N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 6/23/2020	Patient Initials HL	Age 90 y/o	Gender Female F
Race/Ethnicity African American	Occupation Retired	Marital Status Widow	Allergies Aspirin
CodeStatus Full	Height 5'5"	Weight 74.4 kg	

Medical History (5 Points)

Past Medical History: Severe aortic stenosis, osteoporosis, arthritis, benign essential hypertension, GERD, Glaucoma, Hyperlipidemia, Hypertension, Hypothyroidism

Past Surgical History: Hysterectomy, Cholecystectomy

Family History: Father: cancer

Social History (tobacco/alcohol/drugs): Patient has not done drugs and only has drank occasionally in the past.

Assistive Devices: Walker/Lift chair at home/Shower chair at home

Living Situation: Patient lives at home with her grandson.

Education Level: High School

Admission Assessment

Chief Complaint (2 points):Patient fell at home. (worsening Dyspnea & fluid overload-Hypoxia with CHF.

History of present Illness (10 points):: 90-year-old female patient had a few falls over the past few months. She is being seen today for her latest fall. Family reported she fell getting out of chair. Patient is alert and oriented times 3 and cooperative currently. Patient did not lose consciousness and reports no symptoms associated with dizziness, light headedness, headache, back pain—patient does report more shortness of breath. She has had shortness

of breath over the past month, but it has increased significantly within the last three days. She develops shortness of breath when she exerts herself. Her pain does not radiate. Patient currently is on oxygen at 2 liters while at home.

Primary Diagnosis

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

Secondary Diagnosis (if applicable): n/a

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

Congestive heart failure (CHF) is a clinical condition mainly resulting from a weakened ventricular muscle the is unable to pump blood sufficiently into the arterial circulation (Capriotti & Frizzell, 2016). Heart failure affects 5 million people living in the United States and causes 300,000 deaths annually (Capriotti & Frizzell, 2016). This lack of blood supply creates lack of tissue perfusion in the body. In the case of this patient, she has acute on chronic systolic congestive heart failure. Additionally, the patient is African American, and African Americans mortality risk from heart failure is 2.5 times greater compared to Caucasian individuals (Capriotti & Frizzell, 2016). CHF occurs when the heart failure is accompanied by fluid retention. The lack of tissue perfusion from the inability of the heart to contract properly causes profound systemic effects within the body.

In the case of CHF, many adverse effects can occur in the body. These may include: dyspnea, coughing, malaise, edema, weight gain, and urinary frequency. The patient was experiencing much dyspnea, especially on exertion. She also mentioned how fatigued she felt most of the time. Lack of energy and dyspnea are the main symptoms of this patient.

There can be multiple causes of CHF. These may include: diabetes, high blood pressure, heart valve disease, cancer treatments (chemotherapy. radiation), thyroid disease, HIV and AIDs, and alcohol or drug abuse. In the case of this patient, her past medical history includes hypertension and hypothyroidism. The patient's advanced age along with these medical conditions likely contributed to her CHF. Since the patient is short of breath, she most likely has pulmonary edema. Pulmonary edema occurs from the hydrostatic pressure in the lungs. The fluid in the body can override the thoracic space creating congestion and difficulty breathing (Capriotti & Frizzell, 2016). On a cellular level, the fluid in the alveoli of the lungs prevent gas exchange (oxygen) from occurring. The fluid prevents normal diffusion that should occur between inhaled air into the lungs and the transfer of oxygen via the blood capillaries of the lungs to the rest of the body.

Some common diagnostic testing that is completed includes chest Xray along with blood testing. Chest X ray is a common diagnostic test to view the lungs and to identify if there are any abnormalities present. An Xray was completed to check for any abnormalities and thickened septal lines due to interstitial edema were found for this patient. The patient's lab values that indicate CHF include low RBC count, H & H, increased BUN and creatinine levels, and an elevated troponin level. The lack of RBCs along with H & H are common findings in the elderly. These low levels contribute to anemia and the patient's weakness and lack of energy. The increased BUN and creatinine levels are due to her chronic hypertension and heart failure.

