# N321 CARE PLAN #2

Da’Zja Lawson

Lakeview College of Nursing

N321: Adult Health I

Professor Kristal Henry

10/17/2025

## Demographics

| Date of Admission | Client Initials | Age | Biological Gender |
|---|---|---|---|
| 10/5/2025 | CJM | 94 | Female |
| **Race/Ethnicity** | **Occupation** | **Marital Status** | **Allergies** |
| Caucasian | Retired from Finance | Married | Codeine- Hallucination<br>Prednisone- swelling<br>Tramadol- Hallucination<br>Penicillins |
| **Code Status** | **Height** | **Weight** | |
| Full Code | 152.4 cm | 47.8 kg (105 lbs) | |

## Medical History

**Past Medical History:** Anxiety, Arthritis, CKD, stage 3 CAD, depression, Diabetes Mellitus, **Gout, Hematuria,** Hypertension, Kidney disease, Minigenres, and skin cancer

**Past Surgical History:** Brain tumor excision, total hip arthroplasty, total hip Arthroplasty (right), exploration of abdomen, Appendectomy, Tonsillectomy, Hysterectomy, dilation and curettage, endoscopy, colon, diagnostic, ECD, Cholecystectomy, ORIF, distal radius (right 9/8/2023).

**Family History:** Breast cancer (maternal aunt) Chronic Heart Failure her mother.

**Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use):** My patient stated she “never smoked, or used smokeless tobacco in my life,” and does not drink or use drugs.

**Education:** Graduated with a finance degree

**Living Situation:** The patient lives at home with her husband.

**Assistive devices:** Walker

## Admission History

**Chief Complaint:** Shortness of breath and weakness.

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

The patient presented to the ED stating she had begun having shorten of breath about a few days ago and stated it has worsened on 10/06/2025. The client stated that it was “mild at first” but started to worsen` when she started to move around. The patient states that she has difficulty with “breathing” rather than having pain. The symptoms are persistent throughout the day and get worsen with activity, but it does resolve with rest. She has weakness throughout her body, especially in her legs when walking. The patient stated that the shortness of breath is constant but becomes more severe with minimal exertion. Patient said the weakness has started prior to her shortness of breath. The patient describes the breathing as “tightness with pressure throughout the chest” and “hard to catch my breath.” Client states that “sitting up or resting” helps with breathing. Client is not on any oxygen, but she does use furosemide to provide temporary relief. Patient did take her furosemide, but no other medication was taken for symptoms.

## Admission Diagnosis

**Primary Diagnosis:** Chronic Heart Failure

**Secondary Diagnosis (if applicable):** N/A

## Pathophysiology

Heart failure is diagnosed in several ways, it can either be acute or chronic, systolic or diastolic dysfunction, HFrEF or HFpEF, high output or low output failure, right sided or left sided heart failure and forward and backward failure. My client was diagnosed with chronic heart failure (Capriotti, 2024). According to the European Society of Cardiology, ESC 2016, defines heart failure as a clinical syndrome which can be characterized by certain symptoms such as dyspnea, ankle swelling, fatigue that may be accompanied by signs of elevated jugular,

peripheral edema caused by a structural and or functional cardiac output and or elevated intracranial pressure at rest or during stress (Schwinger 2021). The primary side of dysfunctional as left sided, right sided, or biventricular influenced the clinical manifestation of heart failure (Schwinger, 2021). Chronic heart failure is a complex clinical occurrence in which the heart is unable to pump enough blood to meet the requirements of the body (Singh, 2024). Chronic heart failure is where the heart gradually suffers weakening over an extended period of time (Capriotti, 2024). The efficiency, rhythmicity, and strength of all the chambers is what the heart depends on (Caprotti, 2024). Both ventricles become affected by the biochemical and the pressure changes that affect the myocardium in heart failure (Caprotti, 2024). This can be characterized by a decline in stroke volume as result of a dysfunction of systole, diastole, or both (Singh, 2024). Systolic chronic heart failure corresponds with increased end, which normally results in a decline cardiac contractility (Singh, 2024). There is a reduce end diastolic volume in diastolic chronic heart failure and this results from impaired ventricular filling, that results from a fall of compliance of ventricle, in which the walls are stiffen from the dysfunction (Singh, 2024). Chronic heart failure results from myocardial injury which leads to impaired contractility and ventricular remodeling (Singh, 2024). With the decrease cardiac output it triggers neurohormanal activation of the sympathetic nervous system and the renin-angiotensin aldosterone system this causes vasoconstriction and sodium and water retention (Singh, 2024). This mechanism initially maintains perfusion leading to contributing to ventricular hypertrophy, fibrosis, and further decline in cardiac efficiency (Singh, 2024).

Neurohumoral dysfunction is the fundamental pathophysiological mechanism underlying chromic heart failure, which is three basic elements in which hemodynamic adaptive reaction is most crucial (Singh, 2024). During the adaptive process the perfusion pressure is keep in the

major organs by increasing circulation of blood volume, inducing vasoconstriction, and activating the heart (Singh, 2024). There is an inflammatory response to counteract hormonal imbalance correlated with increased production of inflammatory cytokines and reactive oxygen species (Singh, 2024). Last, there is a physiological hypertrophic response and ventricular remodeling, with structural changes in cardiac muscle cells and in the shape of the ventricular chamber which causes CO to improve.

Some clinical findings in chronic heart failure can consist of, having the retention of fluid in the pulmonary causing crackles on the lungs upon auscultation and peripheral veins resulting in edema, fatigue and dyspnea upon exercise, ambulating or at rest, and increased heart rate (Capriotti, 2024). There are plenty of laboratory and diagnostic studies when it comes to diagnosing heart failure, such as elevated brain natriuretic peptide (BNP) levels, showing ventricular stretch and volume overload (Capriotti, 2024). An important diagnostic test that should be used to assess ejection fraction and structural abnormalities is Echocardiography (Capriotti, 2024). An additional diagnostic test may include chest x-ray to indicate cardiomegaly and pulmonary edema, as well as EKG to determine abnormalities in the heart rhythm (Capriotti, 2024).

My patient presented to the emergency room with the symptoms of shortness of breath and weakness and signs of crackles on the lungs, weak peripheral in the lower extremity, and elevated BUN level. My client was assessed with a stress walk test, to see how far she walks without having dyspnea. The laboratory testing showed my client having a 41 BUN level which indicate the decreased in the cardiac output in the heart which led to poor renal perfusion. My client treatment plans include her going to a rehab therapy to regain some strength and to be able to ambulate without dyspnea. The chest x ray that was done on my patient showed that the heart

was a little enlarged and there were some fluids in the lungs which can mean the heart isn't pumping correctly. A radiologist specialist did not review the x chest ray. An EKG was completed which showed premature ventricle's complexes as well as premature arterial complexes. The treatment plan for my client is to discharge her to a rehab facility to help manage her new medications and to regain some strength.

