# N321 Care Plan #1

Lakeview College of Nursing

Hannah Johnson

## Demographics (3 points)

| **Date of Admission** 9/2/2019 | **Patient Initials** C.W. | **Age** 71 | **Gender** Male |
|---|---|---|---|
| **Race/Ethnicity** White | **Occupation** Retired | **Marital Status** Married | **Allergies** Iodine (one functioning, kidney) Verapamil (Diarrhea) Carvedilol (Diarrhea) Ciprofloxacin (Diarrhea/vomiting) Codeine (vomiting) diltiaZEM (Diarrhea) |
| **Code Status** Full Code | **Height** 175 cm | **Weight** 139.9 kg | |

## Medical History (5 Points)

**Past Medical History:** acute decompensated diastolic heart failure, acute on chronic hypoxemic respiratory failure, hyponatremia, hyperkalemia, acute kidney injury, normocytic anemia (anemia of chronic disease), History of CAD, Atrial fibrillation, CKD, COPD, hypertensive cardiovascular disease, hypothyroidism, GERD, morbid obesity, OSA, edema of lower extremity, type 2 diabetes mellitus (without complications)

**Past Surgical History:** H/O retinal detachment (8/24/2017), Repair of retina (05/02/2017), Endoscopy (06/01/2017), Battery (07/13/2015), History of hernia repair (10/03/2014)

**Family History:** Mother: cardiovascular & heart disease

**Social History (tobacco/alcohol/drugs):** alcohol→ denies, drugs→denies, tobacco→former smoker

**Assistive Devices:** walker/cane, in hospital patient has been using hoyer lift

**Living Situation:** at home with his wife (was in rehab facility upon arriving to hospital)

**Education Level:** Patient states he attended some college

## Admission Assessment

**Chief Complaint (2 points):** SOB, lower extremity edema

**History of present Illness (10 points):** This 71-year-old man was admitted into Sarah Bush a week ago following a fall. He complained of shortness of breath. Upon physical examination and after diagnostic testing it is known that he is having an acute on chronic CHF exacerbation. He has 4+ pitting edema in his lower extremities.

## Primary Diagnosis

**Primary Diagnosis on Admission (2 points):** acute on chronic heart failure exacerbation

**Secondary Diagnosis (if applicable):** fluid volume overload

**Pathophysiology of the Disease, APA format (20 points):** Heart failure (HF) is a complex clinical syndrome in which the heart is unable to pump sufficient blood to meet the body's metabolic demands. It is caused by structural or functional cardiac disorders that impair the ventricle's ability to fill with or eject blood. HF is a chronic condition that is prone to acute exacerbations (Swearingen, 2016, p.168). Some signs and symptoms of heart failure are irregular or rapid heart rate, crackles (rales), pitting edema in lower extremities. (Swearingen, 2016, p.169). A chest X-ray was completed on my patient and determined that he had suggested mild CHF with Basilar Pleural effusion and Perihilar interstitial edema. A lab result that also indicates heart failure is the BNP. A normal BNP should be at <100 pg/mL and his was at 774 indicating the patient had heart failure. Fluid volume overload occurs when the bloodstream has an excess amount of water. One of the most common causes in CHF (chronic heart failure). In heart failure, the RAAS is constantly cycling, which brings an excessive amount of water into the bloodstream. Blood volume increases, which increases the hydrostatic pressure. High hydrostatic pressure overwhelms osmotic pressure at every capillary bed, leading to edema in various places

of the body. Some signs and symptoms of fluid volume overload are ascites, crackles in lungs, dyspnea, edema and weight gain (Capirotti & Frizzell, 2016, p. 124 & 127). A CMP can be done to determine if a patient has fluid volume overload. Since the patient has hyponatremia this allows for excess fluid in the bloodstream. Some treatments for fluid volume overload are being on a fluid restricted diet due to fact there is excess fluid in the bloodstream.

