N321 Care Plan #2

Lakeview College of Nursing

Hannah Johnson

Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
9/25/2019	R.C.	59	F
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Full time employed	Married	NKA
Code Status	**Height**	**Weight**	
Full Code	171 cm	108.1 kg	

Medical History (5 Points)

Past Medical History: Anxiety, Benign essential hypertension, Chronic GERD, Depression, Diabetic kidney disease, Diabetes Mellitus, Diastolic heart failure grade 2 (newly diagnosed). History of Bells Palsy, Hyperlipidemia, Obesity, OSA on CPAP, Other long term (current) drug therapy, Perimenopausal disorder.

Past Surgical History: Caesarean Section (6/26/1986), Tonsillectomy

Family History: Father: Bleeding disorder, Mother: Alzheimer's, Diabetes Mellitus, Hypertension

Social History (tobacco/alcohol/drugs): Tobacco: never uses, Alcohol: denies use, Drugs: denies use

Assistive Devices: Gait belt, CPAP machine

Living Situation: Patient lives at home with her husband

Education Level: The patient has attended some college

Admission Assessment

Chief Complaint (2 points): shortness of breath, fever, and chest/back pain

History of present Illness (10 points): This 59-year-old female was admitted to Sarah Bush Lincoln on 9/25/2019 due to shortness of breath, fever, and back and chest pain. She stated upon admission she had a fever for more than 24 hours. Her pain upon admission was a 6/10 which

was sharp and shooting, though during the clinical time she stated her pain was a 0/10. She was then admitted into the hospital and is being treated for community-acquired right lower lobe pneumonia. During the clinical time she stated to be feeling a lot better and was ready to go home. During her hospital visit she was also diagnosed with diastolic heart failure grade 2, she had 1+ pitting edema in her lower extremities.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): community-acquired right lower lobe pneumonia

Secondary Diagnosis (if applicable): Bells Palsy

Pathophysiology of the Disease, APA format (20 points): Pneumonia is an inflammation of the lung parenchyma caused by various microorganisms, including bacteria, mycobacteria, fungi, and viruses (Hinkle, Cheever, & Brunner, 2018, p. 587). The upper airway prevents potentially infectious particles from reaching the sterile lower respiratory tract. Pneumonia arises from normal flora present in patients whose resistance has been altered or from aspiration of flora present in the oropharynx; patients often have an acute or chronic underlying disease that impairs host defenses. Pneumonia affects both ventilation and diffusion. An inflammatory reaction can occur in the alveoli, producing an exudate that interferes with the diffusion of oxygen and carbon dioxide. White blood cells, mostly neutrophils, also migrate into the alveoli and fill the normally air-filled spaces (Hinkle, Cheever, & Brunner, 2018, p. 589). Some signs and symptoms are cough, increased sputum production, fever, pleuritic chest pain, dyspnea, chills, headache and myalgia. (Swearingen, 2016, p.116). A CT chest W/O contrast was performed that stated it was bilateral upper lobe pneumonia, mild mediastinal lymphaderiopathy, bilateral small pleural effusions. Treatments include antibiotics and staying up to date on your vaccines.

Bells palsy (facial paralysis) is caused by unilateral inflammation of the seventh cranial nerve, which results in weakness or paralysis of the facial muscles on the affected side. (Hinkle, Cheever, & Brunner, 2018, p. 2088). Some signs and symptoms are drooling, difficulty eating and drinking, facial weakness, muscle twitches in the face, headache, and sensitivity to sound. The objectives of treatment are to maintain the muscle tone of the face and to prevent or minimize denervation. Corticosteroid therapy may be prescribed to reduce inflammation and edema; this reduces vascular compression and permits restoration of blood circulation to the nerve. Facial pain is controlled with analgesic agents (Hinkle, Cheever, & Brunner, 2018, p. 2088).

Pathophysiology References (2) (APA):

Hinkle, J. L., Cheever, K. H., & Brunner, L. S. (2018). *Brunner & Suddath's textbook of medical-surgical nursing*. Philadelphia: Wolters Kluwer.

