N431 Care Plan Three

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 07/13/2020	**Patient Initials** BG	**Age** 85	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Widow	**Allergies** Penicillin, sulfa
Code Status DNR	**Height** 167 cm	**Weight** 59.2 kg	

Medical History (5 Points)

Past Medical History: Acute exacerbation of CHF, aortic aneurysm, aortic regurgitation, coronary artery disease, hypertensive cardiovascular disease

Past Surgical History: Cardiac catheterization, patient does not recall the date.

Family History: Father- heart attack, Mother- ovarian cancer

Social History (tobacco/alcohol/drugs): Patient denies the use of alcohol, smoking, tobacco or drugs.

Assistive Devices: Patient uses a walker at home.

Living Situation: Patient lives home alone and her son lives nearby.

Education Level: Patient has a high school degree.

Admission Assessment

Chief Complaint (2 points): SOB, bilateral lower leg edema

History of present Illness (10 points): Patient came into the emergency department via ambulance complaining of shortness of breath. Patient denies chest pain and any pain in general. Patient does present with bilateral lower leg edema. Patient has a history of congestive heart failure. Patient is poor historian but admits to not remaining compliant with her medication regimen. Patient's main concern at this time is her shortness of breath.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): CHF

Secondary Diagnosis (if applicable): SOB

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

Heart failure occurs due to the ineffectiveness of the ability of the ventricles to fill or eject blood. Heart failure is often a secondary diagnosis caused by coronary artery disease, hypertension, cardiomyopathy, valve disorders, or renal dysfunction with volume overload. In systolic heart failure, a decrease in blood ejected from the ventricles results in decreased blood flow to the body. This decrease is sensed by baroreceptors, which stimulates the sympathetic nervous system to release epinephrine and norepinephrine. These hormones take effect by increasing heart rate and contractility to account for the decrease in the ejection of blood. If the reduction in blood flow is not corrected, the kidneys will respond to the decreased volume by activating the renin-angiotensin-aldosterone system (RAAS). Ultimately, the RAAS works to increase blood pressure and afterload (Hinkle & Cheever, 2018). Afterload is the force that the ventricles must overcome to pump the blood from the heart (Capriotti & Frizzell, 2016). The RAAS increase not only the blood volume, but also the overall fluid volume. The increase in fluid volume is a common struggle in patients with heart failure. This increase causes the heart to have to work harder to compensate for the increased amount, which can result in thickening of the myocardial muscle and increase the size of the ventricle. This hypertrophy leads to further complications related to heart function (Hinkle & Cheever, 2018).

Diastolic heart failure occurs when the ventricle experiences difficulty relaxing, which does not allow for complete ventricular expansion. Since the ventricle is unable to expand

properly, it cannot fill with blood, resulting in decreased output. There is also heart failure that can be specifically right-sided or left-sided, which both present differently. However, over time the failure of one side of the heart will eventually lead to failure of the other. (Capriotti & Frizzell, 2016).

Signs and symptoms associated with heart failure can vary based upon the type of heart failure the patient has. Congestive heart failure (CHF) often presents with dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cough, pulmonary crackles, weight gain, dependent edema, abdominal bloating or discomfort, ascites, jugular venous distension, sleep disturbances and fatigue (Hinkle and Cheever, 2018). BG presented with dyspnea, dependent edema, fatigue, and sleep disturbances. When the patient was asked how she slept, she responded that she did not sleep well due to her breathing issues. BG also had 2+ edema bilaterally in her lower extremities. She complained of shortness of breath during the day as well and stated she had fatigue. BG did not have crackles upon auscultation; however, her lower lobes presented with diminished breath sounds. Patients can also present with hypertension, increased heart rate, increased respirations, and decreased oxygen saturation. BG presents with hypertension, increased respiration rate, and decreased oxygen saturation. The patient was placed on oxygen to increased her saturation levels. The patients with heart failure also typically have an altered BNP level, which BG also had.

The diagnosis is confirmed with the BNP level. Other diagnostics include examination via an echocardiogram, which identifies cardiac abnormalities and the ejection fraction. Chest x-ray and EKG's also assist with diagnosis by identifying cardiomegaly and abnormal heart rhythms (Hinkle & Cheever, 2018). BG had an echocardiogram, chest x-ray, and EKG performed.