**Pathophysiology References (2) (APA):**

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

Schwinger R. H. G. (2021). *Pathophysiology of heart failure. Cardiovascular diagnosis and therapy*, *11*(1), 263–276. https://doi.org/10.21037/cdt-20-302

Singh, R. B., Fedacko, J., Hristova, K., & Elkilany, G. E. N. (Eds.). (2024). *Pathophysiology, Risk Factors, and Management of Chronic Heart Failure*. Academic Press.

**Laboratory/Diagnostic Data**

| Lab Name | Admission Value | Today's Value | Normal Range | Reasons for Abnormal |
|---|---|---|---|---|
| **BUN** | **16mg/dL** | **41mg/dL** | **6-20mg/dL** (Pagana et al., 2023) | Due to decreased cardiac output in CHH leads to reduced renal perfusion (Pagana et al., 2023). |
| **Potassium** | **3.2mmol/L** | **4.6mmol/L** | **3.5-5.1mmol/L** (Pagana et al., 2023) | Hypokalemia could be from the managing of diuretic use in CHF. Replacement therapy (IV) helped to get the patient back to normal range (Pagana et al., 2023). |
| **Chloride** | **108mmol/L** | **98mmol/L** | **98-107mmol/L** (Pagana et al., 2023) | This could be due to dehydration (Pagana et al., 2023). |
| **CO2, Venous** | **21mmol/L** | **27mmol/L** | **22-30mmol/L** (Pagana et al., 2023) | Low CO2 suggest metabolic acidosis or respiratory alkalosis could be linked to early decompensation (Pagana |

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| | | | | et al., 2023). |
| **Creatinine, Blood** | **1.16mg/dL** | **1.77mg/dL** | **0.60-1.00mg/dL** (Pagana et al., 2023) | Patient has renal impairment from poor perfusion due to CHF (Pagana et al., 2023). |
| **Glucose** | **115 mg/dL** | **117 mg/dL** | **70-99 mg/dL** (Pagana et al., 2023) | This could be due to stress or poorly controlled diabetes (Pagana et al., 2023). |
| **GFR estimated** | **44** | **26** | **>=60** (Pagana et al., 2023) | This could be due to acute kidney injury or chronic kidney disease (Pagana et al., 2023). |
| **Total Protein** | **5.3 g/dL** | **5.8 g/dL** | **6.0-8.0 g/dL** (Pagana et al., 2023) | This could be due to the CHF or malnutrition (Pagana et al., 2023). |
| **Albumin** | **2.6 g/dL** | **3.1 g/dL** | **3.5-5.0g/dL** (Pagana et al., 2023) | This is likely in CHF patientt due to the inflammation or volume overload (Pagana et al., 2023). |
| **GFR est non African** | **44** | **27** | **>=60** (Pagana et al., 2023) | Acute kidney injury or chronic kidney disease |

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| | | | | (Pagana et al., 2023). |
| **GFR African** | **53** | **32** | **>=60** (Pagana et al., 2023) | Acute kidney injury or chronic kidney disease (Pagana et al., 2023). |
| **NT Probnp** | **2787.7** | **Not taken** | **<450.0 pg/mL** (Pagana et al., 2023) | This confirms CHF exacerbation (Pagana et al., 2023). |
| **pH Arterial** | **7.46** | **Not taken** | **7.35-7.45** (Pagana et al., 2023) | Possibly respiratory its slightly alkalosis (Pagana et al., 2023). |
| **PCO2 (arterial)** | **31mmHg** | **Not taken** | **35-45 mmHgh** (Pagana et al., 2023) | This indicates respiratory alkalosis is happening in the patient (Pagana et al., 2023). |
| **WBC** | **3.62mol** | **7.64mol** | **4.00-12.00 10(3)mol** (Pagana et al., 2023) | This could be indication on viral infection or chronic illnes (Pagana et al., 2023). |
| **RBC** | **2.99mcL** | **3.14mcL** | **3.80-5.30 10(6)mcL** (Pagana et al., 2023) | The patient low RBC means anmia which is common in CHF patient due to the chronic disease |

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| | | | | (Pagana et al., 2023). |
| **Hemoglobin** | **9.3g/dL** | **9.9g/dL** | **12.0-15.8g/dL** (Pagana et al., 2023) | This contributes to the shortness and weakness (Pagana et al., 2023). |
| **Hemocrit** | **29.2%** | **31.2%** | **36.0-47.0%** (Pagana et al., 2023) | The patient has anemia (Pagana et al., 2023). |
| **MCV** | **97.7fl** | **99.4fl** | **82.0-96.0fl** (Pagana et al., 2023) | This could be hight due to nutritional deficiencies (Pagana et al., 2023). |
| **Plaletet count** | **444 mol** | **467 mol** | **140-440 10(3)mol** (Pagana et al., 2023) | This is elevated due to inflammation stress or anemia (Pagana et al., 2023). |
| **MPV** | **9.5fl** | **10.3fl** | **9.7-12.4fl** (Pagana et al., 2023) | This could be caused by suppressed marrow activity (Pagana et al., 2023). |
| **Monocytes** | **12.7%** | **16.2 %** | **4.0-12.0%** (Pagana et al., 2023) (Pagana et al., 2023) | This is due to chronic inflammation or stress response in the patient (Pagana et al., 2023). |
| **Immature** | **1.4%** | **2.0%** | **0.0-0.4%** | This maybe an indication |

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| **Granulocyte** | | | (Pagana et al., 2023) | of marrow stress or infection (Pagana et al., 2023). |
| **Absolute Lymphocyte** | **0.50mol** | **1.62mol** | **1.30-3.20 10(3)mol** (Pagana et al., 2023) | This is mostly due to the infection or inflammation which reinforces the presence of marrow stimulation (Pagana et al., 2023). |
| **Absolute immature granulocyte** | **0.05mol** | **0.15mol** | **0.00-0.03 10(3)mol** (Pagana et al., 2023) | This means that there is stress or an infection in the body (Pagana et al., 2023). |
| **Basophil** | **Not taken** | **1.2 %** | **0.0-1.0%** (Pagana et al., 2023) | This could be due to the inflammatory state in the patients body (Pagana et al., 2023). |
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| **Previous diagnostic prior to admission (ER, clinic etc.) if pertinent to admission diagnosis** | **Previous diagnostic results and correlation to client admission** | **Current Diagnostic Test & Purpose** | **Clients Signs and Symptoms** | **Results and correlate to client diagnosis and condition** |
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| | | **X-Ray Chest 2 views: The purpose of an X-ray of a chest is to assess for pulmonary congestion, cardiomegaly and pleural effusion which are common in patient with chronic heart failure, and a two view completes a more evaluation of lungs fields and heart size (Pagana et al., 2023).** | **Clients symptoms are shortness of breath and signs are fluid in the lungs upon auscultation. Client also is diagnosed with Chronic Heart Failure,** | **The heart is enlarged and there is fluid in the lungs which results in shortness of breath.** |
| | | **EKG (12 lead): An EKG can detect arrhythmias that can reduce cardiac output and** | **The has shortness of breath. Chronic Heart failure.** | **There were premature ventricular complexes and** |