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

Capriotti, T., Frizzell, J. P., (2016). *Pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia, PA: FA Davis

Swearingen, P. L., (2016). *All-in-one nursing: Care Planning Resource*. Missouri, St. Louis: Mosby Inc.

## Laboratory Data (15 points)

**CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

| Lab | Normal Range | Admission Value | Today's Value | Reason for Abnormal Value |
|---|---|---|---|---|
| **RBC** | 4-5.5 million cells | 3.00 | 2.76 | Low due to his normocytic anemia |
| **Hgb** | 14-16 | 9.4 | 8.6 | Low due to his normocytic anemia |
| **Hct** | 35%-47% | 28.4 | 25.9 | Low due to his normocytic anemia |
| **Platelets** | 150,00-400,00 | 300 | 285 | |
| **WBC** | 4,500-11,000 cells/mm3 | 6.5 | 7.8 | |
| **Neutrophils** | 45%-75% | 74.8 | 80.2 | Indication of inflammation (could be related to COPD) |
| **Lymphocytes** | 20%-40% | 12.1 | 8.9 | Could be related to possible infection |
| **Monocytes** | 4%-6% | 9.6 | 8.0 | Indication of inflammation (could be related to COPD) |
| **Eosinophils** | <7% | 2.3 | 2.2 | |
| **Basophils** | <3% | 1.2 | 0.7 | |

**Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

| Lab | Normal Range | Admission Value | Today's Value | Reason For Abnormal |
|---|---|---|---|---|
| **Na-** | 136-145 mEq/L | 124 | 131 | Related to patient's lower extremity edema |
| **K+** | 3.5-5.0 mEq/L | 5.7 | 4.4 | |
| **Cl-** | 98-106 mEq/L | 90 | 90 | Could be related to patient loosing 32 pounds in 1 week |
| **CO2** | 23-29 mEq/ L | 25 | 33 | Could be related to patient's COPD |
| **Glucose** | 70-100 mg/dL | 120 | 100 | |
| **BUN** | 7 to 20 mg/dL | 78 | 76 | Related to clients fluid restricted diet |
| **Creatinine** | 0.6-1.2 mg/dL | 2.39 | 1.78 | Due to impaired kidney function (only having one kidney) |
| **Albumin** | 3.4-5.4 g/dL | 3.5 | 3.2 | Due to the patient's lower extremity edema |
| **Calcium** | 9.0-10.5 mg/ dL | 8.9 | 9.3 | |
| **Mag** | 1.3-2.1 mEq/L | 1.8 | 1.8 | **from admission date |
| **Phosphate** | | | | LAB NOT PERFORMED |
| **Bilirubin** | 0.1-1.2 mg/dL | 0.5 | 0.5 | |
| **Alk Phos** | 20-140 IU/L | 113 | 86 | |
| **AST** | 10-40 u/L | 12 | 18 | |
| **ALT** | 7-56 u/L | 9 | 13 | |
| **Amylase** | | | | LAB NOT PERFORMED |
| **Lipase** | | | | LAB NOT PERFORMED |

| | | | | |
|---|---|---|---|---|
| **Lactic Acid** | | | | LAB NOT PERFORMED |

**Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

| Lab Test | Normal Range | Value on Admission | Today's Value | Reason for Abnormal |
|---|---|---|---|---|
| **INR** | | | | LAB NOT PERFORMED |
| **PT** | | | | LAB NOT PERFORMED |
| **PTT** | | | | LAB NOT PERFORMED |
| **D-Dimer** | | | | LAB NOT PERFORMED |
| **BNP** | <100 pg/mL | 774 | 774 **from admission date | Indication of heart failure |
| **HDL** | | | | LAB NOT PERFORMED |
| **LDL** | | | | LAB NOT PERFORMED |
| **Cholesterol** | | | | LAB NOT PERFORMED |
| **Triglycerides** | | | | LAB NOT PERFORMED |
| **Hgb A1c** | | | | LAB NOT PERFORMED |
| **TSH** | | | | LAB NOT PERFORMED |

