N431 Care Plan #2

Lakeview College of Nursing

Whitney Evans

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
3/31/20	M.L.	72	Female
Race/Ethnicity Hispanic	**Occupation** Retired	**Marital Status** Widowed	**Allergies** Cyclobenzaprine, bananas, shellfish
Code Status Full code	**Height** 157.48 cm (5 ft 6 in)	**Weight** 48.18 kg (106 lb)	

Medical History (5 Points)

Past Medical History: Hypertension (HTN), Atrial fibrillation (A-fib), Hyperlipidemia, Congestive heart failure (CHF)

Past Surgical History: Cholecystectomy (1995), Total knee replacement (2009)

Family History: Diabetes (mother), Diabetes (brother), Myocardial infarction (father)

Social History (tobacco/alcohol/drugs): Never smoker, drinker or drug user

Assistive Devices: Denies use of assistive devices

Living Situation: Lives at the Oaks Manor Assisted Living Facility

Education Level: GED

Admission Assessment

Chief Complaint (2 points): "Weight gain" and "swelling of the ankles"

History of present Illness (10 points): M. L. is a 72-year-old Hispanic female who presented to the hospital with complaints of "weight gain" and "swelling of the ankles." The client weighs herself daily, and she reports that over the past 4 days she has experience a 12-pound weight gain. She states the swelling increases with ambulation but improves when the extremities are elevated. Pertinent medical history includes HTN, A-fib, hyperlipidemia and CHF. Upon admission, a chest x-ray was completed and showed an enlarged heart as well as pulmonary vascular congestion. An electrocardiography was obtained and showed A-fib at a rate of 88 beats/minute. 3+ pitting edema was noted to bilateral ankles and crackles were heard in the bases of both lungs.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute on chronic exacerbation of congestive heart failure

Secondary Diagnosis (if applicable): Hypokalemia

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

Heart failure results from cardiac ventricular dysfunction. The dysfunction causes inadequate circulation from the heart to the rest of the body's tissues (Henry et al., 2016). The ventricles either don't fill before ejection, or the ability to eject the blood is decreased (Hinkle, 2018). "HF can be caused by a number of conditions, including coronary artery disease, hypertension, cardiomyopathy, valvular disorders, and renal dysfunction with volume overload" (Hinkle, 2018, p. 819). Baroreceptors and the sympathetic nervous system sense the decreased cardiac output and work to increase the blood pressure. The sympathetic nervous system vasoconstricts blood vessels to raise blood pressure. The vasoconstriction causes the kidneys to respond by releasing renin into the bloodstream, which is required to convert angiotensin I to angiotensin II. Angiotensin II also causes vasoconstriction to help raise blood pressure (Hinkle, 2018). In addition to these compensatory factors, the adrenal glands also release aldosterone into the bloodstream. Aldosterone release causes the reabsorption of sodium and water to raise blood pressure (Hinkle, 2018). Because heart failure is a progressive condition, the increased workload on the heart causes hypertrophy of the cardiac cells, thickening the wall of the heart and decreasing the contractibility. The development of heart failure is a cycle of the body trying to compensate for the decrease in ejected blood. Compensation makes the heart work harder, causing the heart muscles to thicken and pump out less and less blood (Hinkle, 2018).

Hypertension is a modifiable risk factor seen in many patients with heart failure (Henry et al., 2016). This client has a history of hypertension that is poorly controlled despite medication compliance. Common signs and symptoms of heart failure include dyspnea or orthopnea, fatigue with minimal exertion, pulmonary congestion, decreased urinary output, weight gain, and dependent edema (Henry et al., 2016). This client had complaints of "weight gain" and bilateral pedal edema. Upon auscultation, crackles were heard in the bases of both lungs. All of which support assessment findings of a heart failure exacerbation. B-type natriuretic peptides (BNP) are monitored in patients with heart failure. BNP levels greater than 100 pg/mL suggest heart failure, but it must be used in conjunction with other findings to diagnose HF (Hinkle, 2018). The client has a history of chronic heart failure, so the BNP level of 4,923 pg/mL indicates an acute exacerbation of chronic heart failure. In addition to monitoring BNP levels, heart failure patients require routine renal studies, including BUN and creatinine levels (Hinkle, 2018). The kidneys are also overworked in patients with heart failure because they are continuously compensating for the fluid imbalances and changes in blood pressure. The client's BUN and creatinine were elevated, indicating a decrease in renal function (Hinkle, 2018). Diagnostic tests are also necessary for diagnosing and treating heart failure. Chest x-rays are used to show the size and position of the heart and evidence of pleural effusions (Hinkle, 2018). Heart failure patients often have cardiomegaly that can be seen on a chest x-ray (Henry et al., 2016). The client's chest x-ray results indicated the heart was enlarged, and pulmonary vascular congestion was present.

