

**N311 Care Plan 4**

Autumn Eldridge

Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Merriweather

5 October 2025

### Demographics

<b>Date of Admission</b> 10/01/2025	<b>Client Initials</b> J.K.	<b>Age</b> 85	<b>Biological Gender</b> Male
<b>Race/Ethnicity</b> White	<b>Occupation</b> Retired Police Officer	<b>Marital Status</b> Widowed	<b>Allergies</b> Gabapentin
<b>Code Status</b> No CPR or any type of resuscitation.	<b>Height</b> 5 foot 7 inches	<b>Weight</b> 133 lbs BMI 20.83	

### Medical History

#### Past Medical History:

hypertension, hyperlipidemia, age-related nuclear cataract (right/ left), prostate cancer, acute cholecystitis, cholecystectomy tube replacement

#### Past Surgical History:

Laminectomy (N.D.), Colonoscopy (N.D.), Cataract Removal with implant (left, 2021/right, 2022), Back surgery (Fusion L3, L4, L5)

#### Family History:

No family history recorded.

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

No drugs or tobacco use. Occasional drinking

#### Education:

College Education

#### Living Situation:

Lives alone in a two-story house.

#### Assistive devices:

Cane and walker

### **Admission Assessment**

**Chief Complaint:** hypotension, confusion, acute decompensated heart failure

**History of Present Illness (HPI) – OLD CARTS:**

Approximately 10 days before admission to the hospital, the client noticed a gradual decline in overall strength. The weakness is diffuse and not localized to any specific area of the body. The weakness has gradually gotten worse. The client is experiencing no pain, numbness, or any other symptoms. They have spent more time resting, but that has not improved the fatigue. There have been no aggravated triggers for the weakness, and it stays about the same throughout the day.

### **Primary Diagnosis**

**Primary Diagnosis on Admission:** Congestive Heart Failure (CHF)

**Secondary Diagnosis (if applicable):** Weakness and shortness of breath (SOB)

## **Pathophysiology**

### **Pathophysiology of Congestive Heart Failure:**

Congestive heart failure is a pathophysiologic syndrome in which the heart is unable to maintain adequate forward output and handle venous return, leading to fluid congestion in tissues and organs. (Capriotti, 2024, p. 478). This reduces cardiac output and elevates intracardiac pressure. (Capriotti, 2024, p. 482). The symptom of shortness of breath is linked to the backward pressure transmitted from the failing left ventricle into the pulmonary vasculature. As the left atrial and pulmonary venous pressure rise, fluid leaks into the lung interstitial and alveolar spaces, diminishing lung compliance and impairing gas exchange. (Capriotti, 2024, p. 485). This forces the clients to increase their ventilatory effort. In severe cases, orthopnea or paroxysmal nocturnal dyspnea may develop as redistribution of fluid into the thorax in the supine position exacerbates pulmonary congestion. (NIH, 2024).

Fatigue and weakness in congestive heart failure are from a convergence of hemodynamic and systemic derangements. With diminished cardiac output, peripheral tissues receive less blood flow and oxygen, which compromises the aerobic metabolism and performance. (Capriotti, 2024, p. 490). Chronic hypoperfusion impairs mitochondrial function in skeletal muscle fibers, limiting ATP production and shifting metabolism toward anaerobic paths, which are less efficient and produce lactate as a byproduct. (Capriotti, 2024, p. 490). Dyspnea and fatigue are early warning signs of decompensation in CHF. Recognizing changes in these symptoms is essential and can prevent further decline and hospitalization. (CDC, 2024). Sustained activation of the sympathetic nervous system and renin-angiotensin-aldosterone system (RAAS) leads to myocardial remodeling, fibrosis, and further weakening of the heart muscle. (Capriotti, 2024, p. 488).

### Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives* (3<sup>rd</sup> ed.). F.A. Davis Company

Centers for Disease Control and Prevention. (2024). About *Heart Failure*.

