

Samantha Garcia

Lakeview College of Nursing

N431: Adult Health II

Care Plan # 2

Jami Dowell

2/28/26

Demographics

Date of Admission 2/23/26	Client Initials S.S.	Age 69	Biological Gender Female
Race/Ethnicity White/ non- hispanic	Occupation Retired school bus driver	Marital Status Single	Allergies No known drug allergies
Code Status Full code	Height 5'7                      170.2cm	Weight 185.2 pounds 84kg	

### Medical History

Past Medical History: cerebrovascular accident (CVA), Chronic Kidney Disease (CKD), gastroesophageal reflex disease (GERD), coronary artery disease (CAD), hypertension (HTN), obstructive sleep apnea (OSA), and osteopenia

Past Surgical History: Breast enhancement surgery. IR manual thrombectomy (9/12/2023).

Family History: Mother and Father: hypertension. Mother Stroke.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient has never smoked, does not drink, and does not use drugs.

Education: Completed 12<sup>th</sup> grade.

Living Situation: Lives at home alone.

Assistive devices: Patient wears glasses.

### Admission History

Chief Complaint: Patient states she came in for shortness of breath. She stated she was sent to convenient care after working with physical therapy. Convenient care drew blood and had the patient come into the emergency room.

History of Present Illness (HPI)– OLD CARTS

The patient stated, “My shortness of breath started today while I was working with physical therapy.” “It was all in my lungs.” “My shortness of breath has been going on since I started my physical therapy session and just stayed with me.” “It felt like I couldn’t catch my breath and I

was winded with anything I was doing. Even just sitting and not doing anything.” “My symptoms were worse with activity and doing anything physical during therapy.” “When I sat there and just rested I had a little relief but never fully got better.” “This all started with physical therapy and stayed about the same the entire time before coming to the ER.” “It was so bad that I felt like I was going to die.”

### Admission Diagnosis

Primary Diagnosis: Congestive Heart Failure (CHF)

Secondary Diagnosis (if applicable): Pulmonary Embolism (PE)

### Pathophysiology

Heart failure (HF) is a progressive disease (Shams et al., 2025). Any acute insult to cardiac structure or acute alteration secondary to genetic mutation, cardiac tissue infiltration, ischemia, valvular heart disease, myocarditis, or acute myocardial injury may initiate the compensatory mechanism, which, once exhausted, results in maladaptation. In the initial stages of congestive heart failure (CHF), several compensatory mechanisms attempt to maintain cardiac output and meet the systemic demands (Shams et al., 2025). The chronic activation of the sympathetic nervous system results in reduced beta-receptor responsiveness and adrenaline stores (Shams et al., 2025). This results in changes in myocyte regeneration, myocardial hypertrophy, and myocardial hypercontractility (Shams et al., 2025). The increased sympathetic drive also results in the activation of the renin-angiotensin-aldosterone system (RAAS) system, systemic vasoconstriction, and sodium retention (Shams et al., 2025). In addition, the RAAS system releases angiotensin II, which has been shown to increase myocardial cellular hypertrophy and interstitial fibrosis, contributing to myocardial remodeling (Shams et al., 2025).

Signs and symptoms of CHF are, shortness of breath, waking up short of breath at night, chest pain, heart palpitations (Cleveland Clinic, 2023). Fatigue when you're active, swelling in your ankles, legs and abdomen, weight gain, need to urinate while resting at night, a dry, hacking cough, a full (bloated) or hard stomach, and loss of appetite or upset stomach (nausea) (Cleveland Clinic, 2023).

Pulmonary embolism (PE) occurs when a blood clot enters the pulmonary circulation (Vyas, Sankari, & Goyal, 2024). Multiple emboli are typically involved within the lower lung lobes more frequently than the upper lobes; bilateral lung involvement is also more common (Vyas, Sankari, & Goyal, 2024). Large emboli tend to obstruct the main pulmonary artery, causing saddle embolus with deleterious cardiovascular consequences (Vyas, Sankari, & Goyal, 2024). In contrast, smaller-sized emboli block the peripheral arteries and can lead to pulmonary infarction, manifested by intra-alveolar hemorrhage (Vyas, Sankari, & Goyal, 2024).