Treatment of CHF involves relieving symptoms and promoting a better quality of life. Patients are instructed on lifestyle changes such as diet, exercise, and smoking. Patients often take oral medications, including angiotensin-converting enzyme inhibitors, angiotensin receptor blockers, hydralazine and isosorbide dinitrate, beta-blockers, diuretics, and digitalis. During their hospital stay, patients may receive medications via intravenous route such as milrinone or dobutamine (Hinkle & Cheever, 2018). BG takes carvedilol, furosemide, and lisinopril to manage her heart failure.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology introductory concepts and clinical perspectives.* F. A. Davis.

Hinkle, J.L., Cheever, K.H. (2018*). Brunner & Suddarth's textbook of medical-surgical nursing*(14th ed.). Wolters Kluwer.

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	**3.9 – 4.98**	**5.64**	**5.48**	RBCs may be elevated due to dehydration, patient states she has not eaten over the past few days (Hinkle & Cheever, 2018).
Hgb	**12 – 15.5g/dl**	**14.7**	**14.2**	
Hct	**34 – 45%**	**44.6**	**43.6**	
Platelets	**150 - 400**	**200**	**188**	
WBC	**4.0 – 9.0**	**6.5**	**5.9**	
Neutrophils	**40 – 70%**	**77.1**	**75**	Neutrophils may be elevated due to dehydration, patient states she has not eaten over the past few days. Patient may have a UTI due to increased WBC and leukoesterase in urine (Hinkle & Cheever, 2018).

Lymphocytes	**20 – 50%**	**21**	**20**	
Monocytes	**2 - 12%**	**7.8**	**7.6**	
Eosinophils	**0- 6.3%**	**1.1**	**1.7**	
Bands	**0 - 6**	**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**	**145**	**145**	
K+	**3.5 – 5**	**3.5**	**3.8**	
Cl-	**98 – 107**	**110**	**109**	Chloride may be elevated due to dehydration, patient states she has not eaten over the past few days (Hinkle & Cheever, 2018).
CO2	**22 – 30**	**28**	**29**	
Glucose	**70 -99**	**119**	**109**	Patient may have undiagnosed pre-diabetes (Hinkle & Cheever, 2018).
BUN	**6 - 20**	**N/A**	**21**	BUN may be elevated due to dehydration, patient states she has not eaten over the past few days (Hinkle & Cheever, 2018).
Creatinine	**0.5 – 1.0**	**1.0**	**0.9**	
Albumin	**3.5 – 5.2**	**3.4**	**N/A**	Albumin is low due to malnutrition (Hinkle & Cheever, 2018). Patient states she has not eaten within the last few days.
Calcium	**8.4 – 10.5**	**9.5**	**9**	
Mag	**1.6 – 2.4**	**N/A**	**N/A**	
Phosphate	**2.5 – 4.5**	**N/A**	**N/A**	

Bilirubin	**0 – 1.2**	**1.1**	**N/A**	
Alk Phos	**35 - 105**	**58**	**N/A**	
AST	**0 – 32**	**12**	**N/A**	
ALT	**24 - 26**	**25**	**N/A**	
Amylase	**23 - 85**	**N/A**	**N/A**	
Lipase	**0 - 160**	**N/A**	**N/A**	
Lactic Acid	**0.5 - 1**	**N/A**	**N/A**	
Troponin- I	**<0.03 ng/ml**	**0.042**	**N/A**	Patient has CHF (Hinkle & Cheever, 2018).
CK-MB	**0%**	**1.81-1.84**	**N/A**	Patient has CHF (Hinkle & Cheever, 2018).
Total CK	**30 – 170 units/L**	**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 – 1.2**	**N/A**	**N/A**	
PT	**11.5 – 15 sec**	**N/A**	**N/A**	
PTT	**23.5 – 37.5 sec**	**N/A**	**N/A**	
D-Dimer	**< 0.4**	**N/A**	**N/A**	
BNP	**0 -100**	**7,761**	**N/A**	The patient has a diagnosis of CHF, which presents with elevated BNP (Hinkle & Cheever, 2018).
HDL	**>40 mg/dl**	**N/A**	**N/A**	
LDL	**<130 mg/dl**	**N/A**	**N/A**	
Cholesterol	**<200 mg/dl**	**N/A**	**135**	