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	F: 4-4.9	4.30	3.39	Due to patient's diabetic kidney function
Hgb	F: 12-15	12.3	9.6	This could be due to patient's kidney disease.
Hct	F: 36-44	36.6	28.9	This could show signs of anemia
Platelets	140,000-450,00	312,000	422,000	
WBC	4,500-11,000	9,000	11,800	Could be high due to the fact the patient is fighting pneumonia.
Neutrophils	45.3-79.0%	69.1	69.1	From date of admission
Lymphocytes	11.8-45.9%	18.8	18.8	From date of admission

Monocytes	4.4-12.0	9.0	9.0	From date of admission
Eosinophils	0.0-6.3	2.2	2.2	From date of admission
Bands	0.0-6.0	4.0	4.0	From date of admission

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-	135-145	136	137	
K+	3.5-5	4.0	3.7	
Cl-	96-108	100	103	
CO2	22-29	26	26	
Glucose	70-115	105	117	This patient is a type 2 diabetic.
BUN	7-20	12	16	
Creatinine	0.7-1.4	0.85	0.79	
Albumin	3.5-5.0	4.0	4.0	From date of admission
Calcium	8.6-10.3	8.8	8.2	This could be related to patient's kidney disorder.
Mag				Test not performed
Phosphate				Test not performed
Bilirubin	0.1-1.2	0.5	0.5	
Alk Phos	40-150	94	94	From date of admission
AST	8-48	25	25	From date of admission

ALT	7-55	16	16	From date of admission
Amylase				Test not performed
Lipase				Test not performed
Lactic Acid				Test 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				Test not performed
PT				Test not performed
PTT				Test not performed
D-Dimer				Test not performed
BNP				Test not performed
HDL				Test not performed
LDL				Test not performed
Cholesterol				Test not performed
Triglycerides				Test not performed
Hgb A1c				Test not performed
TSH				Test not performed

Urinalysis 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

Color & Clarity	Yellow/clear	Yellow/hazy	Yellow/hazy **from date of admission**	Due to patients UTI.
pH	5.0-8.0	5.0	5.0	From date of admission
Specific Gravity	1.005-1.030	1.011	1.011	From date of admission
Glucose	Negative	Negative	Negative	From date of admission
Protein	Negative	Negative	Negative	From date of admission
Ketones	Negative	Negative	Negative	From date of admission
WBC	0-5	18	18 **from date of admission**	Indicative of a UTI.
RBC	0-3	1	1	From date of admission
Leukoesterase	Negative	2+	2+ **From date of admission**	Due to the high number of white blood cells in the urine, due to the patient's UTI.

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	No flora present	Mixed flora	Mixed flora **from date of admission**	Due to patients UTI
Blood Culture	Negative	Negative	Negative	From date of admission
Sputum Culture				Test not performed
Stool Culture				Test 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: normal sinus rhythm/ECG

XR Chest (2 views): middle lobe airspace disease consistent with pneumonia (right middle lobe infiltrate consistent with pneumonia. There may be small amount of fluid along the right minor fissure. Mild heart enlargement and pulmonary vascular congestion. No visualized pneumonia or pleural effusion.)

CT Chest W/O Contrast: bilateral upper lobe pneumonia, mild mediastinal lymphaderiopathy, bilateral small pleural effusions

EC Echo Complete W/ contrasts: normal left ventricular size and systolic function estimated ejection fraction 60-65%, trivial mitral and tricuspid valve regurgitation, grade 2 diastolic dysfunction estimated left atrial pressure is elevated

Diagnostic Test Correlation (5 points): An EKG looks at the electrical activity of the hart comparing it to normal and the patient's baseline. The patient's baseline was normal sinus rhythm, so their baseline didn't change at all. The chest x-ray was done to see if there was fluid buildup in the lungs. According to the results, it showed middle lobe airspace disease consistent with pneumonia, with small fluid along the right minor fissure. The CT chest w/o contrast showed bilateral upper lobe pneumonia and small pleural effusions. A CT scan is an X-ray image

made using a form of tomography in which a computer controls the motion of the x-ray source and detectors, processes the data, and produces the image. An echocardiogram is a test that uses high frequency sound waves (ultrasound) to make pictures of your heart. The patient's echocardiogram showed her new diagnosis of grade 2 diastolic dysfunction with an estimated ejection fraction of 60-65%.