Chronic heart failure cannot be cured, but treatments can decrease symptoms and increase the quality of life for patients. Common medications include diuretics to reduce edema and pleural effusions (Henry et al., 2016). The type of diuretic is dependent on the patient. Effectiveness, electrolyte studies, and existing medical conditions are considered before a diuretic is ordered and administered (Henry et al., 2016). The client takes spironolactone 25 mg by mouth at home, but she was switched to furosemide 40 mg via IV push in the hospital setting.

Pathophysiology References (2) (APA):

Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Ball, B. S., Holman, H. C., … Lemon, T. (2016). *Rn adult medical surgical nursing: review module*. Leawood, KS: Assessment Technologies Institute.

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.*)*. Wolters Kluwer Health Lippincott Williams & Wilkins.

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	4.2-5.4 million/uL	N/A	N/A	
Hgb	12-16 g/dL	13.6	N/A	
Hct	37-47%	N/A	N/A	
Platelets	150,000-400,000 mm3	N/A	N/A	
WBC	4.5-11	9.4	N/A	
Neutrophils	45-75%	N/A	N/A	
Lymphocytes	16-46%	N/A	N/A	
Monocytes	4-11%	N/A	N/A	
Eosinophils	0-8%	N/A	N/A	
Bands	0-3%	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-	135-145	138	N/A	
K+	3.5-5.0	3.1	N/A	The client is receiving furosemide in the hospital which is a potassium losing diuretic, and hypokalemia is a common adverse effect of this medication (Jones, 2019).
Cl-	98-106	N/A	N/A	
CO2	23-29	N/A	N/A	
Glucose	70-100	94	N/A	
BUN	10-20	24	N/A	The client has a history of hypertension and is currently experiencing an acute exacerbation of CHF. Both conditions cause an increase in BUN and creatinine (Hinkle, 2018). In addition to HTN and CHF, the client uses diuretics, lisinopril (ACE inhibitor), which are nephrotoxic (Jones, 2019).
Creatinine	0.6-1.2	2.8	N/A	The client has a history of hypertension and is currently experiencing an acute exacerbation of CHF. Both conditions cause an increase in BUN and creatinine (Hinkle, 2018). In addition to HTN and CHF, the client uses diuretics, lisinopril (ACE inhibitor), which are nephrotoxic (Jones, 2019).
Albumin	3.4-5.4	N/A	N/A	
Calcium	9.0-10.5	N/A	N/A	
Mag	1.3-2.1	N/A	N/A	

Phosphate	3.0-4.5	N/A	N/A	
Bilirubin	0.3-1.0	N/A	N/A	
Alk Phos	30-120	N/A	N/A	
AST	0-35	N/A	N/A	
ALT	4-36	N/A	N/A	
Amylase	30-220	N/A	N/A	
Lipase	0-160	N/A	N/A	
Lactic Acid	<1	N/A	N/A	
Troponin	<0.03	N/A	N/A	
CK-MB	0	N/A	N/A	
Total CK	30-170	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	2-3 seconds	N/A	N/A	
PT	11-12.5 seconds	N/A	N/A	
PTT	30-40 seconds	N/A	N/A	
D-Dimer	<0.4	N/A	N/A	
BNP	<100	4,923	N/A	Elevated BNP levels suggest cardiovascular damage but cannot be used alone to diagnose CHF (Hinkle, 2018). The client has a history of CHF, so the elevation of BNP can suggest an acute

				exacerbation of CHF.
HDL	>45	N/A	N/A	
LDL	<130	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	40-160	N/A	N/A	
Hgb A1c	<5.7	N/A	N/A	
TSH	0.5-5.0	N/A	N/A	

