	81mg by mouth daily	**Pharmacologic**: NSAID /	Pain, inflammation,	**Contraindications:** Active bleeding,	Assess for bleeding, allergy, GI upset, kidney

APA:

Jones & Barlett Learning. (2024). *NDH: Nurse's Drug Handbook: twenty-Four Edition.* World headquarters.

Pope, C. (2025). *Budesonide, glycopyrrolate, and formoterol inhaler*. Drugs.com. https://www.drugs.com/budesonide-formoterol-and-glycopyrrolate.html#:~:text=The%203%20medicines%20are%3A,LABA)%20medicine%20(formoterol).

Cunha, J. (2023). Humalog. RxList.com. https://www.rxlist.com/humalog-drug.htm

headquarters.

Prioritize Three Hospital Medications

Medications	**Why this medication was chosen**	**List 2 side effects. These must correlate to your client**
Furosemide	This medication was chosen because the client has heart failure with fluid overload and pulmonary edema, causing shortness of breath	1. Hypokalemia – may worsen electrolyte imbalance in AKI (Huether & McCance, 2020). 2. Dehydration – may negatively impact kidney function (Huether & McCance, 2020).

	(Huether & McCance, 2020).	
Lisinopril	This medication was chosen because the patient has reduced ejection fraction and Takotsubo syndrome, which increases cardiac workload (Huether & McCance, 2020).	1. Hypotension – may worsen perfusion in already low blood pressure (Huether & McCance, 2020). 2. Hyperkalemia – risky in patients with AKI (Huether & McCance, 2020).
ProAir HFA (Albuterol)	This medication was chosen because the patient has acute dyspnea and a history of respiratory issues causing bronchospasm (Jones & Bartlett, 2024).	1. Tremors – may increase anxiety and interfere with mobility in older adults (Jones & Bartlett, 2024) 2. Tachycardia – may exacerbate cardiac strain in patients with reduced ejection fraction or heart failure (Jones & Bartlett, 2024)

Medications Reference (1) (APA)

Huether, S. E., & McCance, K. L. (2020). *Understanding pathophysiology* (7th ed.). Elsevier.

Jones & Barlett Learning. (2024). *NDH: Nurse's Drug Handbook: twenty-Four Edition.* World headquarters.

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions: Contact (MARSA)** **Client Complaints or Concerns:**	Alert and oriented x4 to person, place, time and situation, respond to verbal stimuli, no sign of distress, well groomed • **Isolation**: Contact • **Precautions**: Gloves, gown, wash hands with soap and water. **Chief Complaint**: Shortness of breath for a few hours, worse with activity, relieved by oxygen; denies chest pain.
VITAL SIGNS: **Temp:** **Resp rate:20** **Pulse:** **B/P:** **Oxygen:93%** **Delivery Method: Nasal canula 3L**	Vitals: • **Temp**: 98.1F, tympanic • **Respiration**: 20/min • **Pulse**: 80/min • **b/p**: 146/74, supine, R arm • **O2**: 93%, 3L nasal canula
PAIN ASSESSMENT: **Time:** **Scale:**	Pain: at 8 AM vitals, no pain presented.

Location: **Severity:** **Characteristics:** **Interventions:**	
IV ASSESSMENT: **Size of IV:** **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **Fluid Type/Rate or Saline Lock:**	IV Assessment • **Location**: o R, cephalic vein • **Size**: 20G • **Date**: 9/25/2025 • **Patency**: able to be flushed, blood return noted • **Signs**: dry, clean and intact, no signs of redness, pain or infiltration • **Dressing**: clean, dry, intact Fluid Type: saline lock.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	Integumentary • **Color**: Usual for ethnicity • **Character**: clean, dry, intact with normal quantity, distribution and texture of hair • **Temp**: warm and dry upon palpation • **Turgor**: within 2 sec. • No rashes or drains • Bruises on arms from IV attempt assertion • No wounds • **Braden Score**: 20
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head/Neck: Head is normocephalic and symmetrical. Face symmetrical; trachea midline without deviation. Thyroid not palpable. Small scalp nodules/lumps