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| | | **exacerbate symptoms such as shortness of breath (Ignatavicius et al., 2020). This is also done to evaluate the heart rhythm, conduction, abnormalities and evidence of ischemia or previous myocardial infarction which can worsen chronic heart failure (Pagana et al., 2023).** | | **premature arterial complexes shown, this is also an indicator of why my patient is having dyspnea.** |
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**Diagnostic Test Reference (1) (APA):**

Ignatavicius, D. D., Workman, M. L., & Rebar, C. R. (2020). *Medical-surgical nursing: Concepts for interprofessional collaborative care* (9th ed.). *Elsevier.*

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

**Active Orders**

| Active Orders | Rationale |
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| **Admission Weight** | **This should be taken on every patient who admitted to the hospital. In CHF patient it is critical to monitor fluid retention or loss, this helps guide diuretic therapy if needed.** |
| **For Blood sugar of 70mg/dL or less** | **This may be the cause of the patient weakness; to prevent hypoglycemia the patient needs to have a blood sugar less than 70mg/dL.** |
| **Home Oxygen Qualification** | **The patient will be assessed to see if they need to have home oxygen due to the shortness of breath.** |
| **Insert/Maintain Peripheral IV** | **Patient will have an IV to administrate IV medication or fluid for electrolytes or diuretics.** |
| **Intake and Output** | **Patient with chronic heart failure is important to monitor the intake and output** |

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| | **to prevent fluid overload.** |
| **Notify Physician** | **This is important to communicate with the physician in case of any changes or concerns with the client.** |
| **Notify physician when prior to admission (PTA) medication review has been completed** | **This is important to avoid duplication or anything that could worsen the patient chronic heart failure.** |
| **Nursing communication- off prune juice if available on the patient's diet.** | **This is due to the patient taking laxatives if the patient has diarrhea.** |
| **Nursing communication- Please provide patient education to reduce/avoid constipating foods such as red meat, fried or fatty foods, milk and cheese** | **This is so the patient will not have constipation.** |
| **Nursing Communication- Promote adequate fluid intake and encourage increase fluid intake if not on a fluid restriction.** | **This is for the prevention of dehydration which can worsen the kidney function causing issues.** |
| **Nursing night Calls** | **This is for the patient needs anything throughout the night.** |
| **Patient May Shower** | **This is to indicate that the patient is stable and able to shower without shortness of breath.** |
| **Perform POC blood glucose- AC and HS** | **The client is diabetic, will need to have it** |

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| | **check before every meal.** |
| **Post hypoglycemia treatment and flood sugar greater than or equal to 80 mg/dL** | **This is put in place to make sure the client can go back to resuming regular diet after a hypoglycemic event.** |
| **Pulse Oximetry** | **Any patient with chronic heart failure should have their oxygen saturation check to detect hypoxemia.** |
| **RT Therapy Assessment Score (Click on Summary Sentence of this order to see the last RT Therapy Assessment Score.)** | **This helps let the nurse know what the patient needs after respiratory therapy, if they need any at home oxygen.** |
| **Telemetry Monitoring** | **This was placed on the patient to monitor for arrhythmias and cardiac rhythm stability.** |
| **Up as tolerated** | **This is to encourage mobility to prevent declining of condition, with safe ambulation.** |
| **Vital signs per unit rotation** | **It is important to take routine rounds on vital signs with a patient who has chronic heart failure this can detect deterioration or response to therapy in patient who has chronic heart failure.** |

**Hospital Medications (Must List ALL)**

| **Brand/ Generic** | **allopurinol (ZYLOPRIM)** | **amLODIPine (NORVASC)** | **brimonidine (ALPHAGAN) 0.2 % solution** | **aspirin chewable tablet** | **empagliflozin (JARDIANCE)** | **furosemide (LASIX)** |
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| **Dose, frequency, route** | **100 mg oral every evening** | **5 mg oral daily** | **1 drop both eyes 2 times daily** | **81mg oral daily** | **10mg oral daily** | **40 mg oral, daily** |
| **Classification (Pharmacological and therapeutic and action of the drug** | **Pharmacological:** Xanthine oxidase inhibitor**,** (Jones &Bartlett, 2024)<br><br>**Therapeutic:** Antigout (Jones &Bartlett, 2024)<br><br>**Action:** Inhibits xanthine oxidase enzyme, thereby decreasing production | **Pharmacological:** Calcium channel blocker (Jones &Bartlett, 2024)<br><br>**Therapeutic:** Antihypertensive (Jones &Bartlett, 2024)<br><br>**Action:** Lower blood pressure by relaxing vascular smooth | **Pharmacological:** Alpha-2 adrenergic agonist (Jones &Bartlett, 2024)<br><br>**Therapeutic:** Anti-glaucoma (Jones &Bartlett, 2024)<br><br>**Action:** Decreases aqueous humor production, lowering intraocular pressure | **Pharmacological:** Salicylate (Jones &Bartlett, 2024)<br><br>**Therapeutic:** Antiplatelet (Jones &Bartlett, 2024)<br><br>**Action:** Inhibits platelet aggregation (Jones &Bartlett, 2024) | **Pharmacological:** SGLT2 inhibitor (Jones &Bartlett, 2024)<br><br>**Therapeutic:** Antidiabetic (Jones &Bartlett, 2024)<br><br>**Action:** Increases urinary glucose excretion (Jones &Bartlett, | **Pharmacological:** Loop diuretic (Jones &Bartlett, 2024)<br><br>**Therapeutic:** Antihypertensive/diuretic (Jones &Bartlett, 2024)<br><br>**Action:** Inhibits sodium and water reabsorption in loop of Henle (Jones &Bartlett, 2024) |

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| | of uric acid**,** (Jones &Bartlett, 2024) | muscles, (Jones &Bartlett, 2024) | (Jones &Bartlett, 2024) | | 2024) | |
| **Reason Client Taking** | To prevent hyperuricemia or gout, (Jones &Bartlett, 2024) | Manage hypertension, (Jones &Bartlett, 2024) | Reduce elevated intraocular pressure, (Jones &Bartlett, 2024) | Prevent cardiovascular events, (Jones &Bartlett, 2024) | Manage type 2 diabetes, (Jones &Bartlett, 2024) | Reduce fluid overload, hypertension, (Jones &Bartlett, 2024) |
| **Two contraindications (pertinent to the client)** | **1.** Severe renal impairment **(** Jones &Bartlett, 2024)<br>**2.** Liver disease, (Jones &Bartlett, 2024) | **1.** Severe hypotension, **(** Jones &Bartlett, 2024)<br>**2 .**Cardiogenic shock (Jones &Bartlett, 2024) | **1.** Children under 2 years old, (Jones &Bartlett, 2024)<br>**2.** Be cautious with severe cardiovascular disease, (Jones &Bartlett, 2024) | **1.** Active GI bleeding, (Jones &Bartlett, 2024)<br>**2.** Bleeding disorder, (Jones &Bartlett, 2024) | **1.** Severe renal impairment, (Jones &Bartlett, 2024)<br>**2.** Ketoacidosis, (Jones &Bartlett, 2024) | **1.** Anuria (Jones &Bartlett, 2024)<br>**2.** Severe electrolyte depletion, (Jones &Bartlett, 2024) |