Treatments that are initiated for CHF patients include: oxygen administration, medications (angiotensin converting enzyme inhibitor -ACE inhibitor, beta-blocker, and hydralazine), diuretics, aldosterone inhibitor, restrict dietary sodium, monitor weight along

with intake and output, restrict fluids as appropriate. The patient is currently on 2 liters of oxygen at the hospital and at home. The patient is also on constant pulse oxygen saturation to assess her oxygen level in her body. Additionally, the patient is on ACE inhibitors, hydralazine, and intake and output to manage her CHF.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J.P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

Van Leeuwen, A. M.,& Bladh, M.L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7ed.) Philadelphia, PA:F.A. Davis Company.

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**	**3.84**	**3.46**	**Red blood cells can be low due to anemia, which is very common in the elderly population (Capriotti & Frizzell, 2016).**
Hgb	**13.0-16.5**	**11.5**	**10.6**	**Hemoglobin can be low as a result of chronic disease, immune disorders, or cancer-NSAID use, aging (osteoporosis) (Capriotti & Frizzell, 2016).**
Hct	**36.0-47.0**	**36.3**	**32.4**	**Hematocrit levels can be low due to the lack of mobility, low vitamin D levels and/or chronic disease (Capriotti & Frizzell, 2016).**
Platelets	**140-440**	**195**	**172**	Click here to enter text.
WBC	**4-12.00**	**5.50**	**7.40**	

Neutrophils	**47.0-73.0**	**62.1**	**67.2**	
Lymphocytes	**18.0-42.0**	**24.7**	**19.5**	
Monocytes	**4.0-12.0**	**10.8**	**11.3**	
Eosinophils	**0.0-5.0**	**1.8**	**1.2**	
Bands	**N/A**	**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**	**144**	**143**	
K+	**3.5-5.1**	**3.8**	**3.6**	
Cl-	**98-107**	**110**	**107**	
CO2	**21-31**	**26**	**27**	
Glucose	**70-99**	**99**	**93**	
BUN	**7-25**	**30 H**	**31H**	**Elevation likely due to chronic hypertension and congestive heart failure (Capriotti & Frizzell, 2016).**
Creatinine	**0.50-1.20**	**1.51 H**	**1.63 H**	**Elevation likely due to chronic hypertension and congestive heart failure (Capriotti & Frizzell, 2016).**
Albumin	**3.5-5.7**	**N/A**	**N/A**	
Calcium	**8.6-10.3**	**8.8**	**8.6**	
Mag	**1.5-2.5**	**1.6-2.6**	**N/A**	
Phosphate	**2.5-4.5**	**N/A**	**N/A**	

Bilirubin	**0.0**	**N/A**	**N/A**	
Alk Phos	**34-104**	**N/A**	**N/A**	
AST	**13-39**	**N/A**	**N/A**	
ALT	**7-52**	**N/A**	**N/A**	
Amylase	**23-470**	**N/A**	**N/A**	
Lipase	**20-86**	**N/A**	**N/A**	
Lactic Acid	**300-239**	**N/A**	**N/A**	
Troponin	**0.000-0.040**	**).050 H**	**0.120H**	**This lab can be high due to cardiac output problems and damage happening in relation to CHF (Capriotti & Frizzell, 2016).**
CK-MB	**0.36**	**N/A**	**N/A**	
Total CK	**N/A**	**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	**0.9-1.1**	**N/A**	**N/A**	
PT	**10.1-13.1**	**N/A**	**N/A**	
PTT	**25-36**	**N/A**	**N/A**	
D-Dimer	**<0.5**	**N/A**	**N/A**	
BNP	**N/A**	**N/A**	**N/A**	
HDL	**N/A**	**N/A**	**N/A**	
LDL	**N/A**	**N/A**	**N/A**	