PE leads to impaired gas exchange due to obstruction of the pulmonary vascular bed, leading to a mismatch in the ventilation-to-perfusion ratio because alveolar ventilation remains the same (Vyas, Sankari, & Goyal, 2024). Still, pulmonary capillary blood flow decreases, leading to dead space ventilation and hypoxemia (Vyas, Sankari, & Goyal, 2024). Also, mediators, eg, serotonin, are released, which cause vasospasm and further decrease pulmonary flow in unaffected lung areas (Vyas, Sankari, & Goyal, 2024). Local accumulation of inflammatory mediators alters lung surfactant and stimulates respiratory drive, resulting in hypocapnia and respiratory alkalosis (Vyas, Sankari, & Goyal, 2024).

Common symptoms of a PE include: Shortness of breath (Mayo Clinic, 2022). This symptom usually appears suddenly (Mayo Clinic, 2022). Trouble catching your breath happens even when resting and gets worse with physical activity (Mayo Clinic, 2022). Chest pain (Mayo

Clinic, 2022). You may feel like you're having a heart attack (Mayo Clinic, 2022). The pain is often sharp and felt when you breathe in deeply (Mayo Clinic, 2022). The pain can stop you from being able to take a deep breath (Mayo Clinic, 2022). You also may feel it when you cough, bend or lean over (Mayo Clinic, 2022). Fainting (Mayo Clinic, 2022). You may pass out if your heart rate or blood pressure drops suddenly. This is called syncope (Mayo Clinic, 2022).

This patient came into the emergency room after being advised to come after being in the convenient care. This patient was doing physical therapy and became extremely short of breath. She rested at the therapy place but never had relief enough to be able to catch her breath. The physical therapist advise this patient to go get check out. The patient then went to the OSF convenient care. The nurse there drew labs. After seeing an elevated d-dimer the nurse then advised the patient that she needed to be seen in the emergency room. While in the emergency room they found out this patient had congested heart failure as well as a pulmonary embolism with testing a BNP that was over 2,000, and the d-dimer that was over 4,000 and a positive CT of the chest showing the pulmonary embolism. While in the emergency room this patient was diaphoretic, short of breath with rest and on exertion, had 2+ pitting edema, she had heart palpitations, decreased capillary refill, hypoxia, decreased lung sounds, and feeling of impending doom. When the patient came up to the fourth floor they treated her for her pulmonary embolism. After two days of receiving anticoagulant this patient was about to discharge. The nurse then weighed this patient and the patient gained 5 almost 6 pounds just in the two days. She was then given Lasix.

Pathophysiology References (2) (APA):

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

Cleveland Clinic. (2023, March 10). *Congestive heart failure*. Cleveland Clinic Health Library. \_

<https://my.clevelandclinic.org/health/diseases/17069-heart-failure-understanding-heart-failure>

Mayo Clinic Staff. (2022, December 1). *Pulmonary embolism — Symptoms and causes*. Mayo Clinic. \_

<https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc-20354647>

Shams, P., Malik, A., & Chhabra, L. (2025). *Heart failure (congestive heart failure)*. In StatPearls

[NIH]. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK430873/>

Vyas, V., Sankari, A., & Goyal, A. (2024). *Acute pulmonary embolism*. In StatPearls [NIH]. StatPearls

Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK560551/>

#### Laboratory/Diagnostic Data

Lab Name	Admission Value 2/23/26	Today's Value 2/25/26	Normal Range	Reasons for Abnormal
Potassium	3.0	3.7	3.5-5.1 mmol/L	This can be low from GI or renal loss (Pagana, et al., 2025). This patient takes diuretics which can cause low potassium.
Glucose	107	100	10-99 mg/dL	This can be off with diabetics (Pagana, et al., 2025). This patient CKD and cardiovascular disease increase

				insulin resistance.
Magnesium	1.4	N/A	1.6-2.6 mg/dL	This can be low from GI or renal loss (Pagana, et al., 2025). This patient magnesium can be decreased due to diuretic use.
Troponin 1 High Sensitivity	18.0	18.7 (02/24/26)	< = 14.0 ng/L	In CKD, this lab can be chronically elevated (Pagana, et al., 2025). This patient had a PE and CHF.
NT PROBNP	2,268.6	N/A	<450.0 pg/mL	This can suggest fluid overload or CHF (Pagana, et al., 2025). This patient had CHF.
D-Dimer	4,628	N/A	0-622 ng/mL FEU	An elevated d-dimer can indicate possible thrombus (Pagana, et al., 2025). This patient had a PE.
Hemoglobin	10.8	9.4	12.0- 15.8 g/dL	Low levels can indicate anemia of a chronic disease (CKD) or possible iron deficiency (Pagana, et al., 2025). This patient may have anemia, a small GI bleed, or just may be due to having