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	lisinopril (Zestril)	rosuvastatin (Crestor)	sitagliptin (Januvia)	lansoprazole (Prevacid)	fluoxetine (Prozac)
Dose	5 mg	10 mg	100 mg	30 mg	20 mg (4 pills)
Frequency	Daily	Daily @ bedtime	Daily	Daily	Daily
Route	PO	PO	PO	PO-delayed release	PO
Classification	Antihypertensive	Antihyperlipidemic	Antidiabetic	Antisecretory	Anti-depressant
Mechanism of Action	May reduce blood pressure by inhibiting conversion of angiotensin I to angiotensin II. Angiotensin II is a potent vasoconstrictor that also	Cholesterol and triglycerides circulate in the blood as part of lipoprotein complexes. Rosuvastatin inhibits the enzyme 3-hydroxy-3-methylglutaryl-c	Inhibits the dipeptidyl peptidase-4 enzyme to slow inactivation of incretin hormones. These hormones	Binds to and inactivates the hydrogen-potassium adenosine triphosphate enzyme system (also called the proton pump) in	Selectively inhibits reuptake of the neurotransmitter's serotonin by CNS neurons and increases the amount of serotonin available in

	stimulates adrenal cortex to secrete aldosterone.	oenzyme A reductase. This inhibition 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.	are released by the intestine throughout the day but increase in response to a meal.	gastric parietal cells. This action blocks the final step of gastric acid production.	nerve synapses. An elevated serotonin level may result in elevated mood and, consequently, reduce depression.
Reason Client Taking	Hypertension	High Cholesterol	Diabetes	GERD	depression
Contraindications (2)	Concurrent aliskiren use in patients with diabetes or patients with renal impairment. Hypersensitivity to lisinopril or other ACE inhibitors.	Active liver disease Breast feeding	Diabetic ketoacidosis Type 1 diabetes	Concurrent therapy with rilpivirine-containing products Hypersensitivity to lansoprazole or its components	Concurrent therapy with pimozide or thioridazine Hypersensitivity to fluoxetine
Side Effects/Adverse Reactions (2)	Nausea, vomiting	Body aches, cough	Dizziness, frequent urination	Abdominal pain, headache	Chills, joint/muscle pain
Nursing Considerations (2)	Should not be given to a patient who is hemodynamically unstable after an acute MI.	Use cautiously in patients who consume large quantities of alcohol or who have a history of liver disease	Assess patient's renal function before starting sitagliptin therapy	Give before meals. Antacids may be given as well, if needed.	Use cautiously in patients with a history of seizures Monitor patients for

	Use cautiously in patients with fluid volume deficit, heart failure, impaired renal function, or sodium depletion.	If ALT or AST levels increase to more than three times the normal range, expect dosage to be reduced or discontinued.	Monitor patient's blood glucose level, as ordered, to determine effectiveness of sitagliptin therapy.	If patient has difficulty swallowing open and sprinkle granules on applesauce, cottage cheese, or pudding. Do not crush the pill.	depression (especially children, adolescents, and young adults) and watch closely for suicidal tendencies, particularly when therapy starts and dosages change, because depression may worsen temporarily during those times.

Hospital Medications (5 required)

Brand/Generic	enoxaparin sodium (Lovenox)	levofloxacin (Levaquin)	methylprednisolone (Medrol)	Ondansetron hydrochloride (Zofran)	azithromycin (Zmax)
Dose	40 mg= 0.4 mL	750 mg = 150 mL	40 mg = 1 mL	4 mg = 2 mL	500 mg
Frequency	Daily	Q24H	Daily	Daily (PRN every 6 hours)	Daily
Route	SQ	IV piggyback	IV push	IV push	IV piggyback
Classification	Antithrombotic	Antibiotic	Anti-inflammatory	Anti-emetic	Antibiotic