**Blood Gases: Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

| Lab Test | Normal Range | Value on Admission | Today's Value | Reason for Abnormal |
|---|---|---|---|---|
| **pH Ven:** | 7.30-7.40 | 7.30 | 7.30 | |
| **pCO2 Ven:** | 42-48 mmHg | 49.7 | 49.7 | Due to patient's respiratory failure |
| **pO2 Ven:** | 35-45 mmHg | 49.8 | 49.8 | Indication of breathing disorder (COPD) |

| | | | | |
|---|---|---|---|---|
| **HCO3 Ven:** | 24-30 mEq/L | 22.4 | 22.4 | Indication of kidney failure |
| **Base Excess Ven:** | -2.1+/- 1.7 | -1.7 | -1.7 | |
| **O2 Sat. Venous:** | 92-100% | 85.6 | 85.6 | Patient has hypoxemic respiratory failure |

**Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.**

| Test | Normal Range | Value on Admission | Today's Value | Explanation of Findings |
|---|---|---|---|---|
| **Urine Culture** | | | | LAB NOT PERFORMED |
| **Blood Culture** | | | | LAB NOT PERFORMED |
| **Sputum Culture** | | | | LAB NOT PERFORMED |
| **Stool Culture** | | | | LAB NOT PERFORMED |

**Lab Correlations Reference (APA):**

Capriotti, T., Frizzell, J. P., (2016). *Pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia, PA: FA Davis

## Diagnostic Imaging

**All Other Diagnostic Tests (5 points):** EKG: Sinus bradycardia, short PR (sinus rhythm replaced A. Fib). Chest XR: suggest mild CHF with Basilar Pleural effusion and Perihilar interstitial edema. An EKG was done to determine the irregularity in the patient's heart rate.

**Diagnostic Test Correlation (5 points):** The chest X-ray was done to see if there was fluid leakage into the interstitum, alveoli, or pleural space. According to the chest x-ray there was

fluid leakage into the pleural space and interstitium. An EKG detects the irregularity in your heart rhythm. The patient's Atrial Fibrillation rhythm was replaced with a sinus bradycardia rhythm.

**Diagnostic Test Reference (APA):**

Capriotti, T., Frizzell, J. P., (2016). *Pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia, PA: FA Davis

**Current Medications (10 points, 1 point per completed med)**
***10 <u>different</u> medications must be completed***

**Home Medications (5 required)**

| **Brand/ Generic** | Aspirin (Aspirin) | Rosuvastatin (Crestor) | Lisinopril (Zestril) | Ipratropium-albuterol (Atrovent) | Doxazosin (Cardura) |
|---|---|---|---|---|---|
| **Dose** | 81 mg | 5 mg | 20 mg | 3 mL | 1 mg |
| **Frequency** | Daily | HS daily | Daily | Q6H-PRN | Daily |
| **Route** | PO | PO | PO | NEB | PO |
| **Classification** | Anti-inflammatory | Antihyperlipidemic | Antihypertensive; vasodilator | Anticholinergic, bronchodilator | Antihypertensive, benign prostatic hyperplasia therapeutic agent |
| **Mechanism of Action** | Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis. Prostaglandins, important mediators in the inflammator | Cholesterol and triglycerides circulate in the blood as part of lipoprotein complexes. Rosuvastatin inhibits the enzyme 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) | May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II. Angiotensin II is a potent vasoconstrictor that also stimulates | After acetylcholine is released from cholinergic fibers, ipratropium prevents it from attaching to muscarinic receptors on membranes of smooth | Competitively inhibits alpha, -adrenergic receptors in the sympathetic nervous system, causing peripheral vasodilation and reduced peripheral |