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	N/A	N/A	
pH	5-9	N/A	N/A	
Specific Gravity	1.010-1.025	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	Negative	N/A	N/A	
RBC	Negative	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

Arterial Blood Gas 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**

pH	7.35-7.45	N/A	N/A	
PaO2	80-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	95-100	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	Negative	N/A	N/A	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	N/A	N/A	

Lab Correlations Reference (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

Jones & Bartlett Learning. (2019). *2020 Nurse's Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Chest x-ray: Consistent with an enlarged heart and pulmonary vascular congestion

ECG: A-fib at a rate of 88 bpm

Diagnostic Test Correlation (5 points):

Chest x-ray is indicated for CHF patients to show the size, shadow and position or the heart as well as pleural effusions (Henry et al., 2016). Enlarged heart or cardiomegaly is an expected finding for patients with chronic heart failure due to ventricular hypertrophy (Hinkle, 2018).

Diagnostic Test Reference (APA):

Henry, N. J. E., McMichael, M., Johnson, J., DiStasi, A., Ball, B. S., Holman, H. C., … Lemon, T. (2016). *Rn adult medical surgical nursing: review module*. Leawood, KS: Assessment Technologies Institute.

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

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

Home Medications (5 required)

Brand/ Generic	Prinivil (lisinopril)	Cordarone (amiodarone)	Lipitor (atorvastatin)	Lopressor (metoprolol)	Aldactone (spironolactone)
Dose	40 mg	200 mg	40 mg	50 mg	25 mg
Frequency	Daily	Daily	Daily, HS	BID	Daily
Route	PO	PO	PO	PO	PO
Classification	Antihypertensive (ACE inhibitor), vasodilator	Class III antiarrhythmic	HMG-CoA reductase inhibitor antilipidemic	Antihypertensive (Beta blocker)	Potassium sparing diuretic
Mechanism of Action	Inhibits conversion of angiotensin I to angiotensin II which is a vasoconstrictor; also	Prolongs repolarization and refractory period; relaxes smooth	Inhibits HMG-CoA reductase enzyme and increases LDL reuptake	Blocks beta receptor sites which decreases renin levels in the blood	Competes with aldosterone → retains potassium and phosphate

	decreases release of aldosterone	muscles and improves myocardial blood flow	and breakdown, decreasing total triglycerides		
Reason Client Taking	Hypertension & CHF	A-fib	Hyperlipemia	HTN & CHF	CHF/edema
Contraindications (2)	Angioedema R/T ACE inhibitor GFR<60	Bradycardia 2nd & 3rd degree heart block	Hepatic disease Alcoholism	2nd & 3rd degree heart block Bronchial asthma	Severe renal disease Metabolic acidosis
Side Effects/ Adverse Reactions (2)	Orthostatic hypotension **Angioedema** (rare, but life threatening)	Bradycardia Hypotension	**Liver dysfunction** **Muscle pain** (both are rare, but life-threatening	Palpitations Hypotension	Hyperkalemia Headache
Nursing Considerations (2)	Severe hypotension may occur with concurrent diuretic use, doses may be adjusted prior to therapy Evaluate effectiveness of decreased BP and CHF symptoms	Administer with food to decrease GI upset Assess for chest pain, dyspnea, cough, or fever after admin	Administer in the evening to decrease GI upset Assess for muscle pain/cramping	Administer with or after meals Call provider if heart rate is <60 bpm before administration	Administer in the morning to decrease risk of nocturia Administer with food to decrease GI symptoms
Key Nursing Assessment(s)/Lab(s) Prior to Administration	CBC w/ diff Baseline BP & resp rate; vitals Q4H Electrolytes (esp K, Na, Cl)	ECG I&O Electrolytes Hepatic studies Thyroid function	Cholesterol levels Hepatic studies Renal studies Baseline	ECG I&O Daily weight Baseline BP and resp rate, vitals Q4H Apical pulse	Electrolytes Daily weight Strict I&O Presence of rash prior to admin Hydration