Triglycerides	**<150 mg/dl**	**N/A**	**104**	
Hgb A1c	**0 – 5.7**	**N/A**	**5.7**	
TSH	**0.45 – 5.33**	**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**	**Straw & Clear**	
pH	**6.0**	**N/A**	**5.0**	
Specific Gravity	**1.005-1.034**	**N/A**	**1.006**	
Glucose	**Normal**	**N/A**	**Normal**	
Protein	**Negative**	**N/A**	**N/A**	
Ketones	**Negative**	**N/A**	**N/A**	
WBC	**<5**	**N/A**	**+8**	Patient may have a UTI (Hinkle & Cheever, 2018).
RBC	**0-3**	**N/A**	**+1**	
Leukoesterase	**Negative**	**N/A**	**+1**	Patient may have a UTI (Hinkle & Cheever, 2018).

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	**92 – 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	**No growth**	**N/A**	**N/A**	
Blood Culture	**No growth**	**N/A**	**N/A**	
Sputum Culture	**No growth**	**N/A**	**N/A**	
Stool Culture	**No growth**	**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.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Diagnostic Test Correlation (5 points):

Chest x-ray (07/13/2020)

Results reviewed by Dr. Garett indicate a moderate-sized pleural effusion on the right. The patient does not have any indication of a pneumothorax. The patient also has a pleural effusion present on the left side. Dr. Garett states that there are Kerley B lines at both lung bases and pulmonary vascular congestion. The patient also has mild interstitial opacities and bilateral perihilar and bibasilar opacities. The patient also has stable cardiomegaly. A chest x-ray is necessary for this patient because she came into the ER with SOB. An x-ray can indicate

obstructions or other complications related to the airways (Hinkle & Cheever, 2018).

Echocardiogram without contrast (07/14/2020)

Results recorded by Constantine Katsamakis, DO indicate an average-sized left ventricle with a mildly reduced ejection fraction of 35-45%. He also noted that the left ventricle as a grade 1 in diastolic dysfunction. BG also had an average-sized right ventricle with normal functioning. There is moderate to severe pulmonary systolic hypertension with a PA pressure of 60 mmHg. The right atria presents with mild enlargement and left presents with moderate enlargement. The aortic root is also mildly dilated. The tri-leaflet aortic valve has moderate thickening and calcification, and there is moderate to severe aortic valve regurgitation present. The aortic valve also has mild stenosis. The mitral and tricuspid valve have regurgitation as well. There is no indication of pericardial effusion.

The echocardiogram is pertinent to this patient due to her history of CHF. This test allows for the visualization of heart size and structures and can be used to identify abnormalities within the heart (Hinkle & Cheever, 2018).

NM CD Myocardial Spect Rest and Stress (07/14/2020)

Results from BG's stress test indicate a reduced left ventricular ejection fraction of 30%. She also has a large, predominantly fixed, inferior/inferoseptal wall perfusion defect, which extends from the apex to the base. This test is pertinent to the patient to examine the effects of stress on the patient's heart.

EKG (07/14/2020)

Results still pending. An EKG is necessary for this patient due to her history of CHF. An EKG can identify abnormalities in the electrical rhythm of the heart (Hinkle & Cheever, 2018).

Diagnostic Test Reference (APA):

Hinkle, J.L., Cheever, K.H. (2018*). Brunner & Suddarth's textbook of medical-surgical nursing*(14th ed.). Wolters Kluwer.

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

Hospital Medications (5 required)