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| **Two side effects or adverse effects (Pertinent to the client)** | **1.** Rash (Jones &Bartlett, 2024)<br><br>**2.** GI upset (Nausea and diarrhea), (Jones &Bartlett, 2024) | **1.** Headache, (Jones &Bartlett, 2024)<br><br>**2.** Peripheral edema (Jones &Bartlett, 2024) | **1.** Dry mouth, (Jones &Bartlett, 2024)<br><br>**2.** Eye redness, (Jones &Bartlett, 2024) | **1.** GI upset, (Jones &Bartlett, 2024)<br><br>2. Easy Bruising, (Jones &Bartlett, 2024) | **1.** Urinary tract infections, **(**Jones &Bartlett, 2024)<br><br>**2.** dehydration, (Jones &Bartlett, 2024) | **1.** Hypokalemia**,** **(**Jones &Bartlett, 2024)<br><br>**2.** Hypotension, (Jones &Bartlett, 2024) |
| **Key nursing assessment(s) prior to administration** | **1.** Check uric acid levels, (Jones &Bartlett, 2024)<br><br>**2.** Assess kidney and liver function, (Jones &Bartlett, | **1.** Monitor blood pressure, and heart rate, (Jones &Bartlett, 2024)<br><br>**2.** Assess for edema, (Jones &Bartlett, 2024) | **1.** Asses intraocular pressure**,** (Jones &Bartlett, 2024)<br><br>**2.** Check for ocular irritation (Jones &Bartlett, 2024) | **1.** Asses for bleeding history, (Jones &Bartlett, 2024)<br><br>**2.** Monitor GI disco | **1.** Monitor blood glucose, **(**Jones &Bartlett, 2024) | **1.** Monitor electrolytes, daily weight, (Jones &Bartlett, 2024)<br><br>**3.** Monitor Blood pressure, (Jones |

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| | 2024) | | | mf ort, (Jo nes<br><br>&Bartlett, 2024) | **2.** Monitor signs of UTI, (Jones<br><br>&Bartlett, 2024) | &Bartlett, 2024) |

| **Brand/ Generic** | **heparin (porcine) injection** | **insulin lispro (HumaLOG) 2-6 Units and 3-15 units** | **LORazepam (ATIVAN)** | **metoprolol Succinate (TOPROL-XL) XL** | **potassium chloride SA (KLORCON M)** | **rosuvastatin (CRESTOR)** |
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| **Dose, frequency, route** | **5000 units, subcutaneous every 8 hours scheduled 3 times per day** | **2-6 units, subcutaneous nightly 3-15 units subcutaneous 3 times daily** | **2 mg oral 2 times daily** | **25 mg oral daily** | **20mEq oral 2 times daily with meals.** | **5 mg Oral every evening** |
| **Classification (Pharmacological and therapeutic and action of the drug** | **Pharmacological:** Anticoagulant (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeutic:** Prevent/treat thrombosis (Jones<br><br>&Bartlett, 2024) | **Pharmacological:** Rapid-acting insulin (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeutic:** Antidiabetic (Jones<br><br>&Bartlett, 2024) | **Pharmacological:** Benzodiazepine (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeutic:** Anxiolytic/sedative (Jones<br><br>&Bartlett, 2024) | **Pharmacological:** Beta-1 selective blocker (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeutic:** Antihypertensive/antianginal (Jones<br><br>&Bartlett, 2024) | **Pharmacological:** Electrolyte supplement (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeutic:** Potassium replacement (Jones<br><br>&Bartlett, 2024) | **Pharmacological:** HMG-CoA reductase inhibitor (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeutic:** Lipid-lowering agent (Jones<br><br>&Bartlett, |

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| | **Action:** Inhibits clotting factors to prevent clot formation (Jones &Bartlett, 2024) | **Action:** Lowers blood glucose by facilitating cellular glucose uptake (Jones &Bartlett, 2024) | **Action:** Enhances GABA effect to produce sedation (Jones &Bartlett, 2024) | **Action:** Decreases heart rate and myocardial contractility (Jones &Bartlett, 2024) | **Action:** Replaces potassium to maintain cardiac and muscular function (Jones &Bartlett, 2024) | 2024)<br><br>**Action:** Inhibits cholesterol synthesis in the liver (Jones &Bartlett, 2024) |
| **Reason Client Taking** | Prevent DVT/PE, (Jones &Bartlett, 2024) | Manage type 1 or type 2 diabetes, (Jones &Bartlett, 2024) | Manage anxiety or agitation, (Jones &Bartlett, 2024) | Manage hypertension, angina, (Jones &Bartlett, 2024) | Treat/ prevent hypokalemia, (Jones &Bartlett, 2024) | Manage hyperlipidemia, (Jones &Bartlett, 2024) |
| **Two contraindications (pertinent to the client)** | **1.** Active bleeding, (Jones &Bartlett, 2024)<br><br>**2.** Thrombocytopenia, (Jones &Bartlett, 2024) | **1.** Hypoglycemia, (Jones &Bartlett, 2024)<br><br>**2.** Allegery to insulin, (Jones &Bartlett, 2024) | **1.** Severe respiratory insufficiency, (Jones &Bartlett, 2024)<br><br>**2.** Sleep apnea, (Jones &Bartlett, 2024) | **1.** Severe bradycardia, (Jones &Bartlett, 2024)<br><br>**2.** Cardiogenic shock (Jones &Bartlett, 2024) | **1.** Hyperkalemia (Jones &Bartlett, 2024)<br><br>**2.** Severe renal impairment, (Jones &Bartlett, 2024) | **1.** Active liver disease, (Jones &Bartlett, 2024)<br><br>**2.** Pregnancy, (Jones |