				CKD.
Hematocrit	33.7	29.2	36.0- 47.0 %	Low levels can indicate anemia of a chronic disease (CKD) or possible iron deficiency (Pagana, et al., 2025). This patient may have anemia, a small GI bleed, or just may be due to having CKD.
MCV	80.8	81.6	82.0-96.0 fL	Low levels can indicate anemia of a chronic disease (CKD) or possible iron deficiency (Pagana, et al., 2025). This patient may have anemia, a small GI bleed, or just may be due to having CKD.
MCH	25.9	26.3	26.0- 34.0 pg	Low levels can indicate anemia of a chronic disease (CKD) or possible iron deficiency (Pagana, et al., 2025). This patient may have anemia, a small GI bleed, or just may be due to having

				CKD.
MPV	9.4	9.8	9.7- 12.4 fL	This suggests reactive thrombocytosis (Pagana, et al., 2025). This patient may have anemia, a small GI bleed, or just may be due to having CKD.
Neutrophils	76.8	67.6	47.0- 73.0 %	This suggests stress response (Pagana, et al., 2025). This patient had a PE.
Lymphocytes	14.3	18.4	47.0- 73.0 %	This suggests stress response (Pagana, et al., 2025). This patient had a PE.
Absolute lymphocytes	1.05	1.37	1.30- 3.20 10(3)/mcL	This suggests stress response (Pagana, et al., 2025). This patient had a PE.
Plateletes	486	367	140-400 10*3/uL	Thrombocytosis may be reactive (Pagana, et al., 2025). This patient had a PE and too anticoagulants and antiplatelet.
albumin	3.0	3.1	3.5-5.0 g/dL	Albumin may be low due to chronic illness or possible protein loss (Pagana, et al.,

				2025). This patient has CHF.
Red blood cells	4.17	3.58	3.80- 5.30 10(6)/mCL	Low levels can indicate anemia of a chronic disease (CKD) or possible iron deficiency (Pagana, et al., 2025). This patient may have anemia, a small GI bleed, or just may be due to having CKD.

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
N/A	N/A	2/23 @ 1837  CT angio chest with and without contrast.  Purpose: Is to diagnose disease and injuries (Pagana, et al., 2025).	Increased shortness of breath.	Subsegmental right lower lobe embolism. Large hiatal hernia. Right lower lobe nodule.
N/A	N/A	2/23 @ 0000  12 lead ECG  Purpose: records the	Shortness of breath.	Sinus tachycardia with occasional premature

		electrical signals of the heart to check for different heart arrhythmias (Pagana, et al., 2025).		ventricular complexes.
N/A	N/A	2/25 ECG Purpose: records the electrical signals of the heart to check for different heart arrhythmias (Pagana, et al., 2025).	Shortness of breath.	Sinus rhythm.
N/A	N/A	2/24 Ultrasound bilateral duplex of the lower extremity veins. Purpose: is to assess for deep vein thrombosis (Pagana, et al., 2025).	Elevated D-Dimer with shortness of breath.	Right and left lower extremities show no evidence of deep vein thrombosis or superficial thrombosis.
N/A	N/A	2/24 Echo	Previous cardiac history with	Estimated ejection fracture 60-65%.

		Purpose: used to evaluate heart structure and function (Pagana, et al., 2025).	new PE.	
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Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2025). *Mosby's diagnostic & laboratory test reference*. Elsevier.

#### Active Orders

Active Orders	Rationale
Cardiac diet	This is to make sure the patient receives a cardiac healthy diet.
Consult to Cardiology	This order was placed because the patient has a cardiac history, diagnosis of CHF, and PE.
Telemetry monitoring- continuous	This order was placed to monitor the heart due to low potassium, magnesium, hemoglobin, hematocrit, previous heart history, and CHF.
Admission weight- (Should have daily weights for CHF but not ordered.)	This is a general admission order for just an admission weight but since the patient's primary diagnosis was CHF this patient should have an order for daily weights.

