N321 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/11/2020	**C.F.**	**89**	M
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	**Retired**	**Married**	**Amoxicillin, ephedrine, lovenox**
Code Status	**Height**	**Weight**	
DNR	**172 cm**	**74.4 kg**	

Medical History (5 Points)

Past Medical History: CABG, CHF, chronic neck pain, CKD stage 4, CAD, dizziness, hyperlipidemia, HTN, hypertensive cardiovascular disease, paroxysmal Afib,

Past Surgical History: abdominal hernia, triple coronary bypass

Family History: Father- diabetes mellitus, heart disease

Mother-heart disease, brother- heart attack

Social History (tobacco/alcohol/drugs): denies alcohol and drugs, former smoker 20 pack years, quit more than 30 years ago.

Assistive Devices: none

Living Situation: Assisted living senior apartments

Education Level: high school

Admission Assessment

Chief Complaint (2 points): chest pain

History of present Illness (10 points):Patient presented to the emergency department with a complaint of chest pain that started last Friday. The pain in his is left arm and radiates to the left side of his chest. The pain is intermittent and dull, he isn't sure what aggravates it. He took one nitro yesterday morning. The pain did not subside, so he came to the emergency room.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): CHF

Secondary Diagnosis (if applicable): CAD

Pathophysiology of the Disease, APA format (20 points): In chronic heart failure, the heart continues to decline and get weak over a long period of time. "The biochemical and pressure changes that affect the myocardium in heart failure eventually effect both ventricles," (Capriotti, 2016, p. 383). When one side of the hearts fails to function properly, after some time, the other side of the heart will start to fail as well. Symptoms are usually noticeable when a late stage of disease has already been reached. The type of heart failure that the patient has will determine the symptoms that are noticed clinically. My patient had comorbidities along with heart failure that could have been caused by his heart muscles weakening. He also has coronary artery disease which is damage to the vessels of the heart that is usually caused by a buildup of some kind.

My patient reported that he had dyspnea when he would walk across the street to go visit his wife in the memory care unit at OddFellow. He started to use a scooter to visit. "The patient may report dyspnea upon exertion, dyspnea. When lying flat for more than a few minutes, or a nocturnal cough" (Capriotti, 2016, p. 391). Other signs and symptoms that may accompany the disease are: pulmonary crackles, jugular vewin distention, fluid retention, decreased cerebral perfusion, diminished circulation in extremities, tachycardia, ascites, and dependent edema. (Capriotti, 2016).

In order to diagnose heart failure, the patient has specific criteria that includes one major criteria and two minor criteria from the Framingham Criteria for Diagnosis of

Congestive Heart Failure. (Capriotti, 2016). My patient was bradycardic during most of my observation of him which is the opposite of a normal finding. A BNP can be taken as the blood test measures heart. Since my patient already has the diagnosis of heart failure, a troponin and CKMB was taken to rule out a myocardial infarction. His troponin came back slightly elevated but it was not indicative of an MI. Another lab test that can be taken is electrolytes and my patient did have those drawn. Other tests that can be performed are chest xrays, EKG, ECG, and cardiac catheterization. My patient had a chest xray that indicated shortness of breath and a hiatal hernia, but his heart was fine.

Treatment for CHF is through pharmacological measures and interventional procedures. "Despite continuous improvements in the pharmacological and non-pharmacological treatment options during the last few decades, the clinical outcome of patients with HF still remains poor, with an estimated average 50% mortality at 5 years (Francesconi et al., 2019). My patient has had a triple coronary bypass and he is on tow blood thinners (apixaban and aspirin), he has nitrostat for chest pain as well as isosorbide, he is on a beta blocker (carvedilol), and he is on a diuretic (torsemide).

Pathophysiology References (2) (APA):

Capriotti, T., Frizzell, J.P. (2016) Cellular injury, adaptations, and maladaptive changes. *Pathophysiology: introductory concepts and clinical perspectives*. Philadelphia: F.A. Davis Company.