| | | | | | |
|---|---|---|---|---|---|
| | y response, cause local vasodilation with swelling and pain. | reductase. This inhabitation reduces lipid levels by increasing the number of hepatic low-density lipoprotein (LDL) receptors on the cell surface to increase uptake and catabolism of LDL. | adrenal cortex to secrete aldosterone. Lisinopril may also inhibit renal and vascular production of angiotensin II. | muscle cells. By blocking acetylcholine's effects in bronchi and bronchioles, ipratropium relaxes smooth muscles and causes bronchodilation. | vascular resistance. This action increases heart rate and decreases blood pressure, especially when the patient stands. |
| **Reason Client Taking** | To reduce the risk of death and MI to patients with chronic coronary artery disease; to reduce risk of death and recurrent stroke in patients who have had an ischemic stroke or transient ischemic attack. | To slow the progression of atherosclerosis; to prevent primary cardiovascular disease (reduce the risk of myocardial infarction, stroke, or need for arterial revascularization procedures) in patients without clinically evident CAD but with increased risk factors of cardiovascular disease such as age. | To treat hypertension | To treat bronchitis and COPD<br><br>To treat perennial and allergic rhinitis | To manage hypertension |
| **Contraindications (2)** | Allergy to tartazine dye, bleeding problems | Active liver disease, breastfeeding | Concurrent aliskiren use in patients with diabetes or patients | Hypersensitivity to atropine, ipratropium bromide or | Hypersensitivity to doxazosin, prazosin, terazosin, or |

| | | | | | |
|---|---|---|---|---|---|
| | | | with renal impairment, hereditary or idiopathic angioedema or history of angioedema related to previous treatment with an ACE inhibitor | their components hypersensitive to peanuts, soya lecithin, soybeans, or related products | other components. |
| **Side Effects/ Adverse Reactions (2)** | Bronchospasm, Ecchymosis | Cognitive impairment, chest pain | Arrhythmias, Hyperglycemia | Atrial fibrillation, edema | Arrhythmias, sinus tachycardia |
| **Nursing Considerations (2)** | Don't crush timed-release or controlled-release aspirin tablets unless directed.<br><br>Ask about tinnitus. This reaction usually occurs when blood aspirin level reaches or exceeds maximum dosage for therapeutic effect. | Use rosuvastatin cautiously in patients who consume large quantities of alcohol or who have a history of liver disease.<br><br>If ALT or AST levels increase to more than three times the normal range, expect dosage to be reduced or discontinued. | Be aware that lisinopril should not be given to a patient who is hemodynamically unstable after an acute IM.<br><br>Use lisinopril cautiously in patients with fluid volume deficit, heart failure, impaired renal function, or sodium depletion. | When using a nebulizer, apply a mouthpiece to prevent drug from leaking out around mask and causing blurred vision or eye pain.<br><br>Use ipratropium cautiously in patients with angle-closure glaucoma, benign prostatic hyperplasia, or bladder neck obstruction and in patients with hepatic or renal | Know that drug should not be given to hypotensive patient.<br><br>Use doxazosin cautiously in patients with hepatic disease (because normal dosage may cause exaggerated effects) and in elderly patients (because hypotensive response may be more pronounced) |

| | | | | | |
|---|---|---|---|---|---|
| | | | | dysfunction. | |

**Hospital Medications (5 required)**

| **Brand/ Generic** | Lasix (furosemide) | Metolazone (Zaroxolyn) | Lovenox (enoxaparin) | Naloxone (Narcan) | Zofran (ondansetron hydrochloride) |
|---|---|---|---|---|---|
| **Dose** | 40 mg/4 mL | 2.5 mg | 40 mg | 0.4 mg = 1 mL | 4 mg = 2 mL |
| **Frequency** | BID | Daily | Daily | Q2M-PRN | Q6H - PRN |
| **Route** | IV Push | PO | SubQ inj | IV push | IV Push |
| **Classification** | Antihypertensive, diuretic | Antihypertensive, diuretic | Antithrombotic | Opioid antagonist | Antiemetic |
| **Mechanism of Action** | Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation. As the body's plasma volume decreases, aldosterone production increases, which promotes sodium reabsorption and the loss of potassium and hydrogen ions. Furosemide also increases the excretion | Promotes renal excretion of sodium and water by inhibiting their reabsorption in distal convoluted tubules. The resulting reduction in extracellular fluid volume and plasma reduces blood pressure. | Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors. | Briefly and competitively antagonizes mu, kappa, and sigma receptors in the CNS, thus reversing analgesia, hypotension, respiratory depression, and sedation caused by most opioids. | Blocks serotonin receptors central in chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestine. This action reduces nausea and vomiting by preventing serotonin release in the small intestine. |

