N321 Care Plan #2

Lakeview College of Nursing

Morgan Drennan

Demographics (3 points)

Date of Admission 02/17/2020	Patient Initials RH	Age 84	Gender Female
Race/Ethnicity White/Non-Hispanic	Occupation Patient could not report and not in chart	Marital Status Widowed	Allergies Sulfa antibiotics
Code Status Full	Height 5'4"	Weight 110 lbs 9.6 oz.	

Medical History (5 Points)

Past Medical History: MRSA, Arthritis, chronic pain, dementia, depression, gastric ulcer with perforation, iron deficiency anemia, opiate addiction, osteoporosis, PVD, vitamin D deficiency, CHF, heart murmur

Past Surgical History: pacemaker implantation, amputation of left leg above the knee, abdominal surgery, right knee replacement

Family History: no known problems reported

Social History (tobacco/alcohol/drugs): no history of tobacco or drug use, alcohol is rarely consumed.

Assistive Devices: walker and wheelchair

Living Situation: Patient lives at the Jarman Center for Senior Living where she lives independently with assistance when needed.

Education Level: patient was unable to report.

Admission Assessment

Chief Complaint (2 points): Chest pain following a fall

History of present Illness (10 points):.

Onset of pain was 02/17/20. Location of pain is midsternal chest. The pain is “constant and achy”. Patient had reported falling recently when she came into the ED which is when the chest pain started. There were not any relieving factors or treatments, so patient came to the ED at OSF Urbana. Patient could have possibly lost her balance due to above the knee left leg amputation and fallen.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Diastolic Congestive Heart Failure

Secondary Diagnosis (if applicable): Peripheral Vascular Disease

Pathophysiology of the Disease, APA format (20 points):

On the cellular level on the effects of congestive heart failure include “myocyte hypertrophy, abnormalities of calcium homeostasis, excitation-contraction coupling, cross-bridge cycling, and changes in the cytoskeletal architecture occurs” (Bondmass, Piano & Schwertz, 1998). Heart failure can be caused by calcification and stiffing of the ventricles which causes the ventricles to not fill properly in between beats. When this inefficient filling of the ventricles occurs, the heart cannot keep up with the demands of the body. This can cause insufficient blood flow to the body which could be the result of the patient’s Peripheral Vascular Disease. Signs and symptoms of Congestive Heart Failure include dyspnea, fatigue, edema in feet and ankles, rapid or irregular heartbeat, persistent cough or wheezing, increased need to urinate at night, swelling in the abdomen, rapid weight gain from fluid retention, lack of appetite, difficulty concentrating, chest pain. Expected findings that are related to CHF are an elevated BNP, abnormal heart sounds, congested lungs and hypertension. Diagnostics that can be run could include Chest X-ray to see the

condition of the heart and lungs, a EKG to detect rhythm problems, an ECHO to visualize the heart size and to determine ejection fraction, a CT and MRI can provide images of the heart, a myocardial biopsy to determine the type of heart muscle disease that can CHF. A cardiac enzyme panel can also be done to support the diagnosis of CHF and rule out an MI. Treatment of CHF includes medication such as ACE inhibitors, angiotensin II receptor blockers, beta blockers, diuretics, aldosterone antagonists, inotropes, and Digoxin. The treatment that was used with my patient was diuretics and beta blockers. Furosemide was used to eliminate fluid retention and Carvedilol to slow the heart rate, lower blood pressure, and limit the damage done to the heart. The patient presents with a heart murmur and pitting edema in the right foot. Her BNP was 785 and the normal range is 0-100. The patient's chest CT shows coronary artery and thoracic aortic calcification, cardiac enlargement, and pleural effusions in the lower lobes. Her chest X-ray shows that she has cardiac enlargement with mild pulmonary venous congestion. The calcification of the arteries and the cardiac enlargement are major symptoms indicating Congestive Heart Failure (Mayo Clinic Staff, 2017).