Francesconi, P., Ballo, P., Profili, F., Policardo, L., Roti, L., & Zuppiroli, A. (2019). *Chronic Care Model for the Management of Patients with Heart Failure in Primary Care. Health Services Insights*, 12, N.PAG. https://ezproxy.lakeviewcol.edu:2097/10.1177/1178632919866200

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	4.28-5.56	4.19	3.9	Kidney damage from heart failure prevents the body from making erythropoietin.
Hgb	13-17	13.3	13.1	
Hct	38.1-48.9	40.1	37.7	Reduced red blood cell volume or increased plasma volume.
Platelets	149-393	150	151	
WBC	4-11.7	6.9	6.9	
Neutrophils	45.3-79	68.1	62.5	
Lymphocytes	11.8-45.9	18.1	21.4	
Monocytes	4.4-12	8.7	11.1	
Eosinophils	0-6.3	3.9	4.3	
Bands				

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	137	142	
K+	3.5-5.1	3.8	4.1	
Cl-	98-107	104	106	
CO2	21-31	26	30	
Glucose	74-109	119	96	The patient does not follow a healthy diet and high glucose levels can exacerbate heart disease

BUN	**7-25**	**37**	**38**	**Patient has Stage 4 CKD**
Creatinine	**0.7-1.3**	**3.15**	**3.09**	**Patient has Stage 4 CKD**
Albumin	**3.5-5.2**	**3.6**		
Calcium	**8.6-10.3**	**8.9**	**9.0**	
Mag	**1.6-2.4**		**2.2**	
Phosphate				
Bilirubin	**0.3-1**	**0.6**		
Alk Phos	**34-104**	**73**		
AST	**13-39**	**12**		**Heart damage can cause low AST**
ALT	**7-52**	**7**		
Amylase				
Lipase				
Lactic Acid				

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				
PT				
PTT				
D-Dimer				
BNP				

HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

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				
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				
Leukoesterase				

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				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA): Sarah Bush Lincoln Health Center (2019). *Reference Range. (lab values).* Mattoon, IL.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray 2 views

Diagnostic Test Correlation (5 points): shortness of breath, heart normal, lungs clear, hiatal hernia

Diagnostic Test Reference (APA): Sarah Bush Lincoln Health Center (2019). *Diagnostic Tests.* Mattoon, IL.

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

Home Medications (5 required)

Brand/Generic	**Hytrin/ terazosin**	**torsemide**	**nitrostat**	**isosorbide**	
Dose					
Frequency					
Route	**PO**	**PO**		**PO**	
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					

Hospital Medications (5 required)

Brand/Generic	**aspirin**	**atorvastatin**	**Potassium chloride**	**carvedilol**	**apixaban**
Dose					
Frequency					
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					
Nursing Considerations (2)					

Medications Reference (APA):

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**A&O x 4, no distress noted**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	**Skin color is normal for race, warm, skin turgor is slow, no rashes, wounds, or bruises. No drains present.** **Braden score: 19**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head normocephalic, neck is symmetrical, ears were clear, eyes PERRLA, nose is clear, patient has partial dentures**
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:**	**Heart sounds normal, peripheral pulses +3, capillary refill < 3 seconds, no neck vein distention, no edema**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**No accessory muscles used, breath sounds clear and equal bilaterally**
GASTROINTESTINAL (2 points):	**Patient does not follow a diet at home. He eats**

Diet at home: **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	**anything he wants. He is currently on a heart healthy diet. His weight is 163.2 lbs and height is 172 cm. Bowel sounds are active x 4 quadrants. Last BM was Monday. Abdomen is nondistended and no pain on palpation. No ostomies or tubes present.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**Patient reports clear yellow urine, no pain with urination. No catheters present. Patient is not on dialysis.**
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 ☐**	**Patient has active ROM but cannot lift arms all the way up due to pain near the shoulders. He can move legs but cannot push them out against pressure due to pain. No supportive devices. No ADL assistance. Activity status is 1 assist while in the hospital.** **Fall Score: Moderate/25**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -**	**Patient has equal strength in all 4 extremities. He is oriented to person, place, time, and situation. His mental status is appropriate. Speech is clear. Patient is hard of hearing.**