| | | | | | |
|---|---|---|---|---|---|
| | of calcium, magnesium, bicarbonate, ammonium, and phosphate. | | | | |
| **Reason Client Taking** | To reduce edema caused by cirrhosis, heart failure, and renal disease, including nephrotic syndrome | To manage edema from heart failure or renal disease | To prevent deep vein thrombus (DVT) or pulmonary embolism (PE) | To reverse opioid induced asphyxia | Prevent nausea and vomiting |
| **Contraindications (2)** | Anuria unresponsive to furosemide, hypersensitivity to furosemide, sulfonamides | Anuria; hepatic coma | Active major bleeding, thrombocytopenia | Hypersensitivity to naloxone or its components | Concomitant use of apomorphine, congenital long QT syndrome |
| **Side Effects/Adverse Reactions (2)** | Hyperglycemia, Arrhythmias | Chest pain, syncope | Epistaxis, atrial fibrillation | Hypertension (severe), pulmonary edema | Agitation, Bronchospasm |
| **Nursing Considerations (2)** | Use furosemide cautiously in patients with advanced hepatic cirrhosis, especially those who also have a history of electrolyte imbalance or hepatic encephalopathy; drug may lead to lethal hepatic coma. | Anticipate giving metolazone with a loop diuretic if patient responds poorly to loop diuretic alone.<br><br>Measure patient's fluid intake and output and daily weight to monitor drug's | Don't give drug by I.M. injection.<br><br>Be aware that drug isn't recommended for patients with prostatic heart valves, especially pregnant women, because of risk of prosthetic valve thrombosis, if | Keep resuscitation equipment readily available during naloxone administration.<br><br>Administer parenteral Narcan brand by I.V. route whenever possible. | Place disintegrating tablet or oral soluble film on patient's tongue immediately after opening package. It dissolves in seconds.<br><br>Dilute drug in 50 ml of D5W or normal |

| | | | | | |
|---|---|---|---|---|---|
| | Be aware that patients who are allergic to sulfonamides may also be allergic to furosemide. | diuretic effect. | enoxaparin is needed monitor peak and trough antifactory Xa levels often and adjust dosage as needed. | | saline solution when indicated. However, know that when used to treat postoperative nausea and vomiting in adults, drug is administered undiluted intramuscularly or intravenously. |

**Medications Reference (APA):**

Jones & Bartlett Learning. (2018). *2018 Nurses drug handbook*(17th ed.). Burlington, MA.

## Assessment

**Physical Exam (18 points)**

| | |
|---|---|
| **GENERAL (1 point):**<br>**Alertness:**<br>**Orientation:**<br>**Distress:**<br>**Overall appearance:** | **AOx4** |
| **INTEGUMENTARY (2 points):**<br>**Skin color: pale**<br>**Character: dry, scaly, flakey**<br>**Temperature: warm**<br>**Turgor: good turgor**<br>**Rashes: n/a**<br>**Bruises: noticeable on upper extremities**<br>**Wounds: n/a**<br>**Braden Score: 16**<br>**Drains present: Y☐ N ☒**<br>**Type:** | |