Pathophysiology References (2) (APA):

Bondmass, M., Piano, MR., Schwertz, DW. (1998). ***The Molecular and Cellular Pathophysiology of Heart Failure*****. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/9493878**

Mayo Clinic Staff. (2017, December 23). ***Heart Failure*****. Retrieved from: https://www.mayoclinic.org/diseases-conditions/heart-failure/diagnosis-treatment/drc-20373148**

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	3.80-5.30	4.27	4.28	
Hgb	12-15.8	13	13	
Hct	36-47	39.7	39.7	
Platelets	140-440	240	224	
WBC	4-12	10.80	6.90	
Neutrophils	47-73	89.5	79.8	Possibly caused by possible infection or trauma from her fall.
Lymphocytes	18-42	42	76	Patient could possibly have an infection.
Monocytes	4-12	5.4	8.3	
Eosinophils	0-5	0.5	3.5	
Bands	<1	n/a	n/a	

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-	133-144	138	140	
K+	3.5-5.1	3.8	3.2	Patient is on a diuretic (furosemide), causing K+ excretion.
Cl-	98-107	106	104	
CO2	21-31	20	26	CO2 was low upon admission because of the use of loop diuretic (furosemide)
Glucose	70-99	112	94	Patient could have just possibly eaten prior to admission

BUN	**7-25**	**14**	**12**	
Creatinine	**0.50-1.20**	**0.99**	**0.92**	
Albumin	**3.5-5.7**	**4.0**	**3.7**	
Calcium	**8.6-10.3**	**9.3**	**9**	
Mag	**1.3-2.1**	**n/a**	**n/a**	
Phosphate	**3.0-4.5**	**n/a**	**n/a**	
Bilirubin	**0.2-0.8**	**0.5**	**0.6**	
Alk Phos	**34-104**	**64**	**61**	
AST	**13-39**	**22**	**18**	
ALT	**7-52**	**13**	**12**	
Amylase	**60-120**	**n/a**	**n/a**	
Lipase	**0-160**	**n/a**	**n/a**	
Lactic Acid	**5-20**	**n/a**	**n/a**	

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	**0.8-1.1**	**n/a**	**n/a**	
PT	**11-12.5 seconds**	**n/a**	**n/a**	
PTT	**60-70 seconds**	**n/a**	**n/a**	
D-Dimer	**<0.4**	**n/a**	**n/a**	
BNP	**0-100**	**785**	**n/a**	**BNP is elevated because the**

				patient has congestive heart failure.
HDL	**>40**	**n/a**	**67**	
LDL	**<130**	**n/a**	**81**	
Cholesterol	**<200**	**n/a**	**164**	
Triglycerides	**<150**	**n/a**	**79**	
Hgb A1c	**4-5.6%**	**n/a**	**n/a**	
TSH	**0.270-4.200**	**5.146**	**n/a**	**TSH elevation can be caused by severe and chronic illness, such as CHF.**

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 and clear**	**n/a**	**n/a**	
pH	**5-9**	**n/a**	**n/a**	
Specific Gravity	**1.003-1.030**	**n/a**	**n/a**	
Glucose	**Negative**	**n/a**	**n/a**	
Protein	**Negative**	**n/a**	**n/a**	
Ketones	**negative**	**n/a**	**n/a**	
WBC	**0-5**	**n/a**	**n/a**	
RBC	**0-2**	**n/a**	**n/a**	
Leukoesterase	**negative**	**n/a**	**n/a**	

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	**<10,000 bacteria (negative)**	**n/a**	**n/a**	
Blood Culture	**negative**	**n/a**	**n/a**	
Sputum Culture	**negative**	**n/a**	**n/a**	
Stool Culture	**Normal intestinal flora**	**n/a**	**n/a**	

Lab Correlations Reference (APA):

Pagana & Pagana. (2010). *Mosby's: Manual of Diagnostic and Laboratory Tests* (4th ed.)