Cholesterol	**N/A**	**N/A**	**N/A**	
Triglycerides	**N/A**	**N/A**	**N/A**	
Hgb A1c	**N/A**	**N/A**	**N/A**	
TSH	**0.270-4.200**	**N/A**	**0.138 L**	**Thyroid function can be low due to hypothyroidism and also may be questionable if client is compliant with her medication and/or needs dosage adjustment (Capriotti & Frizzell, 2016).**

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	**5.0-9.0**	**N/A**	**N/A**	
pH	**5.0-8.5**	**N/A**	**N/A**	
Specific Gravity	**1.001-1.035**	**N/A**	**N/A**	
Glucose	**Neg**	**N/A**	**N/A**	
Protein	**Neg**	**N/A**	**N/A**	
Ketones	**Neg**	**N/A**	**N/A**	
WBC	**Neg 0-5**	**N/A**	**N/A**	
RBC	**Neg 0-5**	**N/A**	**N/A**	
Leukoesterase	**Neg**	**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	**N/A**	**N/A**	**N/A**	**N/A**

PaO2	**N/A**	**N/A**	**N/A**	**N/A**
PaCO2	**N/A**	**N/A**	**N/A**	**N/A**
HCO3	**N/A**	**N/A**	**N/A**	**N/A**
SaO2	**N/A**	**N/A**	**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	**N/A**	**N/A**	**N/A**	**N/A**
Blood Culture	**N/A**	**N/A**	**N/A**	**N/A**
Sputum Culture	**N/A**	**N/A**	**N/A**	**N/A**
Stool Culture	**N/A**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (APA):

CBC and ABG's are consistent with CHF and age-related problems. Low oxygen levels of the blood and red blood cells can cause impaired gas exchange. These tests show what is occuring in relation to blood gases and the red blood cells. Red blood cell levels can show how well the cells are carrying oxygen which can help determine the reasons for low levels in such cases as CHF or other age-related conditions.

Capriotti, T., & Frizzell, J.P. (2016). *Pathophysiology Introductory Concepts and Clinical Perspectives*. Philadelphia, PA: F.A. Davis Company.

Van Leeuwen, A. M.,& Bladh, M.L. (2017). *Davi's Comprehensive Handbook of Laboratory and Diagnostic Tests with Nursing Implications* (7ed.) Philadelphia, PA:F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest Xray, Hip Xray, EKG, CT (Leg and head)

Diagnostic Test Correlation (5 points):

- Hip CT and head CT completed. No fractures of the hip were noted. No hemorrhage was found only age-related changes.
- Chest Xray – thickened septal lines due to interstitial edema
- EKG completed to help monitor the heart.

Diagnostic Test Reference (APA):

Swearington, P. (2018). *All-In-One Nursing Care Planning Resource.* [S.I.]:Mosby. St.Louis, Missouri: Mosby, Inc.

Sorenson, M., Quinn, L., Klein, D. (2019). *Pathophysiology: concepts of human disease*. Hoboken, NJ: Pearson, Education, Inc

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

Home Medications (5 required)

Brand/ Generic	**Albuterol/ ProAir HFA**	**Vitamin D/cholecalciferol**	**Metoprolol tartrate / Lopressor**	**Acetaminophen/ Tylenol**	**Brimonidine/ Alphagan P**
Dose	**2.5 mg**	**400**	**50 mg**	**325 mg**	**0.2% 1 drop**
Frequency	**PRN Q6H**	**Once daily**	**2x/daily**	**PRN**	**TID**
Route	**Inhalation via**	**PO**	**PO**	**PO**	**Topical**