Ambulate patient TID	This order was placed due to patient's mild weakness when trying to stand and having shortness of breath on exertion.
Maintain peripheral IV	This order was placed to make sure the patient keeps a patent IV while on the floor.
Intake and Output Q8h	This order was put in to monitor the amount of fluid going in and coming out due to CHF.
Notify physician for pulse less than 50 or greater than 120, respirations less than 10 or greater than 30, temperature greater than 101.5, urinary output less than 240ml/8 hours, systolic BP less than 85 or greater than 180, diastolic BP less than 50 or greater than 105, pulse ox less than 90, or new onset or worsening pain	This order was placed because the patient was admitted for CHF and PE so it is critical to monitor any changes hemodynamically.
Notify Physician - Signs/Symptoms of bleeding.	This order was put in due to the patient taking an anticoagulant and is now at increased risk of bleeding.
Nursing Communication - Nurse to initiate apixaban education & distribute apixaban educational materials	This order was put in since Eliquis is a brand new medication for this patient.
Vital signs per unit routine	This order was placed since the

	patient has a new diagnosis of PE and previous cardiac history.
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## Hospital Medications (Must List ALL)

Brand/ Generic	Eliquis/ apixaban	Lopressor/ metoprolol tartrate	Bayer/ aspirin EC	Tylenol/ acetaminophe n	Protonix/ pantopra zole	Cardizem/ diltiazem ER
Dose, frequency, route	10mg, BID, oral	25mg, BID, oral	81mg, daily, oral	650mg, Q4h PRN, oral	40mg, daily, oral	180mg, daily, oral
Classificat ion (Pharmaco logical and therapeuti c and action of the drug	P: Factor Xa inhibitor T: Anticoagula nt A: Inhibits free and clot- bonding factor Xa and prothrombin ase activity. Although this has no effect on platelet aggregation induced by thrombin. This decreases thrombin generation and thrombus developmen t 2025: NDH: Nurse's	T: Antihyperte nsive P: beta blocker A: lowers b/p by beta- blocking effects; reduces elevated renin plasma levels; blocks beta 2- adrenergic receptors in the bronchial, vascular smooth muscle only at high doses; negative chronotropi c effect (2025: NDH:	P: Salicylate  T: NSAID, antiplatele t, antipyretic , nonopioid analgesic  A: Block the activity of cyclooxyge nase, the enzyme needed for prostaglan din synthesis (2025: NDH:Nurs e's drug handbook, 2024).	P: nonsalicylate, para- aminophenold erivative  T: antipyretic, nonopioid analgesic Action: inhibits the enzyme cyclooxygena se, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system (2025: NDH: Nurse's drug handbook, 2024).	P: Proton pump inhibitor T: Antiulcer Action: Interfere nces with gastric inhibitio n the hydrogen - potassiu m- adenosin e triphosph atase enzyme system, or proton pump, in gastric parietal cells (2025: NDH:	P: calcium channel blocker T: antiangina l, antihypert ensive, antiarrhyt hmic A: Inhibits calcium movement into coronary and vascular smooth- muscle cells by blocking slow calcium channels in cell membrane s (2025: NDH: Nurse's drug