Elsevier

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Nasal swab for MRSA, ECHO, cardiac enzyme panel, Chest CT with contrast, head or brain CT, Chest X-ray

Diagnostic Test Correlation (5 points): Nasal swab was negative for MRSA; ECHO impression: mild aortic regurgitation (murmur), ejection fraction is 52% with grade 1 diastolic dysfunction; cardiac enzyme panel: troponin-0.040 (range: 0-0.040), CK- 146 (range: 30-223); Chest CT with contrast impression: coronary artery and thoracic aortic calcification, cardiac enlargement, small to moderate sized pleural effusions bilaterally in lower lobes, partial filling of air spaces in lungs (ground glass); Brain and head CT impression: no intercranial hemorrhage or abnormalities, generalized cerebral and cerebellar atrophy that are consistent with chronic degenerative changes; Chest X-Ray

impression: mild to moderate bilateral pulmonary infiltrates, cardiac enlargement with mild pulmonary venous congestion, pacemaker in place, sclerosis at left humeral head and glenoid with deformities.

Diagnostic Test Reference (APA):

Mayo Clinic Staff. (2018, October 4). *Echocardiogram*. Retrieved from:

https://www.mayoclinic.org/tests-procedures/echocardiogram/about/pac-20393856

Pagana & Pagana. (2010). *Mosby's: Manual of Diagnostic and Laboratory Tests* (4th ed.)

Elsevier

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

Home Medications (5 required)

Brand/Generic	Clopidogrel (Plavix)	Tramadol (ultram)	Acetaminophen (Tylenol)	Duloxetine (Cymbalta)	Nitroglycerin (nitrostat)
Dose	75 mg	50 mg	325 mg	60 mg	0.4 mg
Frequency	Daily	Every 8hrs PRN	Nightly PRN	Daily	Every 5 min PRN
Route	PO	PO	PO	PO	SL
Classification	Platelet aggregation inhibitor	analgesic	Antipyretic; Nonopioid analgesic	antidepressant	antianginal
Mechanism of Action	Binds with ADP receptors on platelets, which blocks fibrinogen from	Binds with receptors and inhibits the reuptake of norepinephrine and serotonin	Blocks prostaglandin production and interferes with pain impulse generation in the peripheral	Inhibits dopamine, neuronal serotonin, and norepinephrine reuptake to potentiate noradrenergi	Causes vasodilation which decreases venous return to the heart which reduces

	forming, so a clot cannot form		**nervous system**	**c and serotonergic activity in the CNS**	**pressure in the left ventricle and pulmonary artery**
Reason Client Taking	**Prevent clots**	**pain**	**Pain relief so patient can sleep**	**Elevate mood**	**Chest pain**
Contraindications (2)	**Active bleeding, allergic to clopidogrel**	**Acute or severe bronchial asthma, known or suspected GI obstruction**	**Severe hepatic impairment, severe active liver disease**	**Uncontrolled glaucoma, hepatic insufficiency**	**Severe anemia, orthostatic hypotension**
Side Effects/Adverse Reactions (2)	**Chest pain, edema**	**Orthostatic hypotension, depression**	**Peripheral edema, dyspnea**	**Cough, extremity pain**	**Pneumonia, edema**
Nursing Considerations (2)	**Discourage use of NSAIDs, expect to give aspirin with clopidogrel**	**Monitor patient for respiratory depression, monitor for suicidal ideations**	**Monitor renal function; inform patient of the signs of hepatotoxicity like bleeding**	**Educate patient to take capsule whole; educate patient that the drug will take weeks to take effect**	**Make sure nitro dissolves completely; place patient in sitting position**

Hospital Medications (5 required)