Mechanism of Action	Potentiates the action of antithrombin III, a coagulation inhibitor. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors. Without thrombin, fibrinogen can't convert to fibrin and clots can't form.	Interferes with bacterial cell replication by inhibiting the bacterial enzyme DNA gyrase, which is essential for repair and replication of bacterial DNA.	Binds to intracellular glucocorticoid receptors and suppresses inflammatory and immune responses by inhibiting accumulation of monocytes and neutrophils at inflammatory sites, stabilizing lysosomal membranes, suppressing the antigen response of macrophages and helper T cells, and inhibiting the synthesis of inflammatory response mediators, such as cytokines, interleukins, and prostaglandins.	Blocks serotonin receptors centrally in the 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 (probable cause of chemotherapy- and radiation-induced nausea and vomiting) and by blocking signals to the CNS. Ondansetron may also bind to other serotonin receptors and to mu-opioid receptors.	Binds to a ribosomal subunit of susceptible bacteria, blocking peptide translocation and inhibiting RNA-dependent protein synthesis. Drug concentrates in phagocytes, macrophages, and fibroblast which release it slowly and may help move it to infection sites.
Reason Client Taking	Treat blood clots & DVTs	Community acquired pneumonia	Kidney disease	Nausea	Pneumonia
Contraindications (2)	Active major bleeding pork products	Hypersensitivity to levofloxacin Myasthenia gravis	Fungal infection Hypersensitivity to methylprednisolone or its components.	Concomitant use of apomorphine Congenital long QT syndrome	History of cholestatic jaundice or hepatic dysfunction hypersensitivity to azithromycin
Side Effects/Adverse Reactions (2)	Easy bruising, severe headache	Headache, nausea	Nausea, vomiting	Stomach pain, vision changes	Upset stomach, diarrhea

Nursing Considerations (2)	Don't give by I.M. injection Use multidose vials cautiously in pregnant women because benzyl alcohol may cross the placenta and cause fetal harm.	Use cautiously in patients with renal insufficiency Use cautiously in patients with CNS disorders, such as epilepsy, that may lover the seizure threshold.	Arrange for low-sodium diet with added potassium, as prescribed. Administer methylprednisolone with extreme caution in patients with a recent myocardial infarction because corticosteroid use may increase risk of left ventricular free wall rupture.	Be aware that oral disintegrating tablets may contain aspartame, which metabolized to phenylalanine and must be avoided in patients with phenylketonuria. Monitor patients closely for signs and symptoms of hypersensitivity to ondansetron because hypersensitivity reactions, including anaphylaxis and bronchospasms, may occur.	Monitor elderly patients closely for arrhythmias because they are more susceptible to drug effects on the QT interval. Don't give azithromycin by I.V. bolus or I.M injection because it may cause erythema, pain, swelling, tenderness, or other reaction at the site. Infuse it over 60 minutes or longer.

Medications Reference (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient was A&O x 4 with no signs of acute distress

INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:** n/a	The patient's skin was pink, dry, and warm. There were no signs for rashes, bruises or wounds. Skin turgor of normal elasticity, no tenting present. The patient had a Braden score of 19 and there was no drains present.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is normocephalic ears showed no sign of drainage eyes were equal, round and reactive to light nose is midline teeth were clean with moist oral mucosa
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐** **Location of Edema:** peripheral (2+)	Heart sounds were normal with no murmurs present. Auscultated bilaterally at aortic, pulmonic, tricuspid, mitral and Erb's point. Patient has a normal sinus rhythm according to their EKG that was performed. Peripheral pulses were 3+ and a capillary refill of less than 3 seconds. There was no neck vein distention. The patient seemed to have 1+ pitting edema bilaterally in the lower extremities.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Lung sounds were auscultated bilaterally with crackles heard in the right lower lobe.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	The patient sticks to a regular diet at home and a regular diet in the hospital. She is 171 cm tall and weighs 108.1 kg. Upon auscultation of the abdomen there was bowel sounds present in all 4 quadrants. Her last BM was around 1230 and there was no pain on palpation. During inspection there was not a presence of distention, incisions, drains or wounds. The patient does have a scare from her previous C. Section. There were no signs of Ostomys, Nasogastric or feeding tubes.

Ostomy: Y ☐ N ☒ **Nasogastric: Y ☐ N ☒** **Size:** n/a **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** n/a	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☒ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** n/a **Size:** n/a	The patient's urine was yellow and hazy, and she voided three times during our clinical shift. There was a little pain with urination due to the patients acute UTI. The patient was not on dialysis and no catheter was present.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk**☐	The patient was able to perform all range of motion exercises. She used a gait belt for a supportive device. She requires no ADL assistance and isn't a fall risk. Her fall risk score is a 35. She independent and doesn't need assistance with equipment or support to stand or walk.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient was able to move all extremities well. Her pupils were equal, round, reactive to light and accommodating. She had equal strength in both her arms and her legs. Her speech was normal, and she knew where she was and was able to make conscious decisions.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home**	The patients coping methods include spending time with her husband. The client is Methodist and is involved within her community. She lives at home with her husband and is very close with her family.

environment, family structure, and available family support):	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1130	57	136/68	18	36.4	97
1545	70	146/72	20	36.5	97

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1130	0	n/a	n/a	n/a	n/a
1545	0	n/a	n/a	n/a	n/a

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	The patient's IV size was an 18-gauge and located in the right anticubital vein. The IV was put in on admission at the ER on 9/25/2019, the catheter is patent. There is no signs of phlebitis or infiltration present. IV dressing intact.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
The patient consumed about 500 mL in fluid during clinical shift.	The patient voided 3 times during clinical shift.