	nebulizer				
Classification	**Bronchodilator**	**Mineral required to regulate calcium and phosphorus/ needed for bone structure**	**Beta blocker**	**Analgesic**	**Alpha Adrenergic Agonist**
Mechanism of Action	**Works by opening the airways/bronchodilation**	**Maintain D levels/low phosphate in the blood**	**Affects the response to nerve impulses in the heart**	**Helps reduce pain and inflammation**	**decreasing the amount of aqueous humor made and increasing the amount that drains.**
Reason Client Taking	**Shortness of breath**	**Reduction in kidney function/ atherosclerosis/ Heparin interacts with vitamin D –u need to eat a diet rich in calcium & vitamin D when on heparin**	**CHFS**	**Pain and joint soreness due to age**	**Open angle glaucoma**
Contraindications (2)	**-Use caution if the pt has hypothyroidism -Seizure disorder, or heart disease should also be discussed with provider before administering**	**-Weakness -loss of appetite**	**-Risk for orthostatic hypotension - bradycardia**	**- Hemorrhage or -liver failure**	**-closed angle glaucoma, -injury or trauma of the eye**
Side Effects/ Adverse Reactions (2)	**Nausea, Nervousness-**	**-Deficiency can cause failure of**	**- Monitor BP,**	**- hypersensitivity,**	**-Irritation, redness, burning, -**

		bone calcification/ -monitor D levels/monitor bone deficiencies	**dizziness-AV block**	**-liver failure**	**compromised vision**
Nursing Considerations (2)	**Monitor patient's vital signs, May increase risk of death or hospitalization in people with asthma**	**Eat food high in calcium and vitamin D Regular blood tests to monitor levels**	**Check pulse rate/to be above 60 monitor BP**	**S/s of bleeding, patient safety**	**Insert eye drops properly- patient education, one eye drop administration**
Key Nursing Assessment(s) /Lab(s) Prior to Administration	**Lung assessment, and pulse ox**	**Vitamin D levels, altered metabolism**	**Monitor BP, vertigo, feelings of dizziness, monitor pulse rate, patient education**	**Liver test, pain scale**	**Assess eye for irritation/complication, tip head back/5 rights med administration**
Client Teaching needs (2)	**-Med Admin of how to use inhaler /Wait 5 min in between inhalers/prime unit before use**	**-To report excessive drowsiness which could be a sign of low vitamin D levels, -Take in the morning for maximum absorption**	**Tell pt to take their BP (pulse) before taking medication -Take w/meals as directed, avoid driving**	**-Pt to let staff know when in pain, -pt to tell staff if stomach irritation occurs**	**-take as directed, -follow up with provider**

Hospital Medications (5 required)

Brand/ Generic	**Bisacodyl/ Ducolax**	**Lovenox/ Enoxaparin**	**Lactobacillus / Bacid**	**Norco/ acetaminophen and hydrocodone**	**Hydralazine/ Apresoline**
Dose	**10 mg**	**30 mg**	**1 capsule of 50 million colonies**	**5-325 mg**	**50mg**
Frequency	**1 X daily**	**1 X daily**	**1 daily**	**PRN Q4H**	**3 times daily**
Route	**PO**	**Sub Q**	**PO**	**PO**	**PO**
Classification	**Laxative/ stimulant**	**anticoagulant**	**antidiarrheal agent**	**Opioid**	**Vasodilator**
Mechanism of Action	**increases the movement of the intestines**	**binds and accelerates the activity of antithrombin III**	**enhancement of the epithelial barrier, competitive exclusion of pathogenic micro-organisms**	**Pain**	**relaxes the muscles in the blood vessels to allow more blood to flow through vessels**
Reason Client Taking	**Constipation**	**DVT prophylaxis while hospitalized.**	**Constipation**	**Pain associated to age related problems/arthritis**	**hypertension**
Contraindications (2)	**Abdominal pain, GI bleed**	**Excessive bleeding, aneurysm**	**Diarrhea/ intestinal gas**	**Hypersensitivity , hepatotoxicity, respiratory**	**Low blood pressure Dizziness , syncope**