| | |
|---|---|
| **HEENT (1 point):**<br>**Head/Neck:**<br>**Ears:**<br>**Eyes:**<br>**Nose:**<br>**Teeth:** | **Head: symmetrical, no hair present**<br>**Ears: no obstruction or drainage, normal shape**<br>**Eyes: reactive to light, moved prompted, no drainage.**<br>**Nose: midline**<br>**Teeth: dentures** |
| **CARDIOVASCULAR (2 points):**<br>**Heart sounds: Normal**<br>**S1, S2, S3, S4, murmur etc.**<br>**Cardiac rhythm (if applicable): s1, s2**<br>**Peripheral Pulses: 2+**<br>**Capillary refill: less than 3 seconds**<br>**Neck Vein Distention: Y ☐ N ☒**<br>**Edema Y ☒ N ☐**<br>**Location of Edema:**<br>**Bilateral lower extremities** | **No murmurs present** |
| **RESPIRATORY (2 points):**<br>**Accessory muscle use: Y☐ N ☒**<br>**Breath Sounds: Location, character**<br>**Diminished lung sounds bilaterally** | **** 2L nasal cannula @ home (continuous)** |
| **GASTROINTESTINAL (2 points):**<br>**Diet at home: regular**<br>**Current Diet: regular**<br>**Height: 175 cm**<br>**Weight: 139.9 kg**<br>**Auscultation Bowel sounds: bowel sounds present in all quadrants**<br>**Last BM: evening of 9/8**<br>**Palpation: Pain, Mass etc.:**<br>**Inspection:**<br>**Distention: n/a**<br>**Incisions: n/a**<br>**Scars: n/a**<br>**Drains: n/a**<br>**Wounds: n/a**<br>**Ostomy: Y ☐ N ☒**<br>**Nasogastric: Y ☐ N ☒**<br>**Size: n/a**<br>**Feeding tubes/PEG tube Y ☐ N ☒**<br>**Type: n/a** | |
| **GENITOURINARY (2 Points):**<br>**Color: clear/yellow**<br>**Character:** | |

| | |
|---|---|
| **Quantity of urine:**<br>**Pain with urination: Y ☐ N ☒**<br>**Dialysis: Y ☐ N ☒**<br>**Inspection of genitals:**<br>**Catheter: Y ☐ N ☒**<br>**Type: n/a**<br>**Size: n/a** | |
| **MUSCULOSKELETAL (2 points):**<br>**Neurovascular status:**<br>**ROM:**<br>**Supportive devices:**<br>**Strength:**<br>**ADL Assistance: Y☐ N ☐**<br>**Fall Risk: Y ☒ N☐**<br>**Fall Score: 60**<br>**Activity/Mobility Status:**<br>**Independent (up ad lib) ☐**<br>**Needs assistance with equipment**<br>**Needs support to stand and walk☐** | **Needs assistance with equipment**<br>**Needs support to stand and walk** |
| **NEUROLOGICAL (2 points):**<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:** | **Strength equal: ** has pitting 4+ edema in lower extremities****<br><br>**Mental Status: normal**<br>**Speech: normal**<br>**Sensory: normal**<br>**LOC: conscious** |
| **PSYCHOSOCIAL/CULTURAL (2 points):**<br>**Coping method(s): watching tv**<br>**Developmental level: Cognitive**<br>**Religion & what it means to pt.: Christian**<br>**Personal/Family Data (Think about home environment, family structure, and available family support): Patient feels safe at home** | . |

**Vital Signs, 2 sets (5 points)**

| Time | Pulse | B/P | Resp Rate | Temp | Oxygen |
|---|---|---|---|---|---|
| **1130** | **72** | **119/58** | **18** | **37.1** | **97** |

| | | | | | |
|---|---|---|---|---|---|
| **1530** | **78** | **123/59** | **18** | **36.3** | **98** |

**Pain Assessment, 2 sets (2 points)**

| Time | Scale | Location | Severity | Characteristics | Interventions |
|---|---|---|---|---|---|
| **1111** | **6** | **Back/coccyx** | **moderate** | **Sharp/shooting** | **Patient was given meds for comfort** |
| **1500** | **7** | **Back/coccyx** | **moderate** | **Sharp/shooting** | **Patient was given meds for comfort** |