	Compare apical pulse to pedal pulse Baseline renal and hepatic studies	Baseline ophthalmic exam recommended	CPK	>60, notify provider if <60 Baseline renal studies Baseline hepatic studies	status Renal studies Hepatic studies
Client Teaching needs (2)	Do not discontinue abruptly Change positions slowly to decrease orthostatic hypotension	Do not take with grapefruit juice → can lead to toxicity May cause skin discoloration, but it is usually reversible	Medication works in conjunction with exercise and diet Report any muscle pain or cramping immediately	Teach client to take pulse at home prior to admin Report bradycardia or dizziness	Avoid foods high in potassium (bananas, avocados, nuts) Notify provider of cramps, diarrhea, lethargy, increased thirst, or skin rash

Hospital Medications (5 required)

Brand/ Generic	Lasix (furosemide)	K-tab (potassium chloride)	Tylenol (acetaminophen)	Colace (docusate)	Aspirin (aspirin)
Dose	40 mg	40 mEq	650 mg	100 mg	81 mg
Frequency	BID	Once	Q6H, PRN	BID, PRN	Daily
Route	IV push	PO	PO	PO	PO
Classification	Loop diuretic	Potassium supplement	Nonopioid analgesic, antipyretic	Emollient laxative; stool softener	Nonopioid analgesic, antipyretic, antiplatelet,

					anti-inflammatory
Mechanism of Action	Inhibits reabsorption of sodium	Replenishes potassium in the blood	Blocks pain impulses peripherally, inhibits prostaglandin production	Increases water in the stool	Decreases platelet aggregation Blocks pain impulses and inhibits prostaglandin production
Reason Client Taking	CHF/edema	Hypokalemia	Mild-moderate pain Fever management	Constipation	Reduce the risk of cardiovascular accident
Contraindications (2)	Hypovolemia Electrolyte depletion	Severe renal disease Conditions that cause potassium retention	Hepatic disease Alcoholism	Fecal impaction Undiagnosed abdominal pain, nausea or vomiting	Hypersensitivity to salicylates Peptic ulcer disorder
Side Effects/Adverse Reactions (2)	Electrolyte imbalances Polyuria	Hyperkalemia N/V/D	Hepatotoxicity Thrombocytopenia	Abdominal cramping Diarrhea	GI bleeding N/V, abdominal pain
Nursing Considerations (2)	Administer in AM to decrease risk of nocturia Potassium replacement may be necessary	Do not break, crush or chew tablet Administer with or after meals	Administer with food to decrease GI symptoms Do not exceed 4g in 24 hours	Can administer in the morning or evening Assess the cause of constipation	Administer with food or milk to decrease GI symptoms Monitor for S/S of GI bleed
Key Nursing Assessment(s)/Lab(s) Prior to Administration	S/S metabolic alkalosis Electrolyte studies Daily weight Strict I&O	ECG Electrolyte studies I&O Cardiac status	Hepatic studies Renal studies CBC w/ diff I&O Assess pain or fever	Presence of abdominal cramping prior to admin	Hepatic studies Renal studies CBC w/ diff

	Lung sounds Orthostatic BP Hydration status Allergies *sulfonamides, thiazides*				
Client Teaching needs (2)	Potassium supplements or increase in potassium rich foods may be necessary Change positions slowly to decrease risk of orthostatic hypotension	Potassium levels will be monitored routinely Report S/S of hyperkalemia (lethargy, confusion, N/V/D, or decreased output)	Do not exceed 4g in 24 hours Do not drink alcohol with this medication	Increase fluids and bulk in diet Stools will form in 1-3 days	Do not exceed recommending dosing Avoid alcohol, smoking, caffeine, or other GI irritants

Medications Reference (APA):