<https://www.cdc.gov/heart-disease/about/heart-failure.html>

National Library of Medicine. (2024). *Chapter 11 Dyspnea, Orthopnea, and Paroxysmal*

*Nocturnal Dyspnea*. <https://www.ncbi.nlm.nih.gov/books/NBK213/>

### Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
CBC with Diff	HGB 11.1 HCT 35.7 MCV 78.1 MCH 24.3	HGB 10.6 HCT 34.9 MCV 78.3 MCH 23.8	HGB 13-16.6 g/dL HCT 38- 50% MCV 82-96 fL MCH 26- 32 pg	Iron deficiency may lead to reduced hemoglobin growth
CMP	Sodium 133 Chloride 97	Sodium 135 Chloride 99	Sodium 136-145 mmol/L Chloride 98-107 mmol/L	Malnutrition, metabolic alkalosis, inflammation, poor protein intake

	Glucose 100 Albumin 3.2	Glucose 103 Albumin 3.4	Glucose 70- 99 mg/dL Albumin 3.5- 5 g/dL	
Lactic Acid	1.5 mmol/L	10/02/2025 No new results recorded	0.7 – 2.0 mmol/L	Tissue hypoxia or sepsis
NT- proBNP	626.9	10/02/2025 No new results recorded	<450 ng/L	Shortness of breath, fatigue or weakness, heart failure, orthopnea
Troponin 1	2.7	10/02/2025 No new results recorded	<=35ng/L	Indicate muscle damage
BMP with Calcium	Creatinin 0.73 Calcium 8.9	Creatinin 0.66 Calcium 8.4	Creatinin 0.70-1.30 mg/dL Calcium 8.7- 10.5 mg/dL	Acute kidney disease, muscle injury, low muscle mass, hypercalcemia, hypocalcemia, hyperparathyroidism, hypoparathyroidism, magnesium deficiency

Urinalysis with reflex	Protein random urine trace	Trace	Negative	Heart failure, hypertension, infection of the urinary tract, early kidney disease
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Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
X-Ray chest Indicate if there is any increased pressure of the pulmonary venous and shows congestion.	Shortness of breath	No pneumothorax, no acute cardiopulmonary process, heart and media sternal are normal, lung hyperinflated, improved aeration lung base, slight improvement of pulmonary interstitial mark, and no new airspace.

**Diagnostic Test Reference (1) (APA):**

**Current Medications**

<b>Brand/Generic</b>	(porcine) Heparin	(erleada) Apalutamide	Ferrous sulfate	(crestor) Nosuvastin	(flomax) Tamsulosin
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<b>Dosage, Route, Frequency given</b>	Injection 5,00 units/ 3x daily	Tablet /oral 120 mg/ 1x daily	Tablet/ oral 325 mg/ 1x daily	Tablet/ oral 20 mg/ 1x evening	Capsule/ oral intake with acidic fruit 0.4 mg/ 1x daily
<b>Reason Client Taking</b>					

### Assessment

#### Physical Exam – **HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS**

General, Psychosocial/Cultural, and TWO focused assessment specific to the client is required.

The student and instructor may complete these assessments together.

<b>GENERAL:</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b>	The client is alert and oriented x3, demonstrating awareness of person, place, and situation. Speech is clear and coherent. Age-related signs of confusion are noted.
<b>INTEGUMENTARY:</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds:</b> .  <b>Braden Score:</b>  <b>Drains present:</b> Y <input type="checkbox"/> N <input type="checkbox"/>  <b>Type:</b>	
<b>HEENT:</b>	

<p><b>Head/Neck:</b></p> <p><b>Ears:</b></p> <p><b>Eyes:</b></p> <p><b>Nose:</b></p> <p><b>Teeth:</b></p>	.
<p><b>CARDIOVASCULAR:</b></p> <p><b>Heart sounds:</b></p> <p>S1, S2, S3, S4, murmur etc.</p> <p><b>Cardiac rhythm (if applicable):</b></p> <p><b>Peripheral Pulses:</b></p> <p><b>Capillary refill:</b></p> <p><b>Neck Vein Distention:</b> Y <input type="checkbox"/> N <input type="checkbox"/> <b>Edema</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Location of Edema:</b></p>	.
<p><b>RESPIRATORY:</b></p> <p><b>Accessory muscle use:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Breath Sounds: Location, character</b></p>	.
<p><b>GASTROINTESTINAL:</b></p> <p><b>Diet at home:</b></p> <p><b>Current Diet</b></p> <p><b>Height:</b></p> <p><b>Weight:</b></p> <p><b>Auscultation Bowel sounds:</b></p> <p><b>Last BM:</b></p> <p><b>Palpation: Pain, Mass etc.:</b></p> <p><b>Inspection:</b></p> <p><b>Distention:</b></p>	.