Nursing Care

Summary of Care (2 points)

Overview of care: The overall nursing care was good throughout the clinical. I was able to administer the patient some of her antibiotics for her antibiotics via IV. I was also able to do a focused assessment on her lungs and heart.

Procedures/testing done: The patient had a CMP, a CBC with differential, Urine Culture, Blood Culture, a urinalysis, EKG, Chest X-ray (2 views), CT chest w/o contrast, EC Echo Complete w/ contrasts were done on the patient.

Complaints/Issues: There were no new complaints or issues during the clinical rotation time.

Vital signs (stable/unstable): Vital signs were stable within normal limits, but patient showed signs of hypertension in second set of vitals. The BP was 146/72. Normal blood pressure is 120/80.

Tolerating diet, activity, etc.: Patient was tolerating regular diet, but needs to be educated on a heart healthy diet or low sodium diet due to her new diagnosis.

Physician notifications: The physician wasn't present during clinical rotation time.

Future plans for patient: The patient needs to keep using her CPAP for her obstructive sleep apnea, and also adapt to her new diet change.

Discharge Planning (2 points)

Discharge location: The patient plans to go home and live with her husband upon discharge.

Home health needs (if applicable): The patient does not require home health needs.

Equipment needs (if applicable): Patient requires CPAP due to her obstructive sleep apnea.

Follow up plan: The patient is to follow up with her with her primary care doctor upon discharge from the hospital and follow up with cardiology for teachings on her new diagnosis of diastolic heart failure grade 2.

Education needs: She needs to be taught on her new diagnosis, dietary plans, and signs and symptoms of a heart failure exacerbation.