Legs ☐ Arms ☐ Both ☐ **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**Patient is protestant. He lives alone in a senior apartment across the street from his wife who lives in the memory care unit due to dementia.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0745	**56**	**134/58**	**18**	**36.4 C**	**100%**
1125	**54**	**159/68**	**18**	**35.6 C**	**95%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0745	**number**		**0**		
1125	**number**		**0**		

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 18g **Location of IV: right wrist** **Date on IV: 02/11/2020** **Patency of IV: flushed easily, no blood return** **Signs of erythema, drainage, etc.: none** **IV dressing assessment: Clean, dry, intact**	Saline locked

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
480 mL	None observed

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was admitted for observation and a cardiology consult to evaluate his current medication regimen in regard to his heart disease.

Procedures/testing done: Troponin, CKMB

Complaints/Issues: Patient's Eliquis was $576 for a 3 moth supply which was expensive for him on a fixed income.

Vital signs (stable/unstable): hypertensive and bradycardic

Tolerating diet, activity, etc.: Patient complains of shortness of breath when he walks long distances. He is not compliant with a cardiac or low sodium diet at home.

Physician notifications: Cardiologist was notified of blood pressures during consult in patient's room.

Future plans for patient: The cardiology consult recommends that the patient stay on the same medications at the same dosage.

Discharge Planning (2 points)

Discharge location: He will be discharged back home to his apartment.

Home health needs (if applicable): none at this time

Equipment needs (if applicable): none at this time

Follow up plan: None at this time. Patient does not have a discharge date yet.

Education needs: Patient needs to be educated on when and how often to use the medications he currently takes.

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. Ineffective health maintenance related to chronic heart failure as evidenced by refusal to change diet	**Patient was adamant about eating what he wanted due to his age and diagnoses**	**Use client centered approach** **Educate on safety issues**	
2. Risk for ineffective Renal Perfusion related to Stage 4 chronic kidney disease as	**The patient's HCT and RBCs are low. His BUN and creatinine are high. This puts him at risk for ineffective renal perfusion.**	**1. Maintain serum electrolytes within normal limits.** **2.Maintain urine output that is yellow and clear**	**The patient's serum electrolytes were within normal range on admission and during my time observing him**

evidenced by lab values.			
3. Deficient Knowledge related to congestive heart failure as evidenced by need for education about medications	**The patient was unaware of the paraments for which to take his nitrostat.**	**1.Patient was reeducated about when to take nitro as well as how often.** **2.The patient was asked to teach back the information that he was reeducated on.**	**The patient was slow to repeat back information but he did get it correct when he said it back.**

Other References (APA): Ladwig, G. B., Ackley, B. J., & Makic, M. B. F. (2017). *Mosbys guide to nursing diagnosis*. St. Louis: Mosby.

Concept Map (20 Points):

Subjective Data

Patient presented to the emergency department with a complaint of chest pain that started last Friday. The pain in his is left arm and radiates to the left side of his chest. The pain is intermittent and dull, he isn't sure what aggravates it. He took one nitro yesterday morning. The pain did not subside, so he came to the emergency room.

Nursing Diagnosis/Outcomes

Objective Data

Chest Xray- heart normal, hiatal hernia, shortness of breath, lungs normal
Low HCT and RBCs
High glucose
High BUN and creatinine

Patient Information

Patient is a white 89 y/o male with a history of CHF and CAD that was admitted for complaints of chest pain on the left side.

Nursing Interventions

1.Patient was reeducated about when to take nitro as well as how often.
2.The patient was asked to teach back the information that he was reeducated on.
1. Maintain serum electrolytes within normal limits.
2.Maintain urine output that is yellow and clear