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| | | | | | | &Bartlett, 2024) |
| **Two side effects or adverse effects (Pertinent to the client)** | **1.** Bleeding, (Jones &Bartlett, 2024)<br><br>**2.** Thrombocytopenia, (Jones &Bartlett, 2024) | **1.** Hypoglycemia, (Jones &Bartlett, 2024)<br><br>**2.** injection site irritation , (Jones &Bartlett, 2024) | **1.** Drowsiness, (Jones &Bartlett, 2024)<br><br>**2.** Dizziness , (Jones &Bartlett, 2024) | **1.** Bradycardia, (Jones &Bartlett, 2024)<br><br>**2.** Fatigue (Jones &Bartlett, 2024) | **1.** GI Upset, (Jones &Bartlett, 2024)<br><br>**2.** Hyperkalemia, (Jones &Bartlett, 2024) | **1.** Muscle aches, (Jones &Bartlett, 2024)<br><br>**2.** Elevated liver enzymes, (Jones &Bartlett, 2024) |
| **Key nursing assessment(s) prior to administration** | **1.** Assess platelet count signs of bleeding, (Jones &Bartlett, 2024)<br><br>**2.** Review coagulation labs, (Jone | **1.** Check blood glucose for hypoglycemia, (Jones &Bartlett, 2024)<br><br>**2.** Rotate injection site, (Jones &Bartlett, 2024) | **1.** Assess level of anxiety, (Jones &Bartlett, 2024)<br><br>**2.** Asses respiratory rate, (Jones &Bartlett, 2024) | **1.** Monitor heart rate and blood pressure, (Jones &Bartlett, 2024)<br><br>**2.** Monitor signs of heart failure, (Jones &Bartlett, 2024) | **1.** Asses ECG changes, **(**Jones &Bartlett, 2024) | **1.** Monitor liver function, (Jones &Bartlett, 2024)<br><br>**3.** Assess for mus |

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| | s<br><br>&Bartlett, 2024) | | | | **2.** Check serum potassium, renal function, (Jones<br><br>&Bartlett, 2024) | cle pa in, (J on es<br><br>&Bartlett, 2024) |
| | | | | | | |
| **Brand/ Generic** | **vitamin b-12 (CYANOCO BALAMIN)** | **acetamino phen (TYLENO L)** | albuterol (PROVENT IL, VENTOLIN) | calcium carbonate (TUMS) | **diphenox ylate-atropine (LOMOT IL)** | **glucose (GLUTO SE) 40 % gel GEL** |
| **Dose, frequenc y, route** | **500mcg oral daily** | **650 mg Oral every 4 hours PRN** | **2.5 mg, nebulizat ion every 6 hours** | **1000 mg, oral every 8 hours** | **1 tablet (2.5-0.025mg) Oral 2 Times daily PRN** | **15g oral PRN** |
| **Classific ation (Pharma cological and therapeu tic and action of the drug** | **Pharmacolo gical:** Vitamin supplement (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeutic :** Hematopoieti c agent (Jones<br><br>&Bartlett, 2024) | **Pharmacol ogical: Non-opioid analgesic** (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeut ic: Antipyreti c/analgesic** (Jones<br><br>&Bartlett, | **Pharmac ological: Beta-2 adrenerg ic agonist** (Jones<br><br>&Bartlett, 2024)<br><br>**Therape utic:** Bronchod ilator (Jones<br><br>&Bartlett, | **Pharmacologi cal:** Mineral supplement, (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeutic:** Antacid/calciu m supplement (Jones<br><br>&Bartlett, 2024) | **Pharmac ological:** Opioid antidiarrh eal (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeu tic** Antidiarrh eal (Jones<br><br>&Bartlett, 2024) | **Pharmac ological:** Carbohyd rate suppleme nt (Jones<br><br>&Bartlett, 2024)<br><br>**Therapeu tic:** Anti-hypoglyce mic (Jones<br><br>&Bartlett, |

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| | **Action:** Essential for DNA synthesis and red blood cell formation (Jones &Bartlett, 2024) | 2024)<br><br>**Action:** Inhibits prostaglandin synthesis to reduce pain and fever (Jones &Bartlett, 2024) | 2024)<br><br>**Action:** Relaxes bronchial smooth muscle to improve airflow (Jones &Bartlett, 2024) | **Action:** Neutralizes stomach acid, provides calcium for bones (Jones &Bartlett, 2024) | **Action:** Slows intestinal motility, (Jones &Bartlett, 2024) | 2024)<br><br>**Action:** Provides rapid glucose absorption (Jones &Bartlett, 2024) |
| **Reason Client Taking** | Treat or prevent b12 deficiency, (Jones &Bartlett, 2024) | Pain or fever relief, (Jones &Bartlett, 2024) | Treat or prevent bronchospasm, (Jones &Bartlett, 2024) | Treat/prevent calcium deficiency or heartburn, (Jones &Bartlett, 2024) | Treat diarrhea, (Jones &Bartlett, 2024) | Treat hypoglycemia, (Jones &Bartlett, 2024) |
| **Two contraindications (pertinent to the client)** | **1.** Leber's disease (hereditary optic nerve atrophy) (Jones &Bartlett, 2024)<br><br>**2.** allergy to cobalt (Jones &Bartlett, 2024) | **1.** Severe liver disease, (Jones &Bartlett, 2024)<br><br>**2.** chronic alcohol use (Jones &Bartlett, 2024) | **1.** Tachyarrhythmias, (Jones &Bartlett, 2024)<br><br>**2.** Severe cardiac | **1.** Hypercalcemia, (Jones &Bartlett, 2024)<br><br>**2.** kidney stones (Jones &Bartlett, 2024) | **1.** Severe diarrhea due to infection (Jones &Bartlett, 2024)<br><br>**2.** obstruction (Jones &Bartlett, | **1.** Unconsciousness, (Jones &Bartlett, 2024)<br><br>**2.** Inability to swallow (Jones &Bartlett, |

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| | | | disease (Jones &Bartlett, 2024) | | 2024) | 2024) |
| **Two side effects or adverse effects (Pertinent to the client)** | **1.** Diarrhea, (Jones &Bartlett, 2024)<br>**2.** Dizziness, (Jones &Bartlett, 2024) | **1.** Liver toxicity (Jones &Bartlett, 2024)<br>**2.** Nausea, (Jones &Bartlett, 2024) | **1.** Tremors, (Jones &Bartlett, 2024)<br>**2.** Palpitations, (Jones &Bartlett, 2024) | **1.** Constipation, (Jones &Bartlett, 2024)<br>**2.**Bloating (Jones &Bartlett, 2024) | **1.** drowsiness, (Jones &Bartlett, 2024)<br>**2.** Constipation, (Jones &Bartlett, 2024) | **1.** Nausea (Jones &Bartlett, 2024)<br>**2.**Hyperglycemia (Jones &Bartlett, 2024) |
| **Key nursing assessment(s) prior to administration** | **1.** Assess B12 levels, (Jones &Bartlett, 2024)<br>**2.** Monitor for | **1.** Assess pain/temperature (Jones &Bartlett, 2024)<br>**2.** Assess liver | **1.** Assess lungs sounds, (Jones &Bartlett, 2024)<br>**2.** Asses respirator | **1.** Assess serum calcium, (Jones &Bartlett, 2024)<br>**2.** Asses renal | **1.** Assess bowel pattern (Jones &Bartlett, 2024)<br>**2.** Mon | **1.** Check blood glucose before administration (Jones &Bartlett, 2024) |