Jones & Bartlett Learning. (2019). *2020 Nurse's Drug Handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client is AOx4 No apparent distress noted Client is sitting upright in the chair
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:**	Skin is warm, dry, and pink Skin turgor is edematous No rashes, bruises, or wounds noted Braden score: 20 (low risk) No drains present

Bruises: **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is normocephalic No palpable lymph node in neck or cervical region PERRLA notes Ears and nose free of congestion and drainage
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, S2 noted A-fib noted at a rate of 88 bpm No murmurs, gallops, or rubs Peripheral pulse 3+ bilaterally on upper and lower extremities Capillary refill <3 seconds No NVD noted 3+ pitting edema to bilateral ankles and pedal areas
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Respiration rate avg 24 resp/min Accessory muscles used for respirations Crackles noted in bilateral bases of the lungs
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:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	Home diet: Regular Current diet: Low sodium, fluid restriction of 1,000 mL/day Height:157.48 cm (5 ft 6 in) Weight: 48.18 kg (106 lb) Bowel sounds active in all 4 quadrants Last BM 4/2/20 No pain or mass upon palpation No abdominal distention, incisions, drains, or wounds noted Scar from cholecystectomy in RUQ No ostomy, NG, PEG, or feeding 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:**	Urine is pale yellow Total urine output 1750 mL Client denies pain with urination No dialysis No catheter
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☐**	Active range of motion in all extremities Client denies use of supportive devices Strength 5/5 in upper and lower extremities bilaterally Up ad lib Fall risk score: 25 Low fall risk Does not require assistance with equipment or support to stand/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:**	Moves all extremities well PERRLA notes Strength is equal bilaterally AOx4 Speech is clear and appropriate
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):**	Client received her GED Developmental level normal for age Lives at Oaks Manor Assisted Living Facility Coping methods, religion, personal/family data not provided

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0700	88 bpm	152/68 mmHg	24 resp/min	36.5 C	98% on 2L O2 via NC
1100	68 bpm	138/62 mmHg	24 resp/min	36.8 C	97% on 2L O2 via NC

Vital Sign Trends: The blood pressure was elevated at 0700 and 1100, but it is trending downward as a response to lisinopril, metoprolol, and furosemide administration. Respirations are elevated but consistent; the respiratory rate may be client's baseline related to HF. Vitals are stable and will continue to monitor every 4 hours as ordered.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0700	Numeric	N/A	0/10	N/A	No interventions at this time
1100	Numeric	Head	1/10	"headache"	Tylenol administered

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:**	20G in the left AC dated 4/2/20 IV is patent and flushes easily Saline lock currently No signs or erythema, drainage or swelling Client denies pain at the insertion site Clear dressing is clean, dry, and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL Tea 120 mL Apple juice Total input: 360 mL	Total urine output 1750 mL Stool x2

Nursing Care

Summary of Care (2 points)

Overview of care: Hx of CHF, HTN, Hyperlipidemia, A-fib; Admitted for acute exacerbation of CHF; Client prefers to sit upright in the chair to breathe easier; Client is tolerating medication administrations; Client is up ad lib and uses call light if she requires assistance

Procedures/testing done: Chest x-ray, ECG, Labs

Complaints/Issues: C/O weight gain and swelling; both complaints are improving with medication administration

Vital signs (stable/unstable): Vitals are stable currently; BP and respiratory rate are slightly elevated, but not concerning. Vitals will continue to be monitored every 4 hours as ordered.

Tolerating diet, activity, etc.: Client is tolerating diet and fluid restriction; Up ad lib; Requires frequent rest periods

Physician notifications: Provider was notified of BNP and potassium levels; potassium supplements were ordered and administered

Future plans for patient: Client will be discharged to Oaks Manor Assisted Living Facility. Follow up with primary care provider (PCP) in 1 week following discharge.