Brand/Generic	**Furosemide (Lasix)**	**Ondansetron (Zofran)**	**Aspirin**	**Carvedilol (Coreg)**	**Donepezil (Aricept)**
Dose	**20 mg**	**4 mg**	**81 mg**	**3.125 mg**	**5 mg**
Frequency	**BID**	**Every 12 hrs PRN**	**Daily**	**BID w/ meals**	**Nightly**
Route	**IV**	**IV**	**PO**	**PO**	**PO**

Classification	**Antihypertensive, diuretic**	**antiemetic**	**Anti-inflammatory, antiplatelet**	**Anti-hypertensive**	**antidementia**
Mechanism of Action	**Inhibits sodium and water reabsorption, increases urine formation**	**Blocks serotonin receptors peripherally at vagal nerve terminals in the intestine**	**Inhibits prostaglandin synthesis which causes pain and swelling to subside**	**Reduces cardiac output and tachycardia; causes vasodilation; decreases peripheral vascular resistance which reduces BP**	**Raises acetylcholine level in cerebral cortex which could improve cognition**
Reason Client Taking	**Reduce edema**	**Prevent nausea**	**pain**	**Control hypertension**	**Treat Alzheimer's**
Contraindications (2)	**Hypersensitivity to furosemide; anuria**	**Congenital long QT syndrome; hypersensitivity to ondansetron**	**Asthma; bleeding problems like hemophilia**	**Asthma; severe hepatic impairment**	**Hypersensitivity to donepezil; hypersensitivity to piperidine derivatives**
Side Effects/Adverse Reactions (2)	**Anemia; muscle pain**	**Angina; SOB**	**Confusion; increased bleeding time**	**Angina; depression**	**Angina; edema**
Nursing Considerations (2)	**Monitor weight; give drug in the morning to prevent sleep interruptions**	**Monitor patients' EKG; monitor patient for decreased bowel activity**	**Educate patient to take drug with food; do not crush drug unless directed**	**Warn patient that this drug may cause dizziness; monitor patient's glucose level**	**Monitor heart rate and rhythm; advise patient to take donepezil before going to bed**

Medications Reference (APA):

(2019). *Nurse's Drug Handbook*. (18th ed.). Jones and Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**AOx1 patient is not oriented to situation, time, day, and location; she knows name and DOB** **At times the patient knows the location** **Patient does not appear to be in any distress** **Patient is dressed appropriately**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	**Discoloration to right lower extremity; generalized scabbing from patient picking at herself; bilateral upper extremities cool; left lower extremity cool; right lower extremity cold; turgor is loose; no rashes are present; generalized ecchymosis especially in the right arm (from previous fall); patient has ulcers on lower extremities.** **Braden score: 13**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head, neck, eyes, ears, and nose and symmetrical. No jugular distention is present, and the thyroid is midline.** **There is not any drainage present from the eyes, nose or ears. The sclera is white, conjunctiva is pink and moist. The mucous membrane is intact and moist. Patient does not have dentures and her dentition is in good condition. There is no edema present in the nose and her airway is patent.**
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:**	**S1 and S2 present with murmur; patient is not on a heart monitor, so unable to assess rhythm; Peripheral pulses: upper extremities 3+ and lower extremities 2+; Capillary refill: < 3; Right lower extremity (foot) 2+ pitting edema, right lower extremity (ankle/lower leg) 1+ non-pitting**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Clear and regular bilaterally; patients respiration rate was 16 per minute. Her respiratory pattern was even**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet**	**Diet at home is normal** **Current diet is a low sodium diet** **Height: 5'4"**