Brand/Generic	Aspirin/ acetylsalicylic acid	Lovenox/ enoxaparin	Protonix/ pantoprazole	Tylenol/ acetaminophen	Duramorph/ morphine
Dose	81 mg	0.4 mL	40 mg	650 mg	0.5 mg
Frequency	Daily	Daily	Daily	Q6, PRN	Q2, PRN
Route	PO	subcutaneous	PO	PO	IV
Classification	NSAID	LMWH Anticoagulant	PPI	Antipyretic Nonopioid analgesic	Phenanthrene derivative Analgesic
Mechanism of Action	Aspirin inactivates cyclooxygenase, which binds to serine residue, resulting in irreversible deactivation of the enzyme that is responsible for converting arachidonic acid to thromboxane A2 , and lasts for the lifespan of the platelet.	Enoxaparin binds to antithrombin III, inhibiting the coagulation of clotting factors IIa and Xa.	Pantoprazole inhibits gastric acid secretion through selective and permanent inhibition of H+/K+ ATPase.	Acetaminophen inhibits cyclooxygenase which blocks the production of prostaglandins and interferes with pain impulse generation. Acetaminophen works in the hypothalamus by inhibiting the synthesis of prostaglandin E and decreases	Morphine binds and activates opioid receptors in the brain and spinal cord resulting in analgesia.

				fevers.	
Reason Client Taking	Anticoagulant	Anticoagulant	Indigestion/ Heart burn	Fever/mild pain	Pain
Contraindications (2)	-active gastric or duodenal ulcers -severe renal or hepatic impairment	-Active major bleeding -History of heparin induced thrombocytopenia (HIT)	- Hypersensitivity -concurrent therapy with rilpivirine	- Hypersensitivity - Severe hepatic impairment	- arrythmias -heart failure caused by chronic lung disease
Side Effects/Adverse Reactions (2)	Confusion Ecchymosis	Pneumonia Alopecia	Hypertonia Jaundice	Blisters Fatigue	Amnesia Flushing
Nursing Considerations (2)	-Monitor the patient for tinnitus -Do not crush timed release or control release tablets unless instructed	- Keep protamine sulfate nearby in case of an overdose -Do not give drug by IM injection	- Pantoprazole can cause false positive urine screenings - If therapy lasts longer than three years, the patient may no longer be able to absorb vitamin B12.	-Monitor renal function with patients on long term therapy - Use cautiously in patients with hepatic impairment, chronic malnutrition, or severe hypokalemia.	- Avoid IM route for long term therapy because of injection site irritation. - Store morphine at room temperature.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	-Signs and symptoms of bleeding -liver function -renal function	Coagulation tests CBC K+	PT, INR Urine output diarrhea	AST, ALT, bilirubin creatinine, BUN	Adrenal insufficiency, sedation, assess HR and respirations, BP
Client Teaching needs (2)	-Do not stop taking abruptly. -May bruise or bleed easily.	- Do not rub the site after the injection to prevent bruising. -Instruct the	-Instruct the patient to notify the prescriber if diarrhea occurs or	- Tablets can be crushed or swallowed whole -Do not	- Instruct to take directly as prescribed because excessive

		patient to notify the provider of any adverse reactions, especially bleeding.	persists and becomes severe. -Educate patient that they should experience symptoms relief within 2 weeks.	exceed the recommended dose or take other drugs containing acetaminophen due to risk of liver damage.	or prolonged use can lead to abuse. - Change position slowly due to prevent effects of orthostatic hypotension.

Home Medications (5 required)

Brand/Generic	**Coreg/ carvedilol**	**Lasix/ furosemide**	**Zestril/ lisinopril**	**Klorvess/ Potassium Chloride**	**Lipitor/ Atorvastatin**
Dose	6.25 mg	40 mg	20 mg	20 mEq	40 mg
Frequency	Daily	Daily	Daily	Daily	Daily
Route	PO	PO	PO	PO	PO
Classification	Non-selective beta adrenergic blocking agent	Loop diuretic, antihypertensive	ACE inhibitor	Electrolyte cation/replacement	Antihyperlipidemic, HMC-CoA reductase inhibitor
Mechanism of Action	Beta blockers cause vasodilation and a decrease in peripheral vascular resistance resulting in a decrease in BP. Carvedilol also	Furosemide prevents sodium and chloride reabsorption at the proximal and distal tubules and the ascending loop of Henle**.**	Lisinopril inhibits the RAAS system resulting in a decrease in peripheral vascular resistance and blood pressure.	Potassium chloride activates multiple enzymatic reactions such as nerve transmission and cardiac and skeletal muscle contraction. Potassium maintains	Atorvastatin decreases cholesterol and lipoprotein levels by inhibiting HMG-CoA and cholesterol synthesis. It also increases the number of LDL receptors, which increases he