**IV Assessment (2 Points)**

| IV Assessment | Fluid Type/Rate or Saline Lock |
|---|---|
| **Size of IV: 22 gauge**<br>**Location of IV: left-peripheral**<br>**Date on IV: 9/5/19**<br>**Patency of IV: good**<br>**Signs of erythema, drainage, etc.: none**<br>**IV dressing assessment: good upon assessment** | Lasix was given during clinical time. |

**Intake and Output (2 points)**

| Intake (in mL) | Output (in mL) |
|---|---|
| **615 mL** | **925 mL** |

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care: Nursing care was good throughout; I was able to administer the patient his Lasix and did a focused assessment on his heart and lungs since his is on these loop diuretics.**

**Procedures/testing done CMP/Blood gases/CBC/EKG/X-ray**

**Complaints/Issues: n/a**

**Vital signs (stable/unstable): stable**

**Tolerating diet, activity, etc.: patient needs to ambulate, and maintain a heart healthy diet**

**Physician notifications:n/a**

**Future plans for patient: maintain fluid restriction diet and diet to keep up with CHF, etc.**

**Discharge Planning (2 points)**

**Discharge location: home with wife**

**Home health needs (if applicable): patient needs a walker/cane and assistance upon standing, might need a care taker or in home health nurse to assist with ADLs**

**Equipment needs (if applicable): walker/cane**

**Follow up plan: follow up with doctor as needed**

**Education needs: education needed on fluid restriction, so patient doesn't come in with edema and weight gain again.**

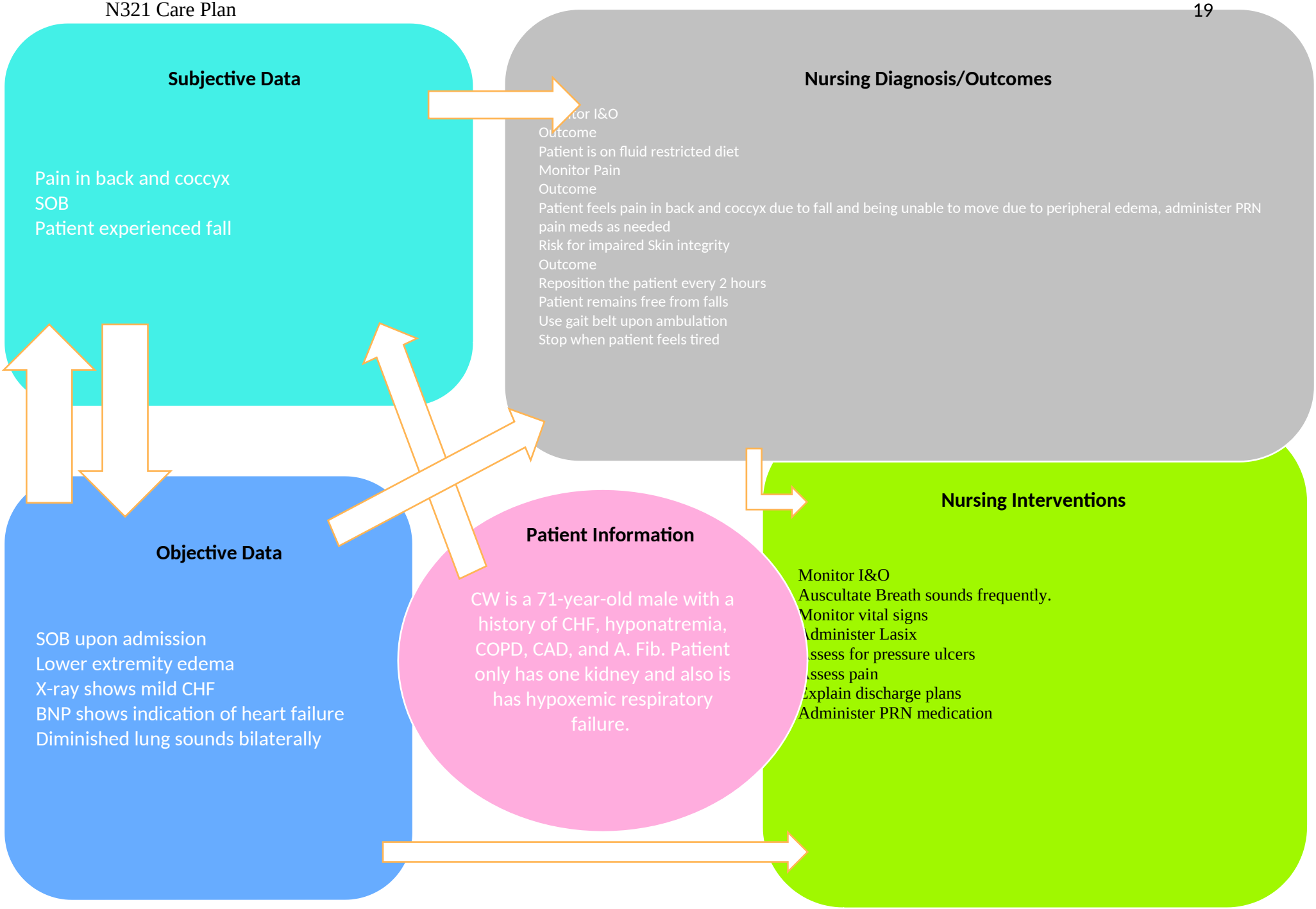
**Nursing Diagnosis (15 points)**
***Must be NANDA approved nursing diagnosis and listed in order of priority***