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| | anemia signs, (Jones &Bartlett, 2024) | function, (Jones &Bartlett, 2024) | y rate and oxygen, (Jones &Bartlett, 2024) | function, (Jones &Bartlett, 2024) | itor for dehydration, (Jones &Bartlett, 2024) | **2.** Ensure patient can swallow, (Jones &Bartlett, 2024) |
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| **Brand/ Generic** | **dextrose 50 % solution** | **Glucagon Emergency injection** | **Melatonin** | **ondansetron (ZOFRAN-ODT) disintegrating or ondansetron (ZOFRAN) injection** | **polyethylene glycol (GLYCOLAX, MIRALAX)** | **senna (SENOKOT)** |
| **Dose, frequency, route** | 12.5g Intravenous PRN | 1mg either intramuscular or subcutaneous PRN | 5mg oral, nightly PRN | 4mg either by oral or intravenous every 6 hours PRN | 17g Oral, 2 Times daily PRN | 2 times daily PRN, Oral, 8.6 mg (1tablet) |
| **Classification (Pharmacological and therapeutic and action of the drug** | **Pharmacological:** Carbohydrate (Jones &Bartlett, 2024) **Therapeutic:** | **Pharmacological:** Pancreatic hormone (Jones &Bartlett, 2024) **Therapeutic:** | **Pharmacological:** Hormone supplement (Jones &Bartlett, 2024) **Therapeutic:** | **Pharmacological:** 5-HT3 receptor antagonist (Jones &Bartlett, 2024) **Therapeutic:** Antiemetic | **Pharmacological:** Osmotic laxative (Jones &Bartlett, 2024) **Therapeutic:** | **Pharmacological:** Stimulant laxative (Jones &Bartlett, 2024) **Therapeutic:** |

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| | Antihypoglycemic (Jones &Bartlett, 2024)<br><br>**Action:** Provides rapid glucose for energy (Jones &Bartlett, 2024) | Antihypoglycemic (Jones &Bartlett, 2024)<br><br>**Action:** Stimulates glycogen breakdown to increase blood glucose (Jones &Bartlett, 2024) | Sleep aid (Jones &Bartlett, 2024)<br><br>**Action:** Regulates sleep-wake cycle (Jones &Bartlett, 2024) | (Jones &Bartlett, 2024)<br><br>**Action:** Blocks serotonin receptors in CNS and GI tract to prevent nausea **(**Jones &Bartlett, 2024) | Laxative (Jones &Bartlett, 2024)<br><br>**Action:** Draws water into colon to soften stool and increase bowel movements (Jones &Bartlett, 2024) | Laxative (Jones &Bartlett, 2024)<br><br>**Action:** Stimulates intestinal peristalsis (Jones &Bartlett, 2024) |
| **Reason Client Taking** | Treat severe hypoglycemia (Jones &Bartlett, 2024) | Treat severe hypoglycemia (Jones &Bartlett, 2024) | Promote sleep or adjust circadian rhythm (Jones &Bartlett, 2024) | Treat or prevent nausea/vomiting (Jones &Bartlett, 2024) | Treat constipation (Jones &Bartlett, 2024) | Treat constipation (Jones &Bartlett, 2024) |
| **Two contraindications (pertinent to the client)** | **1.** Intracranial hemorrhage (relative) (Jones &Bartlett, 2024) | **1.** Pheochromocytoma**,** (Jones &Bartlett, 2024) | **1.** autoimmune disease (caution), (Jones &Bartlett, 2024) | **1.** Prolonged QT interval, **(**Jones &Bartlett, 2024)<br><br>**2.** severe | **1.** Bowel obstruction, (Jon | **1.** Intestinal obstruction, **(**Jo |

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| | **2.** hyperglycemia (Jones &Bartlett, 2024) | **2.** Insulinoma (Jones &Bartlett, 2024) | **2.** severe liver disease (Jones &Bartlett, 2024) | hepatic impairment (Jones &Bartlett, 2024) | es &Bartlett, 2024) **2.** fecal impaction (Jones &Bartlett, 2024) | nes &Bartlett, 2024) **2.** acute abdominal pain (Jones &Bartlett, 2024) |
| **Two side effects or adverse effects (Pertinent to the client)** | **1.** hyperglycemia (Jones &Bartlett, 2024) **2.** phlebitis at IV site (Jones &Bartlett, 2024) | **1.** Nausea (Jones &Bartlett, 2024) **2.** Vomiting (Jones &Bartlett, 2024) | **1.** Drowsiness **(**Jones &Bartlett, 2024) **2.** Headace, (Jones &Bartlett, 2024) | **1.** Headache, (Jones &Bartlett, 2024) **2.** Constipation, (Jones &Bartlett, 2024) | **1.** Abdominal cramping**,** (Jones &Bartlett, 2024) **2.** Diarrhea, (Jones &Bartlett, 2024) | **1.** Abdominal cramping**, (**Jones &Bartlett, 2024) |

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| | | | | | | **2.** Diarrhea( Jones &Bartlett, 2024) |
| **Key nursing assessment(s) prior to administration** | **1.** Check blood glucose, (Jones &Bartlett, 2024)<br><br>**2.** Assess IV site, (Jones &Bartlett, 2024) | **1.** Assess blood glucose, (Jones &Bartlett, 2024)<br><br>**2.** Ensure patient safety when given the med, (Jones &Bartlett, 2024) | **1.** Assess sleep pattern, (Jones &Bartlett, 2024)<br><br>**2.** Timing of dose, (Jones &Bartlett, 2024) | **1.** Assess nausea and vomiting, (Jones &Bartlett, 2024)<br><br>**2.** Monitor ECG (Jones &Bartlett, 2024) | **1.** Asses abdominal distention, (Jones &Bartlett, 2024)<br><br>**2.** Assess electrolytes, (Jones &Bartlett, 2024) | **1.** Assess bowel pattern and abdominal pain, (Jones &Bartlett, 2024)<br><br>**2.** Assess hydration status, (Jones &Bartlett, 2024) |

**Prioritize Three Hospital Medications**

| Medications | Why this medication was chosen | List 2 side effects. These must correlate to your client |
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| 1. Furosemide (LASIX) | This medication was chosen first due to the fluid that's on the patient's heart. | 1. Electrolyte imbalances (Jones &Bartlett, 2024)<br>2. Hypotension (Jones &Bartlett, 2024) |
| 2. Metoprolol Succinate (TOPROL-XL) XL | This medication was chosen because it is proven to reduce mortality. | 1. Bradycardia (Jones &Bartlett, 2024)<br>2. Fatigue or dizziness (Jones &Bartlett, 2024) |
| 3. Empagliflozin (JARDIANCE) | This medication was chosen because it helps improves cardiovascular outcomes and promotes sodium loss helping with fluid control. | 1. Dizziness (Jones &Bartlett, 2024)<br>2. Low Blood Pressure (Jones &Bartlett, 2024) |