	decreases orthostatic tachycardia and exercise induced tachycardia, and decreases CO.			electroneutrality through the exchange od intracellular and extracellular ions.	uptake of LDL.
Reason Client Taking	HTN, CHF	HTN, CHF	HTN, CHF	Low potassium due to furosemide being potassium wasting	Hyperlipidemia
Contraindications (2)	-asthma or related bronchospastic conditions -severe bradycardia	-anuria unresponsive to furosemide -hypersensitivity	-Hypersensitivity -Hereditary or idiopathic angioedema	-acute dehydration -Addison's disease	-Active hepatic disease -Hypersensitivity
Side Effects/Adverse Reactions (2)	headache angina	Azotemia Hyperglycemia	Ataxia Abdominal pain	Rash Dyspnea	thrombocytopenia lip swelling
Nursing Considerations (2)	-Know that if a patient has heart failure, they will likely take digoxin, a diuretic and an ACE inhibitor. - Be aware that chronic therapy is not routinely held with surgery	-Be aware that elderly patients are at an increased risk for hypotensive and electrolyte-altering effects which puts makes them more susceptible for blood clots and shock. -For daily	-Notify prescriber if patient has a persistent cough. - Use cautiously in patients with fluid volume deficit, heart failure, impaired renal function, sodium depletion.	-Administer oral potassium with or immediately after meals. -Be aware that some forms of potassium contain tartrazine, which can cause allergic reactions.	-Be aware that the patient may also take colestipol or cholestyramine. -Be aware that lipid levels will need to be checked 2 to 4 weeks after therapy begins.

	because the benefits outweigh the risks.	dosing administer in the morning to avoid interrupting patient's sleep patterns.			
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Blood glucose BP, HR	Daily wt BP, Hepatic and renal function, BUN, blood glucose, creatinine, electrolyte and uric acid levels, hypokalemia	BP, HR Dehydration Hepatic function	S&S of hypokalemia Serum potassium levels Creatinine Urine output	Blood glucose Lipid levels
Client Teaching needs (2)	-Check blood pressure and Heat rate prior to administration. Hold for Systolic under 100 and heart rate less than 60. -Tell the patient with HF to notify the provider if they gain 5 pounds or more in 2 days, or SOB, which can	- Check blood pressure and Heat rate prior to administration. Hold for Systolic under 100 and heart rate less than 60. - Change position slowly to avoid effects of orthostatic hypotension.	-Educate patient that this medication can impair their ability to drive or operate machinery. - Instruct that they can take this medication with or without food, but that they need to take it at the same time each day. -Check blood pressure and Heat rate	-Teach patient how to check their pulse prior to taking, and notify the provider with any changes in heart rate or rhythm. Hold if less than 60 bpm -Instruct the patient to watch for changes in stool color and consistency. Contact the provider if they become black, tarry or red.	-Stress the importance of maintaining a low cholesterol diet as well as taking medications as prescribed. -Instruct patient to take a missed dose as soon as they remember, or if it is close to their next dose, skip the missed dose.

	indicate worsening of their HF.		prior to administration. Hold if systolic is less than 100 and HR is less than 60.		

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2019 Nurses Drug Handbook.* Burlington, MA.

Sarah Bush Lincoln Hospital. (2020). Drug Reference.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is alert and oriented x4. Patient does not appear to be in distress. Patient is resting comfortably in the hospital bed.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 17** **Drains present: Y☐ N ☒** **Type:**	Skin color is appropriate for ethnic background. Skin is thin, loose, and intact. Skin is warm. Turgor is good, less than 3 seconds. No rashes, bruises, or wounds present upon inspection. Patient does have some erythema on her sacral area that blanches when palpated. Patient has a Mepilex over the area. Braden score is 17. Patient is a high skin risk.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head is normocephalic. Trachea midline. Ears are intact and symmetric with no discharge visible. PERRLA. Eyes are symmetric. Nose is midline with no polyps, epistaxis or deviated septum. Teeth are present. Patient states she wears dentures. Oral mucosa is pink, moist, and intact. .