	drug handbook, 2024).	Nurse's drug handbook, 2024).			Nurse's drug handbook, 2024).	handbook, 2024).
Reason Client Taking	Patient is taking this medication for PE.	Patient takes this medication for hypertension.	Patient take this medication for PE.	Patient is taking this medication for mild pain control.	Patient takes this medication for GERD.	Patient is taking this medication for CAD.
Two contraindications (pertinent to the client)	-hepatic dysfunction (2025: NDH: Nurse's drug handbook, 2024). - renal impairment (2025: NDH: Nurse's drug handbook, 2024).	-CHF (2025: NDH: Nurse's drug handbook, 2024). - bradycardia (2025: NDH: Nurse's drug handbook, 2024).	- renal impairment (2025: NDH: Nurse's drug handbook, 2024). -GI bleed (2025: NDH: Nurse's drug handbook, 2024).	-renal impairment (2025: NDH: Nurse's drug handbook, 2024). -hypertension (2025: NDH: Nurse's drug handbook, 2024).	- GI bleed (2025: NDH: Nurse's drug handbook, 2024). - hypertension (2025: NDH: Nurse's drug handbook, 2024).	-renal impairment (2025: NDH: Nurse's drug handbook, 2024). - hypotension (2025: NDH: Nurse's drug handbook, 2024).
Two side effects or adverse effects (Pertinent to the client)	- hypotension (2025: NDH: Nurse's drug handbook, 2024). - GI bleeding (2025: NDH: Nurse's drug handbook, 2024).	-Dyspnea (2025: NDH: Nurse's drug handbook, 2024). -Heart failure (2025: NDH: Nurse's drug handbook, 2024).	1. CNS depression (2025: NDH: Nurse's drug handbook, 2024). 2. Bronchospasms (2025: NDH: Nurse's drug handbook, 2024).	1.Hypertension (2025: NDH: Nurse's drug handbook, 2024). 2. Peripheral edema (2025: NDH: Nurse's drug handbook, 2024).	- hypokalemia (2025: NDH: Nurse's drug handbook, 2024). - Dyspnea (2025: NDH: Nurse's	-Acute renal failure (2025: NDH: Nurse's drug handbook, 2024). -dyspnea (2025: NDH: Nurse's drug handbook,

	2024).		2024).		drug handbook, 2024).	2024).
List two teaching needs for the medication pertinent to the client	<p>– Emphasize the importance of taking this medication exactly as prescribed (2025: NDH: Nurse’s drug handbook, 2024).</p> <p>-Advise patient to report any unusual bleeding or bruising to the prescriber(2025: NDH: Nurse’s drug handbook, 2024).</p>	<p>-Caution patient to not stop medication abruptly (2025: NDH: Nurse’s drug handbook, 2024).</p> <p>-Tell patient to contact provider if breathing difficulties occur, edema, or other signs of heart failure worsen, or if other persistent, serious or unusual adverse reactions occur (2025: NDH: Nurse’s drug handbook, 2024).</p>	<p>_Report any signs of bleeding (2025: NDH: Nurse’s drug handbook, 2024).</p> <p>-Take with a full glass of water to avoid GI irritation (2025: NDH: Nurse’s drug handbook, 2024).</p>	<p>-Do not exceed recommended daily dose (2025: NDH: Nurse’s drug handbook, 2024).</p> <p>_Encourage patient to consult doctor before taking any new over the counter medications(2025: NDH: Nurse’s drug handbook, 2024).</p>	<p>-Instruct patient to notify prescriber if diarrhea occurs and becomes prolonged or severe as additional therapy may be needed (2025: NDH: Nurse’s drug handbook, 2024).</p> <p>-Review bleeding and infection control measures with patient (2025: NDH: Nurse’s drug handbook, 2024).</p>	<p>-Tell patient do not abruptly stop medication (2025: NDH: Nurse’s drug handbook, 2024).</p> <p>-Advise patient to monitor blood pressure and pulse regularly (2025: NDH: Nurse’s drug handbook, 2024).</p>
Two Key nursing assessment(s) prior	-Assess for bleeding (2025: NDH:	-Assess abrupt withdrawal, which may	- Assess patient for bleeding (2025:	1.Assess patients pain level (2025: NDH:	-Check for use of NSAIDs,	-Assess apical pulse and blood

to administration	Nurse's drug handbook, 2024). -Check baseline hemoglobin and hematocrit (2025: NDH: Nurse's drug handbook, 2024).	cause a MI (2025: NDH: Nurse's drug handbook, 2024). -Assess blood pressure and heart rate (2025: NDH: Nurse's drug handbook, 2024).	NDH: Nurse's drug handbook, 2024).  - Assess patient's pain level (2025: NDH: Nurse's drug handbook, 2024).	Nurse's drug handbook, 2024).  2. Assess liver functions (2025: NDH: Nurse's drug handbook, 2024).	anticoagulants, and antiplatelet drugs (2025: NDH: Nurse's drug handbook, 2024). -Assess for any GI symptoms (2025: NDH: Nurse's drug handbook, 2024).	pressure (2025: NDH: Nurse's drug handbook, 2024). -Assess for digitalis toxicity (2025: NDH: Nurse's drug handbook, 2024).
Brand/ Generic	Lovenox/ enoxaparin	Lasix/ furosemide	Mag-ox/ magnesium oxide	Lipitor/ atorvastatin		
Dose, frequency, route	80mg, Q12h, subcutaneous	40mg, x1, IVP	400mg, daily, oral	40mg, HS, oral		
Classification (Pharmacological and therapeutic and action of the drug)	P: low molecular-weight-heparin T: Anticoagulant A: Potentiates the action of antithrombin III, rapidly binds with and inactivates	P: Loop diuretic T: Antihypertensive, diuretic A: Inhibits sodium and water reabsorption in the loop of Henle and	P: Mineral T: Electrolyte replacement A: Assists all enzymes involved in phosphate transfer reactions	P: HMG-CoA reductase inhibitor T: Antihyperlipidemic A: Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol		