				depression	
Side Effects/Adverse Reactions (2)	**Monitor pt stools/for diarrhea, Nausea**	**Monitor for bleeding and B/P/risk of falls due to blood loss**	**Do not give in patients with yeast sensitivities or weakened immune systems**	**Nausea or vomiting can occur, intolerance to pain medications due to age**	**Weakness, low blood pressure,**
Nursing Considerations (2)	**Taken for constipation to avoid straining, monitor stools for effectiveness**	**Educate on S/S of bleeding/Bruising/GI Bleed/ Observe for unusual bleeding/complications of low blood pressure, pt safety**	**Dairy products & yogurt contain lactobacillus education, take prior to eating**	**Monitor respiratory statues of patient, monitor for hypersensitivity**	**Monitor vitals, Up with assistance, I/O's, patient safety**
Key Nursing Assessment(s) /Lab(s) Prior to Administration	**Pt does not have an allergy to drug, 5 rights, Pt not having diarrhea**	**Skin assessment for signs of excessive bruising**	**Take with water, Pt should take sitting up**	**Pulse ox, respiratory status**	**Vitals, I/O's, distal pulses**
Client Teaching needs (2)	**Pt to report signs of bowels not moving, Pt to report cramping or excessive diarrhea to provider**	**Pt safety, pt to use call light to ask for assistance when getting up, Pt to report any signs and symptoms for bleeding /patient to remain free from falls during the hospital stay**	**Take prior to eating/ Patient to take according to medication regimen**	**Opoid pain medication/tell your doctor if you plan to stop/Can be habit forming**	**Medication education to monitor blood pressure at home , avoid orthostatic hypotension with proper measures**

Medications Reference (APA):

Burlington: Jones & Bartlett Learning.*2018 Nurse's Drug Handbook*. (2018). 17th ed.

Burlington:MA

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness: Alert and orientated** **Orientation:X3** **Distress: None noted** **Overall appearance: cheerful and cooperative**	**Pt is sitting up in bed orientated times 3, Pt showing no distress at this time. Pt states she is doing well. Pt speaks good English with normal tone. Pt MAEW for current age and condition. Strength is bilateral and equal. Pt follows commands with no restrictions. Pt has no signs of neurological deficit.**
INTEGUMENTARY (2 points): **Skin color: pink/tan** **Character: dry** **Temperature: warm** **Turgor: Normal** **Rashes: N/A** **Bruises: N/A** **Wounds: N/A** **Braden Score: 20** **Drains present: Y☐ N X** **Type:**	**Pt is African American skin average in color. Skin is fair to dry. Normal elasticity warm to touch. No signs of lesions or wounds. Pt complained of sore bottom. Slight redness to coccyx area foam dressing applied- Pt repositioned to relieve pressure. No open areas. No drainages. Patient states that she is just stiff from being in bed. No rashes normal skin turgor. Hair is gray in color. Braden Scale 20**
HEENT (1 point): **Head/Neck: (please refer to right)*** **Ears: *** **Eyes: ***	**Head is or normal shape with no apparent deviations. Hair is gray. Ears have no drainage or discomfort, tympanic membrane**