| Nursing Diagnosis | Rational | Intervention (2 per dx) | Evaluation |
|---|---|---|---|
| • Include full nursing diagnosis with "related to" and "as evidenced by" components | • Explain why the nursing diagnosis was chosen | | • How did the patient/family respond to the nurse's actions?<br>• Client response, status of goals and outcomes, modifications to plan. |

| | | | |
|---|---|---|---|
| 1. Free from falls related to previous falls as evidenced by admission into the hospital. | Patient was admitted to the hospital due to a fall. | 1. Use of gait belt upon ambulation<br><br>2.explain the use of assistive devices | Patient responded well |
| 2. The patient has optimal fluid balance related to fluid volume overload as evidenced by lower extremity edema. | Patient has lower extremity edema. | 1. Maintain fluid restricted diet.<br>2. maintain normal electrolyte balances, explain how to maintain sodium levels. | Patient is indifferent about diet but is trying to become more understanding |
| 3. Impaired skin integrity related to immobility as evidenced by Braden score of 16. | Since patient has lower extremity edema it is hard for him to walk. | 1. Rotate every 2 hours.<br><br>2. Try and get patient up every so often. | Patient responded well. |

**Other References (APA):**

**Concept Map (20 Points):**


Subjective Data
Pain in back and coccyx
SOB
Patient experienced fall
Nursing Diagnosis/Outcomes
tor I&O
Outcome
Patient is on fluid restricted diet
Monitor Pain
Outcome
Patient feels pain in back and coccyx due to fall and being unable to move due to peripheral edema, administer PRN pain meds as needed
Risk for impaired Skin integrity
Outcome
Reposition the patient every 2 hours
Patient remains free from falls
Use gait belt upon ambulation
Stop when patient feels tired
Objective Data
SOB upon admission
Lower extremity edema
X-ray shows mild CHF
BNP shows indication of heart failure
Diminished lung sounds bilaterally
Patient Information
CW is a 71-year-old male with a history of CHF, hyponatremia, COPD, CAD, and A. Fib. Patient only has one kidney and also is has hypoxemic respiratory failure.
Nursing Interventions
Monitor I&O
Auscultate Breath sounds frequently.
Monitor vital signs
dminister Lasix
ssess for pressure ulcers
ssess pain
xplain discharge plans
Administer PRN medication