	clotting factors (2025: NDH: Nurse's drug handbook, 2024).	increases urine formation (2025: NDH: Nurse's drug handbook, 2024).	that use adenosine triphosphate (ATP), as magnesium is required for the normal function of ATP-dependent sodium-potassium pump in muscle membrane (2025: NDH: Nurse's drug handbook, 2024).	synthesis in liver by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown (2025: NDH: Nurse's drug handbook, 2024).
Reason Client Taking	Patient is taking this for a PE.	Patient takes this medication for CHF.	Patient is taking this medication for low magnesium.	Patient takes this medication for hyperlipidemia.
Two contraindications (pertinent to the client)	-renal impairment (2025: NDH: Nurse's drug handbook, 2024). -active bleeding (2025: NDH: Nurse's drug	- Hypotension (2025: NDH: Nurse's drug handbook, 2024). -Renal impairment (2025: NDH: Nurse's drug	- renal impairment (2025: NDH: Nurse's drug handbook, 2024). -heart failure (2025: NDH: Nurse's drug	-renal impairment (2025: NDH: Nurse's drug handbook, 2024). -CAD (2025: NDH: Nurse's drug handbook, 2024).

	handbook, 2024).	handbook, 2024).	handbook, 2024).	
Two side effects or adverse effects (Pertinent to the client)	-CHF (2025: NDH: Nurse's drug handbook, 2024). -dyspnea (2025: NDH: Nurse's drug handbook, 2024).	1. Hypokalemia (2025: NDH: Nurse's drug handbook, 2024). 2. Thromboembolism (2025: NDH: Nurse's drug handbook, 2024).	1. Dyspnea (2025: NDH: Nurse's drug handbook, 2024). 2. Respiratory depression (2025: NDH: Nurse's drug handbook, 2024).	-acute renal failure (2025: NDH: Nurse's drug handbook, 2024). -dyspnea (2025: NDH: Nurse's drug handbook, 2024).
List two teaching needs for the medication pertinent to the client	-inform patient they may bleed or bruise more easily (2025: NDH: Nurse's drug handbook, 2024). -instruct patient to seek immediate help for evidence of thromboembolism (2025: NDH: Nurse's drug	-instruct patient to check weight daily (2025: NDH: Nurse's drug handbook, 2024). -instruct patient to take blood pressure and heart rate prior to administration (2025: NDH: Nurse's drug	-stress the importance of not taking more than prescribed (2025: NDH: Nurse's drug handbook, 2024). -advise patient to regularly get labs drawn (2025: NDH: Nurse's drug	-Reinforce the benefits of therapy and urge patient to comply (2025: NDH: Nurse's drug handbook, 2024). -Advise patient with diabetes to monitor blood glucose levels closely (2025: NDH: Nurse's drug handbook, 2024).

	handbook, 2024).	2024).		
Two Key nursing assessment(s) prior to administration	-assess platelet count (2025: NDH: Nurse's drug handbook, 2024). -assess renal function (2025: NDH: Nurse's drug handbook, 2024).	1. Assess the patient's weight (2025: NDH: Nurse's drug handbook, 2024). 2. Assess patients' blood pressure and heart rate (2025: NDH: Nurse's drug handbook, 2024).	1. Assess serum magnesium level (2025: NDH: Nurse's drug handbook, 2024). 2. Assess patient for heart arrhythmias (2025: NDH: Nurse's drug handbook, 2024).	-Assess baseline creatinine (2025: NDH: Nurse's drug handbook, 2024). -Assess liver enzymes level (2025: NDH: Nurse's drug handbook, 2024).

### Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1. Eliquis	The patient had a pulmonary embolism. D-Dimer was 4, 628 and CT of the chest showed right lower lobe embolism.	1. Hypotension (2025: NDH: Nurse's drug handbook, 2024). 2. GI bleeding (2025: NDH: Nurse's drug handbook, 2024).
2. Lovenox	The patient had a pulmonary embolism. D-Dimer was 4, 628 and CT of the chest showed right lower lobe embolism.	1. CHF (2025: NDH: Nurse's drug handbook, 2024). 2. Dyspnea (2025: NDH: Nurse's drug handbook, 2024).



Fluid Type/Rate or Saline Lock:	Saline locked
<b>INTEGUMENTARY:</b> Skin color: pale Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 18 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	The skin color is pink. Skin is warm and dry. No rashes present. Braden scale is an 18. No drains present.
<b>HEENT:</b> Head/Neck: Ears: Eyes: Nose: Teeth: dentures	The head and neck are symmetrical. Trachea is midline. No JVD noted. No palpation of lymph nodes. The nose is symmetrical. No signs of drainage or discharge. The patient has all teeth.
<b>CARDIOVASCULAR:</b> Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:	Clear S1 and S2. Systolic murmur heard on the right border of sternum. No gallops, or rubs. Apical pulse auscultated at 5 <sup>th</sup> intercostal space midclavicular line. Irregular- Regular rate and rhythm. Capillary refill less than 2 seconds. No JVD noted. Bilateral radial pulse palpable 2+, bilateral pedal pulses palpable 1+. +2 pitting edema present to bilateral lower extremities. The patient states no chest pain.
<b>RESPIRATORY:</b> Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character	The patient has shortness of breath on exertion and at rest. No retractions or accessory muscle use. The patient pursed lip breathing. Chest rise and fall are equal bilaterally. The patient has kyphoscoliosis.
<b>GASTROINTESTINAL:</b> Diet at home: cardiac Current Diet: Is Client Tolerating Diet? Height: 5'7 Weight: 179 lbs 3.2 oz admission Auscultation Bowel sounds: Last BM: 2/25/26 Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: under bilateral breasts	The patient eats a cardiac diet at home. The current diet is cardiac. The patient tolerated the diet well. The patient is 5 foot 7 inches. The patient weighs 185.2 pounds on 2/25/26. Bowel sounds are present in all 4 quadrants and normoactive. Patient's last bowel movement 2/25/26. The patient had a large amount of formed stool. No pain or masses upon palpation. Abdomen is round, non- distended, and soft. No ostomy, nasogastric, or feeding / PEG tubes

Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	
GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:	Urine is clear yellow and no odor. Patient voided 6 times, but did not have a hat in the toilet to accurately measure. No pain with urination. No dialysis. Perineal is free from excoriation. No internal or external catheter used.
Intake (in mLs)   Output (in mLs)	In 24 hours the patient has had 1,200ml intake and voided 6 times (No accurate amount listed).
MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: high Activity/Mobility Status: Activity Tolerance: Independent (up ad lib) Needs assistance with equipment Needs support to stand and walk	The patient is alert and oriented x4 to person, place, time and situation. The patient has equal strength in bilateral upper extremities and bilateral lower extremities. The patient uses no assistive devices while ambulating. The patient needs frequent breaks to complete ADLs since she gets short of breath with exertion and at rest. The fall risk scale is 79. This means the patient is at a high fall risk. Patient tolerated activity well with frequent breaks. The patient needs minimal assistance to stand.
NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation:	The patient moves all extremities well. PERRLA is bilaterally intact. No visible signs of drainage. Patient strength is equal and to bilaterally lower and upper extremities. The patient is alert and oriented x4. Speech is clear and concise. No sensory deficits.

Mental Status: Speech: Sensory: LOC:	
<b>PSYCHOSOCIAL/CULTURAL:</b> Coping method(s): watching television and visiting with family Developmental level: Religion & what it means to pt.: N/A Personal/Family Data (Think about home environment, family structure, and available family support):	The patient's coping method is watching tv and visiting with family (sister and brother-in-law). The patient is at the Erikson's ego integrity vs despair stage. The patient does not have a religious preference. The patient states she is close family.