Nose: * Teeth: *	**pearly gray. PEERLA within normal limits. Patient does have glaucoma which she takes eye drops for daily. Patient has glasses but only for reading. Pt eyes show no discharge. Pupils are hazy in color but pt states she can still see just fine. No deviation of the septum, turbinate equal bilaterally. No rhinorrhea. No complaints of congestion or nose bleeds. Oral mucosa is pink and moist with no discharge. Patient is missing some teeth but appropriate due to age. Patient states she is able to eat just fine.**
CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Regular no abnormalities Capillary refill: WNL Neck Vein Distention: Y ☐ N X Edema Y ☐ N X Location of Edema: Lower legs and right arm (right arm edema was due to her landing on her side during fall but no broken bone just swelling)	**Placement auscultated x5 for heart sounds. Pt has normal S1 and S2 no abnormalities, no murmurs, no thrills. Pt has normal cardiac rhythm with Regular cap refill, 2 plus swelling and edema of lower extremities and right arm. Pt is on heart monitor. Radial pulses and pedal pulse 2+ . Negative for any vein distention. Pillow placed to raise right arm above the heart to reduce swelling.**
RESPIRATORY (2 points): Accessory muscle use: Y☐ N X Breath Sounds: Location, character	**Pt has Normal lung sounds No Crackles No rhonchi , Pt shows no signs of distress. No accessory muscle use during breathing. No deviations. Pt denies shortness of breath but does state that she does have shortness of breath at home sometimes. Minor wheezing noted on left side patient does have an albuterol order but has no signs of discomfort. Patient currently on room air. Pt states she feels better and is not normally on oxygen at home. Pt does have PRN oxygen order as needed currently at 2 liters.**
GASTROINTESTINAL (2 points): Diet at home: Current Diet Regular Height: Weight: Auscultation Bowel sounds: all 4 noted Last BM: today at 2pm Palpation: Pain, Mass etc.:	**Pt current regular diet. Pt states food tastes better now. Pt denies alcohol use except for a few times socially. No abnormal distention. Bowel sounds in all four quadrants. No tenderness. No masses. No ostomy. No nasogastric tubes. No wounds. Pt has no signs of distress no diarrhea, no constipation, no bloating or irritability. Last bowel movement**

Inspection: **Distention: Abdominal** **Incisions: none** **Scars: 2 past surgical scars visible** **Hysterectomy and gallbladder** **Drains: N/A** **Wounds: N/A** **Ostomy: Y ☐ N X** **Nasogastric: Y ☐ N X** **Size:** **Feeding tubes/PEG tube Y ☐ N X** **Type:**	**today at 2pm.**
GENITOURINARY (2 Points): **Color: yellow** **Character: Clear** **Quantity of urine:400ml** **Pain with urination: Y ☐ N X** **Dialysis: Y ☐ N X** **Inspection of genitals:** **Catheter: Y ☐ N X** **Type:** **Size:**	**Pt uses bedside commode Urine clear no odor, no urgency, no dysuria. Patient denies pain. No irregularities or discharge. Output 400ml No dialysis or catheter.** **Lower Pelvic area no abnormalities only redness on bottom** **Female genitalia within normal limits no discharge or lesions. Patient is on I&O's**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM: within normal limits** **Supportive devices: walker** **Strength: equal** **ADL Assistance: YX N ☐** **Fall Risk: Y X N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment Y** **Needs support to stand and walk Y**	. **Pt exhibits normal active ROM bilaterally, Patient states she fell at home "slipped out of the chair" .Pt is a fall risk. Pt needs help to stand and support. Pt states at home family does assist with mobility and errands. Grandson lives with her full time.** **No clubbing noted, no effusions, no cyanosis – positive for myalgias right hip –currently no neck or back pain,**
NEUROLOGICAL (2 points): **MAEW: Y X N☐** **PERLA: Y X N☐** **Strength Equal: Y X N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:X3** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**Pt is sitting up in bed orientated time 3, Pt showing no distress at this time. Pt speaks good English with normal tone. PT MAEW for current age and condition. Strength is bilateral and equal. Pt follows commands with no restrictions. Pt has no signs of neurological deficit- Braden Scale 20 No headache, mo gross focal neurological defects. No cranial nerve deficits.**

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):**	**Pt states slightly tired from being in the hospital and states her grandson takes very good care of her and a daughter that is currently her POA** **High school education** **African American** **Very happy with family very supportive**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	**78**	**128/76**	**20**	**98.0**	**100**
1500	**76**	**126/74**	**18**	**97.9**	**100**

Vital Sign Trends:

Vital Sign Trends: Patient had stable vitals during my clinical and denied pain at this time.