	noted, non-tender, no erythema or drainage. **Ears:** External ears symmetrical, without deformities, lumps, or lesions. Bilateral canals clear; no swelling, redness, or drainage. Reports no tinnitus. **Eyes:** Sclera white, cornea clear bilaterally. Pupils equal, round, reactive to light and accommodation (PERRLA). No periocular lumps or lesions; no discharge or discoloration. **Nose:** Septum midline, nares moist and pink. No bleeding or drainage. Frontal sinuses non-tender. Olfactory function intact; nares patent. **Mouth/Throat:** Oral mucosa moist and pink; no lesions. Tonsils 2+ bilaterally; uvula midline. Swallowing intact. Tongue pink. Patient edentulous; uses dentures.
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☐**	Heart sounds: S1 and S2 present, no murmurs. Rhythm: Irregular, with occasional skipped beats. Peripheral pulses: 2+ bilaterally.

Edema Y ☐ N ☐ **Location of Edema:**	Capillary refill: less than 3 seconds in fingers and toes bilaterally. Neck veins: No jugular venous distention (JVD). Extremities: Pitting edema 2+ bilaterally in lower legs and ankles; blanchable.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Normal, regular, unlabored, symmetrical respirations. Breath sounds clear bilaterally anteriorly and posteriorly, no wheezes, crackles, or rhonchi. No accessory muscle use. Thoracic spine shows increased curvature (kyphosis), upper back elevated.
GASTROINTESTINAL: **Diet at home:** **Current Diet:** **Is Client Tolerating Diet?** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:**	Diet: Home – regular. Current – cardiac. • yes Height/Weight: 5’0”, 213 lb. Bowel sounds: Normoactive in all four quadrants. Last bowel movement: 9/29/2025. Abdomen: Soft, non-tender on palpation, no organomegaly or masses;

Wounds: **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	firm/tender noted in specific area. No CVA tenderness. Tubes/Devices: No ostomy, NG, or feeding/PEG tube.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Genitourinary • **Color**: yellow • **Character**: clear • **Quantity of urine:** frequent • **Pain**: no pain upon urination • No dialysis External catheter in place, No foley.
Intake (in mLs) **Output (in mLs)**	Intake • 520cc (12:43pm) Output • Unmeasurable due to independent toileting
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐**	Musculoskeletal • **Neurovascular**: nails without clubbing or cyanosis, all extremities warm, dry and symmetrical

Fall Score: **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	• **ROM**: all extremities have full ROM and symmetrical movement • **Devices**: walker sometimes, when needed • **Strength**: 3+, bilateral normal and equal hand grip strength, pedal pushes and pulls strength equal and normal, dorsiflexion and plantar flexion performed with normal equal strength • **Fall Risk**: **69 High** Mobility: stable gait, standby assist with gait belt and walker.
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Neurological • MAEW: intact • PERLA: intact • Strength Arms – equal 3+ Legs – equal 3+ • Orientation: A/O x4 to person, place, time, and situation Mental status: normal cognition

	Speech: clear, logical, loud LOC: answer questions appropriately, arouse to voice, pain and touch when assessing feet
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):**	Coping method(s): Talks regularly with her son for support. Developmental level: Generativity vs. Stagnation. Religion & meaning to patient: Catholic; personal significance not assessed. Personal/Family Data: Lives in a nursing home; maintains regular contact with her son and grandchildren.

Discharge Planning

Discharge location:

Nursing home – LA Bella of Danville (patient discharged 9/29)

Home health needs:

Regular nursing monitoring for medication intake, vital signs monitoring, and weight check daily. Home health nurse should monitor for fluid overload, shortness of breath, or edema increase.