Discharge Planning (2 points)

Discharge location: Oaks Manor Assisted Living Facility

Home health needs (if applicable): Client requests one-time visit from a Care Coach

Equipment needs (if applicable): Possibly O2; it is unclear if the client used oxygen at home prior to admission

Follow up plan: Follow up with PCP in 1 week following discharge

Education needs: S/S of CHF exacerbation (weight gain, swelling, difficulty breathing especially when lying flat, fatigue); S/S of electrolyte imbalances; Low-sodium diet and fluid restrictions at home

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.
Activity intolerance R/T decreased cardiac output AEB easy fatigue with minimal exertion	Decreased cardiac output causes a decrease in blood flow therefore oxygen transportation to tissues/organs	Encourage the client to increase physical activity with adequate rest periods Refer client to a local cardio-friendly exercise program to help build endurance	The client will tolerate moderate activity without difficulty breathing by discharge The client will have joined a local exercise program by the follow up appointment 1 week after discharge
Excess fluid volume R/T heart failure AEB crackles in lung bases, 3+ pitting edema, and weight gain	Third-spacing causes dehydration and decreased blood volume to tissues/ organs	Administer medications (diuretics) to decrease excess fluid volume Monitor strict I&O and daily weights	The patient will maintain medication compliance and be able to tell the nurse why medications are prescribed/how they help The client will keep a daily weight journal to bring to follow up visit in 1 week and any follow up visit thereafter
Powerlessness R/T heart failure AEB recurrent	It is difficult for clients to cope with chronic	Encourage the client to discuss feelings of powerlessness	The client will openly discuss fears or feelings of powerlessness with staff

hospitalizations	illnesses	Assess the client for signs of depression	prior to discharge The client will answer depression screening honestly prior to discharge and at follow up appointments
Risk for impaired skin integrity R/T edema AEB decreased tissue perfusion	Though the client is at a low risk for skin breakdown, the edematous skin has a decrease in tissue perfusion and skin integrity can be impaired	Monitor bony prominences every 2 hours Encourage the client to change positions frequently	The client will change positions every hour and will rotate between sitting in the chair and the bed The client will report any painful areas on the body to the nursing staff as they occur

Other References (APA):

Concept Map (20 Points):

N431 Care Plan

Subjective Data

“weight gain”
“swelling in the ankles”
Edema is worsened with ambulation

Nursing Diagnosis/Outcomes

Activity intolerance R/T decreased cardiac output AEB easy fatigue with minimal exertion
The client will tolerate moderate activity without difficulty breathing by discharge
The client will have joined a local exercise program by the follow up appointment 1 week after discharge
Excess fluid volume R/T heart failure AEB crackles in lung bases, 3+ pitting edema, and weight gain
The patient will maintain medication compliance and be able to tell the nurse why medications are prescribed/how they help
The client will keep a daily weight journal to bring to follow up visit in 1 week and any follow up visit thereafter
Powerlessness R/T heart failure AEB recurrent hospitalizations
The client will openly discuss fears or feelings of powerlessness with staff prior to discharge
The client will answer depression screening honestly prior to discharge and at follow up appointments
Risk for impaired skin integrity R/T edema AEB decreased tissue perfusion
The client will change positions every hour and will rotate between sitting in the chair and the bed
The client will report any painful areas on the body to the nursing staff as they occur

Objective Data

3+ pitting edema to bilateral ankle/pedal area
Crackles at the bases of bilateral lungs
Elevated BNP
Elevated BUN & creatinine
Decreased serum potassium

Patient Information

M. L., a 72-year-old Hispanic female, presented to the hospital with complaints of “weight gain” of 12 pounds and “swelling of the ankles.” That increases with ambulation but improves with elevation. PMH includes HTN, A-fib, hyperlipidemia and CHF. CXR showed an enlarged heart and pulmonary vascular congestion. 3+ pitting edema in bilaterally ankle area and crackles in bases of bilat lungs

Nursing Interventions

Encourage the client to increase physical activity with adequate rest periods
Refer client to a local cardio-friendly exercise program to help build endurance
Administer medications (diuretics) to decrease excess fluid volume
Monitor strict I&O and daily weights
Encourage the client to discuss feelings of powerlessness
Assess the client for signs of depression
Monitor bony prominences every 2 hours
Encourage the client to change positions frequently