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

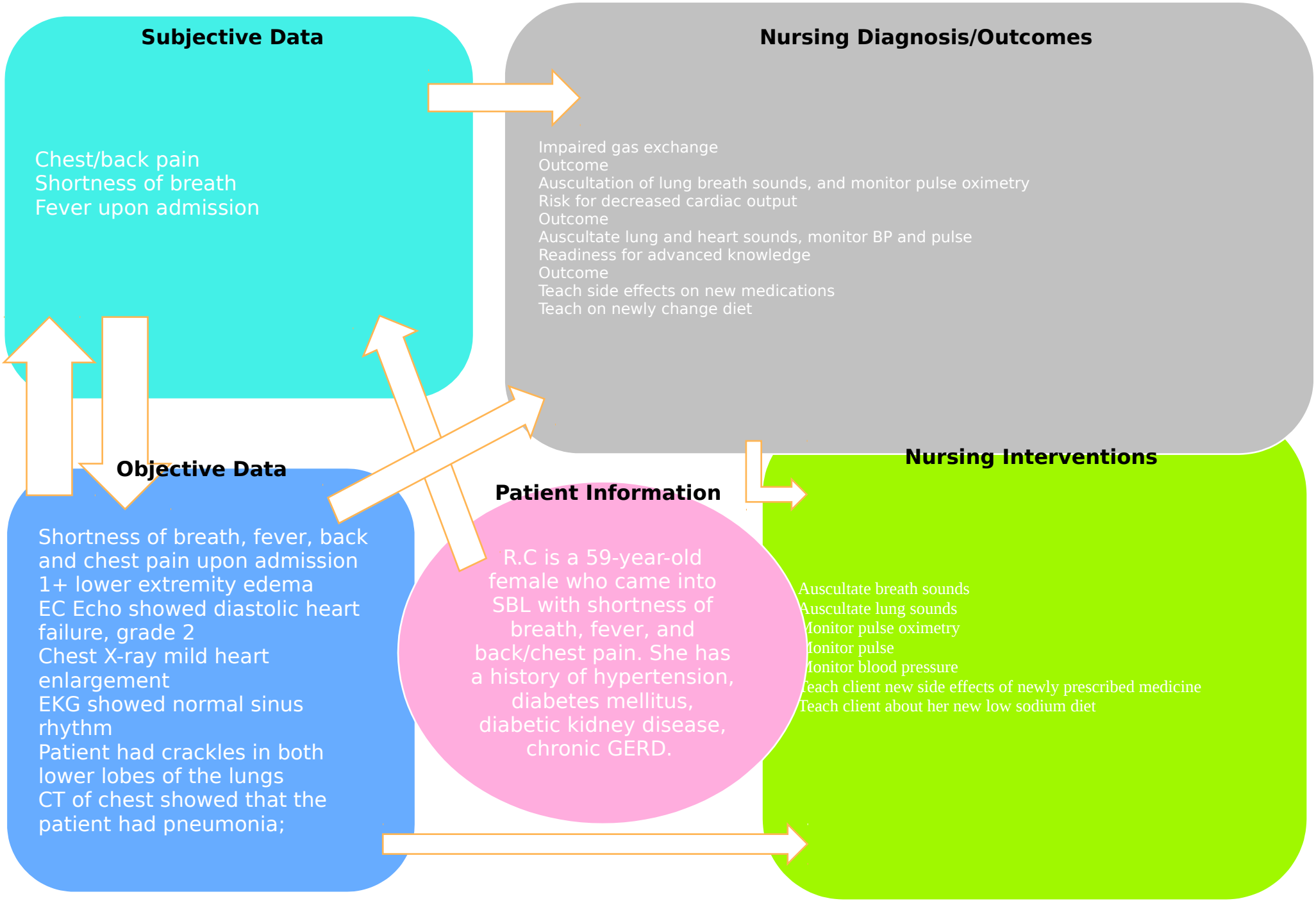
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Impaired gas exchange related to altered oxygen supply as evidenced by shortness of breath.	Patient had shortness of breath upon admission.	**1.** Auscultate breath sounds. Report significant findings. **2.** monitor pulse oximetry levels and report if it is under 92%.	Patient responded well. Auscultated lung sounds and there was crackles in the bases of the lungs. The pulse oximetry level didn't go below 92% during the clinical time.
2. Risk for decreased cardiac output related to newly diagnosed grade 2 diastolic heart failure as evidenced by Chest x-ray.	Patient had been newly diagnosed.	**1.** Assess for abnormal heart and lung sounds. **2.** Monitor blood pressure and pulse.	Patient responded well. There was crackles in the bases of her lungs. Heart sounds were normal. Patients BP and pulse were monitored. Pulse was within normal limits. BP on second side of vitals was slightly hypertensive.
3. Readiness for enhanced	Patient newly diagnosed and	**1.** Educate patient on low sodium	Patient responded well. She was able to state

knowledge of medications and diet related to newly diagnosed grade 2 diastolic heart failure as evidenced by chest x-ray.	needs education on diet and medication changes.	diet and reading food labels. **2.** Educate patient on new Lasix prescription.	back foods that were low sodium and that she could have within restrictions of her diet. She understands Lasix is a look diuretic and might see a change in urine frequency.

Other References (APA):

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

Concept Map (20 Points):


Subjective Data
Chest/back pain
Shortness of breath
Fever upon admission
Nursing Diagnosis/Outcomes
Impaired gas exchange
Outcome
Auscultation of lung breath sounds, and monitor pulse oximetry
Risk for decreased cardiac output
Outcome
Auscultate lung and heart sounds, monitor BP and pulse
Readiness for advanced knowledge
Outcome
Teach side effects on new medications
Teach on newly change diet
Objective Data
Shortness of breath, fever, back and chest pain upon admission
1+ lower extremity edema
EC Echo showed diastolic heart failure, grade 2
Chest X-ray mild heart enlargement
EKG showed normal sinus rhythm
Patient had crackles in both lower lobes of the lungs
CT of chest showed that the patient had pneumonia;
Patient Information
R.C is a 59-year-old female who came into SBL with shortness of breath, fever, and back/chest pain. She has a history of hypertension, diabetes mellitus, diabetic kidney disease, chronic GERD.
Nursing Interventions
Auscultate breath sounds
Auscultate lung sounds
Monitor pulse oximetry
Monitor pulse
Monitor blood pressure
Teach client new side effects of newly prescribed medicine
Teach client about her new low sodium diet