**Medications Reference (1) (APA)**

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

**Physical Exam**

**HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS**

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| GENERAL:<br>**Alertness:**<br>**Orientation:**<br>**Distress:**<br>**Overall appearance:**<br>**Infection Control precautions:**<br>**Client Complaints or Concerns:** | Client was alert times four to person place, time and situation. Patient was anxious but didn't show any signs of distress. The patient was well groomed. Patient looked appropriate for her age. Patient hair is thin throughout head. Patient has eyes lashes and eye brows, Patient looks clean and is responsive to verbal stimuli. Alert and responsive.<br>**Isolation:** none<br>**Precautions:** none<br>**Chief complaints and concerns:** Shortness of breath and weakness. Some concerns are physical worsens of symptoms. |
| **VITAL SIGNS:**<br>**Temp:**<br>**Resp rate:**<br>**Pulse:**<br>**B/P:**<br>**Oxygen:**<br>**Delivery Method:** | **Client vitals were taken at 1100,**<br>• **Temp**: 97.4 Temporal<br>• **Respiration**: 16<br>• **Pulse**: 61<br>• **b/p**: 122/86, sitting in bed, right arm head of the bed at 45 degrees.<br>• **O2**: 92%, room air |
| **PAIN ASSESSMENT:**<br>**Time:**<br>**Scale:**<br>**Location:**<br>**Severity:**<br>**Characteristics:**<br>**Interventions:** | Patient was asked at every 0800, 1100, 1500, 1600 vital sign check in if she was feeling any pain, patient denied of any pain each time. |
| **IV ASSESSMENT:**<br>**Size of IV:**<br>**Location of IV:**<br>**Date on IV:**<br>**Patency of IV:**<br>**Signs of erythema, drainage, etc.:**<br>**IV dressing assessment:**<br>**Fluid Type/Rate or Saline Lock:** | Patient has a size of 22 gauge IV on her left arm dated on 10/6/2025. The IV is clean, dry and covered with no leaks, open and unobstructed with return of blood when flushed. The IV wasn't hooked up. To the machine. No signs of erythema, or drainage. |
| **INTEGUMENTARY:**<br>**Skin color:**<br>**Character:**<br>**Temperature:**<br>**Turgor:** | • **Color**: Usual for ethnicity, no cyanisis or jaundice. |

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| **Rashes:**<br>**Bruises:**<br>**Wounds:** .<br>**Braden Score:**<br>**Drains present: Y☐ N ☒**<br>**Type:** | • **Character**: clean, dry, intact with normal quantity, Client hair was thin throughout the body. Moist.<br>• **Temp**: warm and dry upon palpation<br>• **Turgor**: Skin released slowly upon letting go. Slightly tenting.<br>• **Rashes: No**<br>• **Bruises:** On her abdomen due to administration of medication.<br>• **Wound:** no<br>• **Braden Score**: 22 |
| **HEENT:**<br>**Head/Neck:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth :** | • **Head/Neck**: symmetrical head and face, trachea is midline without deviation, thyroid is not palpable, no nodules noted, Located on the patient right side of her temporal region there was an indention with a depth that was shallow and not to deep.<br>• **Ears**: no visible or palpable deformities, lumps, or lesions, bilateral canals clean and clear no swelling, redness, drainage, or tinnitus.<br>• **Eyes**: sclera white and corneas clear bilaterally, no drainage or discoloration. PERRLA was completed, either eyes were reactive to light Pupil size was 4mm.<br>• **Nose**: Septum is midline, nares moist and pink bilaterally, no bleeding, frontal sinus are no tender upon palpating, smell intact.<br>• **Teeth**: client still has teeth. Oral mucous membrane is moist and pink without sores and lesions. Tonsils and pharynx are moist size 2+ tonsil, uvula midline, tongue pink. |
| **CARDIOVASCULAR:**<br>**Heart sounds:**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable):**<br>**Peripheral Pulses:**<br>**Capillary refill:**<br>**Neck Vein Distention: Y ☐ N ☒**<br>**Edema Y ☐ N ☒** | • **Heart sounds**: Heart sounds are faint with a low pitched with a s3 gallop.<br>• **Rhythm**: luv dub ta, a 3-beat rhythm.<br>• **Peripheral pulses**: 1+ bilaterally, pulse are a little faint radial, dorsal pedus and posterior tibial.<br>• **Capillary refills**: 3 seconds on fingers |

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| **Location of Edema:** | and toes bilaterally<br>● No neck distention<br>No edema was found in the lower or upper extremities. |
| **RESPIRATORY:**<br>**Accessory muscle use: Y☐ N ☒**<br>**Breath Sounds: Location, character** | There was no accessory muscle used.<br>Equal lung aeration bilaterally anteriorly and posteriorly. No pursed lips being used.<br>**Respiratory pattern** is tachypnea.<br>**Breath sounds**: fine crackling, a little of wheezing during expiration.<br>Respirations is tachypnea |
| **GASTROINTESTINAL:**<br>**Diet at home:**<br>**Current Diet:**<br>**Is Client Tolerating Diet?**<br>**Height:**<br>**Weight:**<br>**Auscultation Bowel sounds:**<br>**Last BM:**<br>**Palpation: Pain, Mass etc.:**<br>**Inspection:**<br>**Distention:**<br>**Incisions:**<br>**Scars:**<br>**Drains:**<br>**Wounds:**<br>**Ostomy: Y ☐ N ☒**<br>**Nasogastric: Y ☐ N ☒**<br>**Size:**<br>**Feeding tubes/PEG tube Y ☐ N ☒**<br>**Type:** | **Home diet:** Client has a regular diet at home. Client stated they eat a lot of rotisserie chicken and rice.<br>**Current Diet:** Low Sodium. Client is tolerating the diet.<br><br>**Height:** 152.4 cm<br>**Weight:** 105 lbs<br>**Auscultation Bowel sounds**: Bowel sounds are hypoactive in all quadrants.<br>**Last BM:** 10/06/2025<br>**Palpation: Pain, Mass etc.:** During palpation there no pain or mass.<br>**Inspection:**<br>**Distention:** No.<br>**Incisions:** No<br>**Scars:** No<br>**Drains:** No<br>**Wounds:** No |
| **GENITOURINARY:**<br>**Color:**<br>**Character:**<br>**Quantity of urine:**<br>**Pain with urination: Y ☐ N ☒**<br>**Dialysis: Y ☐ N ☒**<br>**Inspection of genitals:**<br>**Catheter: Y ☐ N ☒**<br>**Type:**<br>**Size:** | **Color:** Yellow<br>**Characteristics:** Clear.<br>No pain during urination. Patient is not on dialysis and doesn't have a catheter. |