Equipment needs:

Walker, wheelchair, gait belt

Follow up plan:

Office visit with Bhaskar Patel, MD on Monday, December 29, 2025, at 1:20 PM

Office visit with Allanah Uche Frances, MD at OSFMG Danville, IL, scheduled as soon as possible within 1 week

Education needs:

- Low-sodium cardiac diet (avoid processed foods and added salt).
- Weight monitoring daily and when to call a sudden increase (>2 lbs in 24 hrs).
- Adherence to medicines, especially diuretics and blood pressure medications.
- Early symptoms of heart failure identification (swelling, shortness of breath, fatigue).
- When to call for emergency help (severe dyspnea, chest pain, confusion).

Nursing Process

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

Nursing Diagnosis • 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** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**
1. . Impaired Physical Mobility related to	Patient demonstrates decreased lower	By the end of the shift,	• Assist patient during all	• Document if patient

decreased strength and musculoskeletal changes as evidenced by need for standby assistance and use of walker. (Phelps, 2020)	extremity strength, high fall risk (69), and relies on a walker and standby assistance. (Phelps, 2020)	patient will safely ambulate with walker and standby assistance, demonstrating stable gait. (Phelps, 2020)	ambulation attempts, providing standby support. (Phelps, 2020) • Perform and guide the patient through at least one set of range-of-motion exercises during the	ambulated safely with walker and assistance. (Phelps, 2020) • Note patient's participation and tolerance during ROM exercises. (Phelps, 2020)

			shift. (Phelps, 2020)	
2. 2. Excess Fluid Volume related to compromised regulatory mechanism as evidenced by bilateral 2+ pitting edema in lower extremities. (Phelps,	Patient presents with bilateral edema 2+, indicating fluid retention likely related to cardiac or renal compromise. (Phelps, 2020)	By the end of the shift, patient will demonstrate no worsening of edema as evidenced by stable measurements of lower	• Measure and document edema (ankles/legs) at the beginning and end of the shift. (Phelps, 2020) • Elevate lower	• Compare edema measurements from start to end of shift. (Phelps, 2020) • Observe patient's comfort and response to leg

2020)		extremities and no sudden weight gain. (Phelps, 2020)	extremities while patient is in bed or sitting during the shift. (Phelps, 2020)	elevation. (Phelps, 2020)
3. Deficient Knowledge related to dietary management and cardiac diet as	Patient's home diet differs from prescribed cardiac diet; may not understand	By the end of the shift, patient will verbalize at least two key	• Provide brief teaching on cardiac diet, focusing on key foods to	• Assess patient's ability to correctly verbalize diet restrictions.

evidenced by patient on cardiac diet while home diet is regular. (Phelps, 2020)	restrictions or importance of diet for cardiac health. (Phelps, 2020)	components of the cardiac diet (e.g., low sodium, portion control). (Phelps, 2020)	limit and portion sizes. (Phelps, 2020) • Review patient's meal tray or plan for the shift to reinforce dietary instructions. (Phelps, 2020)	(Phelps, 2020) • Observe whether patient selects appropriate food choices during meals/snacks on shift. (Phelps, 2020)

Nursing Process Prioritization	**Rationale**
1. Excess Fluid Volume	Prioritized first because it directly impacts oxygenation and can rapidly worsen into pulmonary edema, posing immediate risk to life. (Huether & McCance, 2020).
2. Impaired Physical Mobility	Second, as decreased strength increases the risk of falls and delayed recovery. (Huether & McCance, 2020).
3. Deficient Knowledge	Third, as it affects long-term management and adherence but is less immediately life-

	threatening. (Hinkle, 2022)

Other References (APA):

Phelps, L. (2020). Sparks and Taylor's Nursing Diagnosis Reference Manual: Eleventh Edition. Wolter's Kluwer.

Hinkle, J., Cheever, K., Overbaugh, K. (2022). Brunner & Suddarth's Textbook of Medical-Surgical Nursing: 15th edition. Wolters Kluwer

Huether, S. E., & McCance, K. L. (2020). *Understanding pathophysiology* (7th ed.). Elsevier.