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 heard upon auscultation. No murmurs, gallops, or rubs heard. Regular rate and rhythm. Radial and pedal pulses are equal bilaterally and 3+. Capillary refill is less than 3 seconds in all extremities. Patient has 2+ edema in her legs bilaterally.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Patient has equal and regular respirations bilaterally. Lung sounds are normal in upper lobes and diminished in the lower lobes bilaterally. Patient is on 2 L of oxygen via nasal cannula.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height: 167 cm** **Weight: 59.2 kg** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size: N/A** **Feeding tubes/PEG tube Y ☐ N ☒** **Type: N/A**	Patient has a regular diet at home and a heart failure diet at the hospital. Patient weighs 59.2 kg and is 167 cm tall. Bowel sounds are normoactive in all four quadrants. Patient's last bowel movement was 7/14/2020. Abdomen is soft and nontender upon palpation. No distension, incisions, scars, drains, or wounds present upon inspection.
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**	Urine is clear and yellow. Patient voided 800 mL during the clinical time period. Genitalia is pink and intact.
MUSCULOSKELETAL (2 points):	Patient has active ROM. Patient ambulates with a

Neurovascular status: **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score: 60** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☒** **Needs support to stand and walk☒**	walker. Patient has equal strength in extremities bilaterally. Patient requires standby assistance with ADL activities. Patient is a high fall risk. Fall score is 60. Patient is able to move well with her walker.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patient is able to move all extremities well. PERRLA. Patient has equal strength bilaterally in her arms and legs. Patient is alert and oriented x4. Patient's speech is clear and intact. Patient's sensory is intact.
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 appears to be coping well. Patient's cognition appears appropriate for developmental level. Patient states she is Christian and believes in God. Patient's son lives nearby and is currently present at the bedside.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	**77**	**136/47**	**22**	**36.5**	**90%**
1200	**80**	**138/42**	**20**	**36.7**	**97%**

Vital Sign Trends: Patient's vitals remained stable. Patient's respirations were slightly increased during the morning vitals and oxygen saturation was low. Patient was administered 2L of oxygen

via nasal cannula and has been maintaining oxygen saturation within normal limits. Patient's blood pressure is elevated, patient has a history of HTN.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	**Numeric 0-10**	**N/A**	**0**	**N/A**	**N/A**
1200	**Numeric 0-10**	**N/A**	**0**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 gauge **Location of IV:** right antecubital **Date on IV:** 07/13/2020 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No erythema, phlebitis, or infiltration present. **IV dressing assessment:** Clean, dry, intact	Saline Lock

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL of water	800 ml voided Diarrhea

Nursing Care

Summary of Care (2 points)

Overview of care: Patient ambulated to the bathroom several times during the shift. Patient complained of chronic SOB. Patient's oxygen saturation was taken during morning vitals

and patient was sating 90%. Patient was placed on 2L of oxygen via nasal cannula. Patient has been maintain oxygen saturation around 97%. Patient stated not eating for a few days prior to hospitalization. Patient ate all of her biscuits and gravy for breakfast. Patient saw wound care and PT/OT.

Procedures/testing done: Patient had an echocardiogram, UA, labs, EKG, and stress test today.

Complaints/Issues: Patient complained of shortness of breath but reported the oxygen helped.

Vital signs (stable/unstable): Respirations and oxygen saturation improved after the administration of oxygen. Patient's vital signs are stable.

Tolerating diet, activity, etc.: Patient is tolerating diet and activity well.

Physician notifications: Patient was placed on 2L of oxygen via nasal cannula to maintain oxygen saturation greater than 92%.

Future plans for patient: Contact case management and respiratory therapy for possible need of at home oxygen.

Discharge Planning (2 points)

Discharge location: Patient will discharge home alone, possibly with home health for medication compliance.

Home health needs (if applicable): Home health nurse for medication compliance and potential oxygen administration.

Equipment needs (if applicable): Possibly oxygen.

Follow up plan: Monitor oxygen saturation levels, nutrition status, and medication compliance.

Education needs: Patient will need to receive education on nutrition needs and medication compliance. Patient may also need education on oxygen therapy.