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| **Intake (in mLs)**<br><br>**Output (in mLs)** | Patient intake for the day was 954mL<br><br>Patient output for the day was 3 voids in the toilet which consist of urine and no stool. |
| **MUSCULOSKELETAL:**<br>**Neurovascular status:**<br>**ROM:**<br>**Supportive devices:**<br>**Strength:**<br>**ADL Assistance: Y☐ N ☒**<br>**Fall Risk: Y ☒ N☐**<br>**Fall Score: 92**<br>**Activity/Mobility Status:**<br>**Activity Tolerance:**<br>**Independent (up ad lib)**<br>**Needs assistance with equipment**<br>**Needs support to stand and walk** | Neurovascular: Patient nail bed is pink and clear of cyanosis. Patient lower and upper extremity have no edema, temperature is warm to touch.<br>**ROM:** Active movement, patient can move their upper extremities and lower extremities without issues.<br>**Strength:** 4- active motion against some resistance (slight weakness).<br>**Fall Score:**<br>**Activity/Mobility Status:** Client laid in the bed majority of the shift.<br>**Activity Tolerance:** Not much activity, when walking to the bathroom the patient was out of breath pretty quickly.<br>**Needs assistance with equipment:** No.<br>**Needs support to stand and walk:** Yes. |
| **NEUROLOGICAL:**<br>**MAEW: Y ☒ N☐**<br>**PERLA: Y ☐ N☒**<br>**Strength Equal: Y ☒ N ☐ if no -**<br>**Legs ☐ Arms ☐ Both ☐**<br>**Orientation:**<br>**Mental Status:**<br>**Speech:**<br>**Sensory:**<br>**LOC:** | Orientation: Alert to Person, Place, situation, time.<br>**Cognition/mental:** Normal cognition<br>**Speech: Clear.**<br>**LOC:**<br>- Alert- awake & answers questions appropriately |
| **PSYCHOSOCIAL/CULTURAL:**<br>**Coping method(s):**<br>**Developmental level:**<br>**Religion & what it means to pt.:**<br>**Personal/Family Data (Think about home environment, family structure, and available family support):** | Coping method(s): Talking to a loved one and praying.<br>**Developmental level**: Erik Erikson's Psychosocial Theory (Cherry, K. 2024).<br><br>- **Can the patient read/write?** Yes<br>- **Are they form full structured sentence?** Yes<br>**Do they have the capability of making a fully informed decision?** Yes<br>**Religion:** Methodist, patient stated "I grew up in |

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| | a methodist church my whole life”.<br>**Personal/Family Data:** Patient lives at home with her husband. Patient did state some concerns about him being home with no help to take care of him. |

## Discharge Planning

**Discharge location:** Rehab Facility (Hawthorne)

**Home health needs:** Patient will need assistant with her medications and making sure she takes them on a schedule. Client will need to be on a low sodium diet.

**Equipment needs:** Client will need to use a gait belt for safe transfer, and a walker for ambulation client is up with 1 assist. Bedside commode should be considered if needed.

**Follow up plan:** Client will stay at Hawthorne until client strength improves. After client strength returns client should have a follow up appointment with primary care provider to monitor chronic heart failure, review the medication, and check vitals and lab, (Phelps, 2023).

**Education needs:** Client and family will need to be educated on the disease process of chronic heart failure, medication education, do no skip dose, (AHA, 2022). Client will need to learn how to prevent fluid retention by eating a low sodium diet, (HFSA, 2021). Education on the use of a walker and gait belt to help with ambulation, signs on when to stop activity, monitoring for swelling, increased of shortness of breath or fatigue (Phelps, 2023). The client should also be educated on when to seek help, if the shortness of breath increase, chest pain, palpitations or swelling, or fever or signs if infection while at rehab, (Ignatavicius et al., 2020).

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

| **Nursing Diagnosis**<br>• Include full nursing diagnosis with "related to" and "as evidenced by" components<br>• Listed in order by priority – highest priority to lowest priority pertinent to this client | **Rationale**<br>• Explain why the nursing diagnosis was chosen | **Outcome Goal (1 per dx)** | **Interventions (2 per goal)** | **Evaluation of interventions** |
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| 1. Impaired Gas Exchange related to alveolar-capillary membrane changes and pulmonary congestion secondary to left-sided heart failure as evidence by shortness of breath, fine crackles in lung and tachypnea. (Phelps 2023). | This nursing diagnosis was chosen because maintaining oxygen is the most important life sustaining need when taking care of a patient. | Patient will maintain SpO2 greater or equal to 92% without supplemental O2 within two hours, (Phelps 2023). | 1.Position in high-Fowler's to facilitate lung expansion and ease breathing, (Phelps 2023).<br><br>2.Administer oxygen as ordered if needed and monitor response, (Phelps 2023). | Patient SpO2 maintained between 92-94 throughout the shift, client outcome met. |
| 2. Decrease cardiac output related to impaired contractility | I chose this nursing diagnosis because its cause of the patient | • Patient will demonstrate adequate cardiac | 1. Monitor vital signs, cardiac rhythm, and urine output (Phelps 2023).<br><br>2.Administer cardiac | Patient voided in the toilet three times during my shift and |

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| and increased preload/afterload as evidence by weakness and edema (Phelps 2023). | problem, the heart isn't pumping correctly. | output as evidenced by stable HR, BP, and urine output greater than 30 mL/hr, (Phelps 2023). | medications (furosemide) as ordered; assess response (Phelps 2023). | her HR was 61, BP was 122/86 client still states she "doesn't have any energy". Client goal partially met. |
| 3. Activity Intolerance related to imbalance between oxygen supply and demand secondary to decrease cardiac output as evidence by dyspnea on excretion and weakness (Phelps 2023). | I chose this nursing diagnosis because it affects the patient ability to perform daily activity and maintain independent. | Patient will gradually increase activity while having stable vitals with 72 hours, (Phelps 2023). | 1. Plan rest periods and assist with ADL as needed (Phelps 2023).<br>2. Increase activity gradually while monitoring HR, BP, and SpO2 (Phelps 2023). | Patient ambulated 40 ft with mild shortness of breath, her vital signs were still stable, the goal is still progressing. |

| **Nursing Process Prioritization** | **Rationale** |
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| 1. Impaired Gas Exchange | This is the most immediate life-threatening problem, maintaining adequate oxygenation is critical for survival, (Phelps 2023). |
| 2. Decrease cardiac output | This leads to poor tissue perfusion which contributes to shortness of breath, weakness |

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| | and fatigue due to the heart not pumping effectively, (Phelps 2023). |
| 3. Activity Intolerance | This is results from impaired gas exchange and cardiac output because it affects the patient's ability to be independent while doing their daily activities, (Phelps 2023). |

**Other References (APA):**

American Heart Association. (2022). *Heart failure: Patient education and management guidelines*. https://www.heart.org/en/health-topics/heart-failure

Cherry, K. (2024, May 2). *Erikson's stages of development*. *Verywell Mind.*

Heart Failure Society of America. (2021). *HFSA guidelines for the management of heart failure*. https://hfsa.org/resources/clinical-guidelines

Ignatavicius, D. D., Workman, M. L., & Rebar, C. R. (2020). *Medical-surgical nursing: Concepts for interprofessional collaborative care* (9th ed.). Elsevier.

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