<p><b>Incisions:</b></p> <p><b>Scars:</b></p> <p><b>Drains:</b></p> <p><b>Wounds:</b></p> <p><b>Ostomy:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Nasogastric:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Size:</b></p> <p><b>Feeding tubes/PEG tube</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Type:</b></p>	
<p><b>GENITOURINARY:</b></p> <p><b>Color:</b></p> <p><b>Character:</b></p> <p><b>Quantity of urine:</b></p> <p><b>Pain with urination:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Dialysis:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Inspection of genitals:</b></p> <p><b>Catheter:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Type:</b></p> <p><b>Size:</b></p>	
<p><b>MUSCULOSKELETAL:</b></p> <p><b>Neurovascular status:</b></p> <p><b>ROM:</b></p> <p><b>Supportive devices:</b></p> <p><b>Strength:</b></p> <p><b>ADL Assistance:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Risk:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Fall Score:</b></p> <p><b>Activity/Mobility Status:</b></p>	<p>The client shows intact neurovascular status in all extremities, with no circulation issues noted. Range of motion is functional but limited by generalized weakness and signs of fatigue throughout all limbs. The client requires the use of both a walker and a cane for ambulation and needs assistance with a gait belt during transfers and walking to ensure safety. The client has an alarm on the chair to ensure they do not fall. Muscle strength has decreased in all extremities and has increased fall risk. The client is unable to mobilize independently and depends on devices and the caregiver's assistance.</p>

<p>Independent (up ad lib) <input type="checkbox"/></p> <p>Needs assistance with equipment <input type="checkbox"/></p> <p>Needs support to stand and walk <input type="checkbox"/></p>	
<p><b>NEUROLOGICAL:</b></p> <p><b>MAEW:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>PERLA:</b> Y <input type="checkbox"/> N <input type="checkbox"/></p> <p><b>Strength Equal:</b> Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/></p> <p><b>Orientation:</b></p> <p><b>Mental Status:</b></p> <p><b>Speech:</b></p> <p><b>Sensory:</b></p> <p><b>LOC:</b></p>	<p>The client is alert and oriented, with good orientation, mental status, and speech. Pupils are equal and reactive to light and accommodation. Strength is equal bilaterally and client can move all extremities equally.</p>
<p><b>PSYCHOSOCIAL/CULTURAL:</b></p> <p><b>Coping method(s):</b></p> <p><b>Developmental level:</b></p> <p><b>Religion &amp; what it means to pt.:</b></p> <p><b>Personal/Family Data (Think about home environment, family structure, and available family support):</b></p>	<p>.</p>

Vital Signs, 1 set – **HIGHLIGHT ALL ABNORMAL VITAL SIGNS**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1545	79 bpm	104/63 mmHg	16 bpm	98.1 F	99%

### Pain Assessment, 1 set

Time	Scale	Location	Severity	Characteristics	Interventions
1545	0	NA	NA	NA	NA

### Intake and Output

Intake (in mL)	Output (in mL)
120 mL of water	100 mL urine
50%	No stool

### Nursing Diagnosis

**\*Must be NANDA approved nursing diagnosis\***

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
<ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> <li>• Listed in order by priority – highest priority to lowest priority pertinent to this client</li> </ul>	<ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>			<ul style="list-style-type: none"> <li>• How did the client/family respond to the nurse’s actions?               <ul style="list-style-type: none"> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul> </li> </ul>
<ol style="list-style-type: none"> <li>1. Unable to do daily activities due to decreased cardiac output and generalized weakness and need for assistive devices for</li> </ol>	<p>Adequate delivery of oxygen to tissues, resulting in early fatigue during daily activities.</p>	<ol style="list-style-type: none"> <li>1. Assess the client’s tolerance to physical activity before, during, and after activity.</li> </ol>	<ol style="list-style-type: none"> <li>1. The client will improve tolerance to daily activities and will be able to ambulate short</li> </ol>	<p>The client will participate in physical therapy sessions daily and will reduce fatigue.</p>

mobility.		2. Collaborate with physical therapy to develop a progressive ambulation and strength program.	distances with less fatigue within 10 days.	
2. Impaired physical mobility related to musculoskeletal weakness and fatigue.	Limited mobility and increase fall risk. Assistive devices and supervision are needed for safe ambulation.	1. Aid with all transfers and use a gait belt to encourage use of ambulation.  2. Ensure a safe environment to reduce fall risk. (clear walkway, non-skid footwear, accessible to all personal items while in bed)	1. The client will improve mobility by being able to transfer from chair to bed and bathroom that are in short range of distance with minimal assistive devices within 10 days.	The client will be able to improve mobility and will be able to complete physical therapy at the nursing home and will be able to return home.