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. Decreased gas exchange due to fluid in the lungs at the alveolar - capillary membrane as evidenced by low oxygen saturation.	**Decreased gas exchange can result in poor tissue perfusion leading to ischemia. Ischemia can cause tissue necrosis and organ failure if untreated.**	**1.Adminsiter oxygen as prescribed.** **2.Monitor oxygen saturation levels.**	**Patient was receptive to education about oxygen administration and the importance of monitoring saturation levels. Family was appreciative of the information. Patient appeared uneasy with the initial placement of the nasal cannula but was willing to cooperate. Will continue to monitor patient comfort and oxygen saturation.**
2. Fluid overload due to compromised regulatory mechanisms occurring with decreased cardiac output as evidence by 2+ edema in the lower extremities	**Fluid overload needs to be minimized to decrease the workload on the heart. The harder the heart has to work, the greater the increase for the risk of further complications.**	**1. Assess daily weights in the morning.** **2. Administer diuretics as prescribed.**	**Patient was accepting of daily weights and the administration of diuretics. Patient recognized that she would need to go to the bathroom more frequently. Will instruct staff to monitor patient more frequently for trips to the bathroom.**

bilaterally.			
3. Fatigue with decreased exercise tolerance due to imbalance between oxygen supply and demand occurring with a decrease in cardiac muscle contractility as evidenced by patient stating shortness of breath after getting up to use the bathroom.	**Fatigue is important to address to prevent the patient from becoming breathless and worn out during ADLs.**	**1.Assess patient's physiologic response to activity and report significant findings.** **2. Coordinate care to meet patient's needs. Ensure that bedside environment is organized and that necessary items are within reach.**	**Patient appreciated altering the care to her needs. Patient reports less fatigue after the administration of oxygen. Will continue to monitor patient's fatigue and alter care to suit her needs.**
4. Need for health teaching related to medication compliance as evidenced by patient stating she has not taken her medication.	**Medication compliance is essential for managing CHF. It helps to manages symptoms and promote patient's quality of life.**	**1.Assess current knowledge of medication compliance.** **2. Educate on importance of maintaining medication compliance.**	**Patient does not appear eager to discuss her medication compliance. Patient denies knowledge of the importance in taking her medications regularly. After education patient states an understanding of the reasoning behind medication compliance. Will continue to provide education and monitor patient understanding.**

Other References (APA):

Swearingen, P. L. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

Patient reports being short of breath. Patient states she has continuous shortness of breath which makes it difficult to sleep at night. Patient admits to medication noncompliance.

Objective Data

Patient's oxygen saturation was 90% during morning vitals. Patient was place on 2L oxygen nasal cannula and saturation levels increased to 97%. Patient's respirations were 22 during am vitals and were 20 with afternoon vitals. Patient has 2+ edema in lower extremities bilaterally. Patient has elevated BNP, troponin and CK-MB. Patient has diminished lung sounds in the lower lobes bilaterally.

Patient Information

Patient is an 85 year old female admitted for SOB and bilateral lower leg edema with a history of CHF.

Nursing Diagnosis/Outcomes

Decreased gas exchange due to fluid in the lungs at the alveolar -capillary membrane as evidenced by low oxygen saturation.
Patient will maintain oxygen saturation of at least 92% until discharge.
Patient will have a consult for home oxygen by discharge.
Fluid overload due to compromised regulatory mechanisms occurring with decreased cardiac output as evidence by 2+ edema in the lower extremities bilaterally.
Patient will have no edema by discharge.
Patient will not experience any weight gain by daily weight tomorrow.
Fatigue with decreased exercise tolerance due to imbalance between oxygen supply and demand occurring with a decrease in cardiac muscle contractility as evidenced by patient stating shortness of breath after getting up to use the bathroom.
Patient will report a decrease in breathlessness by the end of the shift.
Patient will report decreased fatigue by the end of the day tomorrow.
Need for health teaching related to medication compliance as evidenced by patient stating she has not taken her medication.
Patient will state an understanding of medication compliance by discharge.
Patient will demonstrate why it is important to maintain medication compliance by discharge.

Nursing Interventions

1.Adminsiter oxygen as prescribed.

2.Monitor oxygen saturation levels.
1. Assess daily weights in the morning.

2. Administer diuretics as prescribed.

1.Assess patient's physiologic response to activity and report significant findings.

2. Coordinate care to meet patient's needs. Ensure that bedside environment is organized and that necessary items are within reach.
1.Assess current knowledge of medication compliance.

2. Educate on importance of maintaining medication compliance.