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:**	**Weight: 110 lbs 9.6 oz.** **Sounds heard in all 4 quadrants and the sounds were active** **Last BM: patient stated "yesterday morning" but nothing was recorded in her chart** **No pain upon palpitation, no masses present** **Stomach is presenting distention, but this tissue is soft, patient states "its' from having so many kids". There are not any incisions, scars, drains, or wounds present on the abdomen.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Color: pale yellow** **Character: clear** **Patient was incontinent in her chair following the assessment, so urine quantity was not observed during assessment.** **Genitals are pink, moist, and intact**
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 and her strength is equal on both sides at a 3 on a 0-5 scale; she moves against gravity with little resistance.** **Patient uses a walker and wheelchair on a daily basis.** **The patient needs assistance with transferring, toileting, and dressing.** **The patient is a high fall risk** **Fall Score is a 20** **The patient needs assistance with her walker and wheelchair, but also needs assistance in transferring.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:**	**The patient moves all her extremities well and PERLA. Her strength is equal in the legs and arms. The blood flow to her hands is better than the blood flow to her foot. Her upper extremities were cool, but her lower extremities were cold. The patient is AOx1,**

Mental Status: **Speech:** **Sensory:** **LOC:**	**she only knows her name and date of birth. She is cognitively impaired and has short term memory deficits related to her diagnosis of dementia. She is able to follow command and is easy to direct. Patient is alert to her risk precautions and is adhering to them. Her speech is clear. She does not have any sensory deficits present. The patient is awake and answers questions.**
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):**	**The patient is not coping with the loss of her leg. She was crying at the bedside discussing her amputation. Her developmental level is delayed due to dementia. The patient did not mention anything related to religion. Her family is not in the area, so she does not have close familial support.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0808	**91 bpm**	**151/91 mmHg**	**18 breaths/min**	**98.9° F (oral)**	**96%**
1520	**81 bpm**	**143/83 mmHg**	**16 breaths/min**	**97.8° F(oral)**	**98%**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1415	**0-10**	**Patient states "Joints, legs"**	**5**	**Constant, aching**	**Pain meds PRN**
1520	**0-10**	**Patient states "All over my body"**	**4**	**Constant, aching**	**Pain meds PRN**

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:**	IV was taken out the morning of 2/20/20 and no further information was found in the patient's chart.

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
300 mL (charted) urine	**430 mL (charted) urine; patient was incontinent of bladder in her chair, so an observed output was not measurable**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient's needs were attended to as needed and she was discharged at 1635 on 2/20/2020

Procedures/testing done: nasal swab for MRSA, ECHO, CT of chest, CT of brain and head, X-Ray of chest prior to 2/20/2020

Complaints/Issues: constant pain in joints

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: tolerating diet and activity; patient states she "eats what I want at home", but she should be following a low sodium diet

Physician notifications: Doctor was notified by nurse of the discontinuation of the IV.

Future plans for patient: Anticipate that the patient will need more assistance at the Jarman Center than she has required before; patient will also need her diet monitored.

Discharge Planning (2 points)

Discharge location: Discharged from OSF Urbana to Jarman Center in Tuscola by ambulance

Home health needs (if applicable): Patient is going to the Jarman Center

Equipment needs (if applicable): wheelchair and walker

Follow up plan: follow up with primary care provider on 2/25/20

Education needs: teach client about the low sodium diet and give her ways to help remember her location, appointments, and the date or time.

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. Angina related to a previous fall as evidenced by patient reporting chest pain	**The patient came into the ED reporting chest pain following a fall.**	**1.Asses heart rate and blood pressure** **2.Educate the patient on the importance of reporting her chest**	**The patient was cooperative to her vitals being assessed. The patient understands that she needs to report her chest pain, but since**