### Discharge Planning

Discharge location: Patient is discharging home.

Home health needs: The patient would benefit from some outpatient physical therapy.

Equipment needs: The patient would benefit from grab bars, a lift chair, and lifted toilet seat.

Follow up plan: The patient needs to follow up with her primary care provider and cardiologist.

Education needs: The patient needs to be educated on management of congestive heart failure and pulmonary embolisms.

### 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	Rationale • Explain why the nursing diagnosis was chosen	Outcome Goal (1 per dx)	Interventions (2 per goal)	Evaluation of interventions

<p>by” components</p> <ul style="list-style-type: none"> <li>Listed in order by priority – highest priority to lowest priority pertinent to this client</li> </ul>				
<p>1. Impaired gas exchange related to pulmonary embolism as evidenced by shortness of breath (Phelps, 2023).</p>	<p>The patient was having shortness of breath at rest and on exertion.</p>	<p>The patient will maintain effective gas exchange as evidenced by oxygen saturation &gt;90% and respiratory rate at 12-20 breaths per minute within 4 hours of intervention (Phelps, 2023).</p>	<ol style="list-style-type: none"> <li>The patient will take frequent breaks with ADLs (Phelps, 2023).</li> <li>The patient will receive anticoagulation therapy (Phelps, 2023).</li> </ol>	<p>The patient stated she felt less short of breath by taking breaks in between activities. The patients oxygen saturation was 90% or above and respirations were 18-20.</p>
<p>2. Excessive fluid volume related to fluid intake as evidenced by weight gain (Phelps, 2023).</p>	<p>The patient gained 5.9 pounds in two days.</p>	<p>The patient will demonstrate decreased peripheral edema and maintain a urine output of at least 30ml/hr within 8 hours of intervention (Phelps, 2023).</p>	<ol style="list-style-type: none"> <li>Administer diuretics (Phelps, 2023).</li> <li>Educate the patient of fluid and sodium intake (Phelps, 2023).</li> </ol>	<p>The patient had 750ml of urine output in 4 hours after receiving Lasix. The patient understands fluid and sodium intake and will limit each when discharged home.</p>
<p>3. Decreased cardiac output related to altered</p>	<p>The patient is having shortness of</p>	<p>The patient will report an absence of</p>	<p>1. Administer diuretics (Phelps, 2023).</p>	<p>After receiving diuretics, the</p>

heart rate and rhythm as evidenced by shortness of breath (Phelps, 2023).	breath and is having an irregular regular heart rhythm.	shortness of breath as evidenced by no dyspnea within 2 hours of intervention (Phelps, 2023).	2. Encourage rest periods with ADLs (Phelps, 2023).	patient is less short of breath and can get up out of the chair without assistance.
4. Activity intolerance as related to weakness as evidenced by fatigue (Phelps, 2023).	The patient had significant fatigue in the morning that improved after receiving diuretics.	The patient will demonstrate vital signs and heart rhythm within normal limits during activity as evidenced by heart rate between 60- 100 and blood pressure within 20 mmHg of baseline and absence of dysrhythmias during ambulation (Phelps, 2023).	1. Teach methods to conserve energy (Phelps, 2023). 2. Provide a calm environment (Phelps, 2023).	The patient was able to perform ADLs in the room without help with rest periods. Blood pressure was no more than 130 systolic and heart rate was between 85-90 with activity.

Other References (APA):

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

Nursing Process Prioritization	Rationale
1. Impaired gas exchange related to pulmonary embolism as evidenced by shortness of breath (Phelps, 2023).	The patient was having shortness of breath at rest and on exertion
2. Excessive fluid volume related to fluid intake as evidenced by weight gain (Phelps, 2023).	The patient gained 5.9 pounds in two days.
3. Decreased cardiac output related to altered heart rate and rhythm as evidenced by shortness of breath (Phelps, 2023).	The patient is having shortness of breath and is having an irregular regular heart rhythm.

<p>4. Activity intolerance as related to weakness as evidenced by fatigue (Phelps, 2023).</p>	<p>The patient had significant fatigue in the morning that improved after receiving diuretics.</p>
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Other References (APA):

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