		pain immediately to the health care team	**she also has memory issues, so she may forget this education and have to be reminded.**
2. Decreased tissue perfusion related to decreased blood flow with edema as evidenced by 2+ pitting edema and cold extremities.	**The patient has a previous diagnosis of PVD and is presenting with 2+ pitting edema in the right foot and 1+ non pitting in the ankle and leg. The patient's skin is also cold to the touch on the lower extremity. Her lower extremity pulses are 2+.**	**1. Assess the degree of edema and pulses.** **2.Elevate the patients' right leg to promote venous return**	**The patient was cooperative to being assessed for edema and pulses. The patient wanted to sit in her chair and did not want to elevate her leg. The goal of decreasing her edema was not met.**
3. Decreased ability to cope related to a misunderstanding of why she had to get her left leg amputated above the knee as evidenced by patient stating, "I should have never gotten this done, that doctor didn't know anything".	**The patient was crying at the bedside when discussing her amputation and was very upset with the doctor because she did not see a reason why the amputation had to be done. Patient states, "I should have never had this done, it has ruined my life".**	**1. Establish therapeutic and effective communication with the patient in reference to her amputation.** **2Assess the patient's knowledge behind the reason for her leg being amputated above the knee to try to get a better understanding of what she knows and how it correlates to her feelings.**	**The patient was very willing to communicate, she talked openly about how she felt in reference to her amputation and she is not coping well. The patient does not seem to remember or know why she had to get her leg amputated. This student nurse listened to the patient while she expressed her feelings about her amputation and used therapeutic communication with the patient about her amputation. The patient did not**

			understand why her leg was amputated and this student nurse did not have the information to educated her at the time of assessment.

Other References (APA):

Swearingen, P. & Wright, J. (2019). ***All in One: Nursing Care Planning Resource*****. Elsevier.**

Concept Map (20 Points):

Subjective Data

Allergies: Sulfa antibiotics

Patient is experiencing a pain of a 4 on a 0-10 scale all over her body at 1520. Patient's onset of pain was 2/17/20, which is when she cam e into the ED. The location of her pain is midsternal chest. The pain is "constant and achy"; there weren't any relieving or treatment factors, which led the patient to come to the ED following a fall.

Objective Data

Upon auscultation a heart murmur was noted. Patient's BP was high at 151/91 and 143/83. Her BNP was 785 on a range of 0-100. ECHO was abnormal showing regurgitation and an ejection fraction of 52%. CT of chest is showing calcification of arteries and cardiac enlargement.

Patient Information

Patient is an 84 year old white, Non-Hispanic female. Her admittance date was 2/17/2020. Patient is widow. Her code status is full code. Patient's past medical hx: MRSA, CHF, arthritis, chronic pain, dementia, depression, opiate addiction, gastric ulcers, iron deficiency anemia, osteoporosis, PVD, vitamin D deficiency, heart murmur. Patient's past surgical hx: pacemaker implantation , amputation of left leg above the knee, right knee replacement, abdominal surgery (unspecified).

Nursing Diagnosis/Outcomes

Angina related to a previous fall as evidenced by patient reporting chest pain

Decreased tissue perfusion related to decreased blood flow with edema as evidenced by 2+ pitting edema and cold extremities.

Decreased ability to cope related to a misunderstanding of why she had to get her left leg amputated above the knee as evidenced by patient stating, "I should have never gotten this done, that doctor didn't know anything".

Outcomes:

The patient was cooperative to her vitals being assessed. The patient understands that she needs to report her chest pain, but since she also has memory issues, so she may forget this education and have to be reminded.

The patient was cooperative to being assessed for edema and pulses. The patient wanted to sit in her chair and did not want to elevate her leg. The goal of decreasing her edema was not met.

The patient was very willing to communicate, she talked openly about how she felt in reference to her amputation and she is not coping well. The patient does not seem to remember or know why she had to get her **leg amputated. This student nurse listened to the patient while she expressed her feelings about her amputation and used therapeutic communication with the patient about her amputation. The patient did not understand why her leg was amputated and this student nurse did not have the information to educated her at the time of assessment.**

Nursing Interventions

1.Asses heart rate and blood pressure

2.Educate the patient on the importance of reporting her chest pain immediately to the health care team

1. Assess the degree of edema and pulses.

2.Elevate the patients' right leg to promote venous return

1. Establish therapeutic and effective communication with the patient in reference to her amputation.

2Assess the patient's knowledge behind the reason for her leg being amputated above the knee to try to get a better understanding of what she knows and how it correlates to her feelings.