Patient was on a heart monitor blood pressure was within normal range.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1300	**0**	**N/A**	**N/A**	**N/A**	**Pt denies pain at this time**
1400	**0**	**N/A**	**N/A**	**N/A**	**Pt denies pain at this time**

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.:**	Patient currently did not have an IV—The staff had to many unsuccessful attempts at the time of my clinical-Pt was to receive a central line but staff waiting for it to be scheduled

IV dressing assessment:	

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
120+120+300=540 ml	**400ml**

Nursing Care

Summary of Care (2 points)

Overview of care:): Patient is very interactive with staff. Patient has a good support system with her family. The nursing student assisted the nurse with the taking the patient's vital signs and assisting to the bathroom as needed. The nursing student observed the interaction of the nurse with the patient and her family members. The nursing student also assisted with administering some of the patient's medicines. Patient seems satisfied with care. Patient not in any pain nor does she show signs of discomfort. Patient breathing unlabored and he showed no signs of distress throughout the day. Vitals are stable. Patient oxygen levels stayed within normal ranges. No labored breathing or difficulty as this time. Patient very cooperative with care and looking forward to returning home with family.

Procedures/testing done: Labs and Xray of the hip and chest—were all clear of any abnormalities or fractures.

Complaints/Issues: Patient had no complaints at this time.

Vital signs (stable/unstable): Vital signs were stable throughout the clinical time I was there. Patient did have heart monitor and vitals were within normal ranges.

Tolerating diet, activity, etc.: Patient on regular diet.

Physician notifications: Patient to follow up with provider.

Future plans for patient: Patient will probably return home since x-rays were negative for any fracture. Family is very active with care of their mother and grandmother. Patient will

continued to be monitored while in the hospital. Discharge planning will be discussed near the end of the patient's hospitalization.

Discharge Planning (2 points)

Patient will need medication administration education, home oxygen, and designated caregivers (grandson and daughter). Patient should be evaluated to see if she qualifies for continued home therapy and care assistance. Patient currently does not drive states grandson and family will provide transportation. Patient does currently qualify for home health services such as in home assistance with bath or ambulation skills which will be helpful until she regains her strength. Patient currently has an oxygen concentrator at home in case she needs it. Neither patient nor family members smoke. Home and in public oxygen use safety precaution education will be helpful at this time. Family education on throw rugs, shower chairs, grab bars, and other assistive devices to reduce the chances of patient falls.

Discharge location: Home Preferably as requested per family-Home rehab services

Home health needs (if applicable): Patient has current home healthcare and family members that attend to help her with her daily routines.

Equipment needs (if applicable): Patient has necessary equipment at home

Follow up plan: Patient to follow up with provider in a week and patient to attend or have home care for any rehabilitative services—home care as scheduled

Education needs: Patient needs to be more clear on safety concerns and asking for help when needing assistance to ensure patient safety to avoid future falls.

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis	• Explain why the		• How did the patient/family

with "related to" and "as evidenced by" components	nursing diagnosis was chosen		respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Pt at risk for decreased cardiac output RT altered myocardial contractility AEB generalized weakness and frequent falls	**Weakness and falls**	**1. Assess vital signs Q4H** **2. Strength assessment before each transfer out of bed**	**Pt to use gait belt and walker when out of bed and use bed or chair alarm for safety** **Pt to have no respiratory distress with care**
2. Pt at risk for fluid volume excess RT increased sodium and water retention AEB bilateral lower extremity edema and dyspnea on exertion	**Respiratory instability and BLE edema due to CHF**	**1. Saturations less than 90% to PRN oxygen** **2. Check pulse ox with any episode of dyspnea at rest or with exertion**	**Pt to be able to increase activity to complete tasks as tolerated daily** **O2 Saturation during clinical time was above 90%**
3. Self-care deficit RT fatigue from the increased work of breathing	**ROM activities as tolerated to improve mobility**	**1. Pt goal to assist with ROM's without exhaustion or fatigue** **2. Pt to have therapy consult (PT/OT) to improve mobility**	**Pt to perform ROM's with increased mobility**
4. Chronic low self-esteem related to chronic	**As evidenced by CHF and lack of activity**	**1. Pt to meet with social service for coping skills** **3. Pt to have positive**	**Pt to exhibit positive expression with completing tasks**

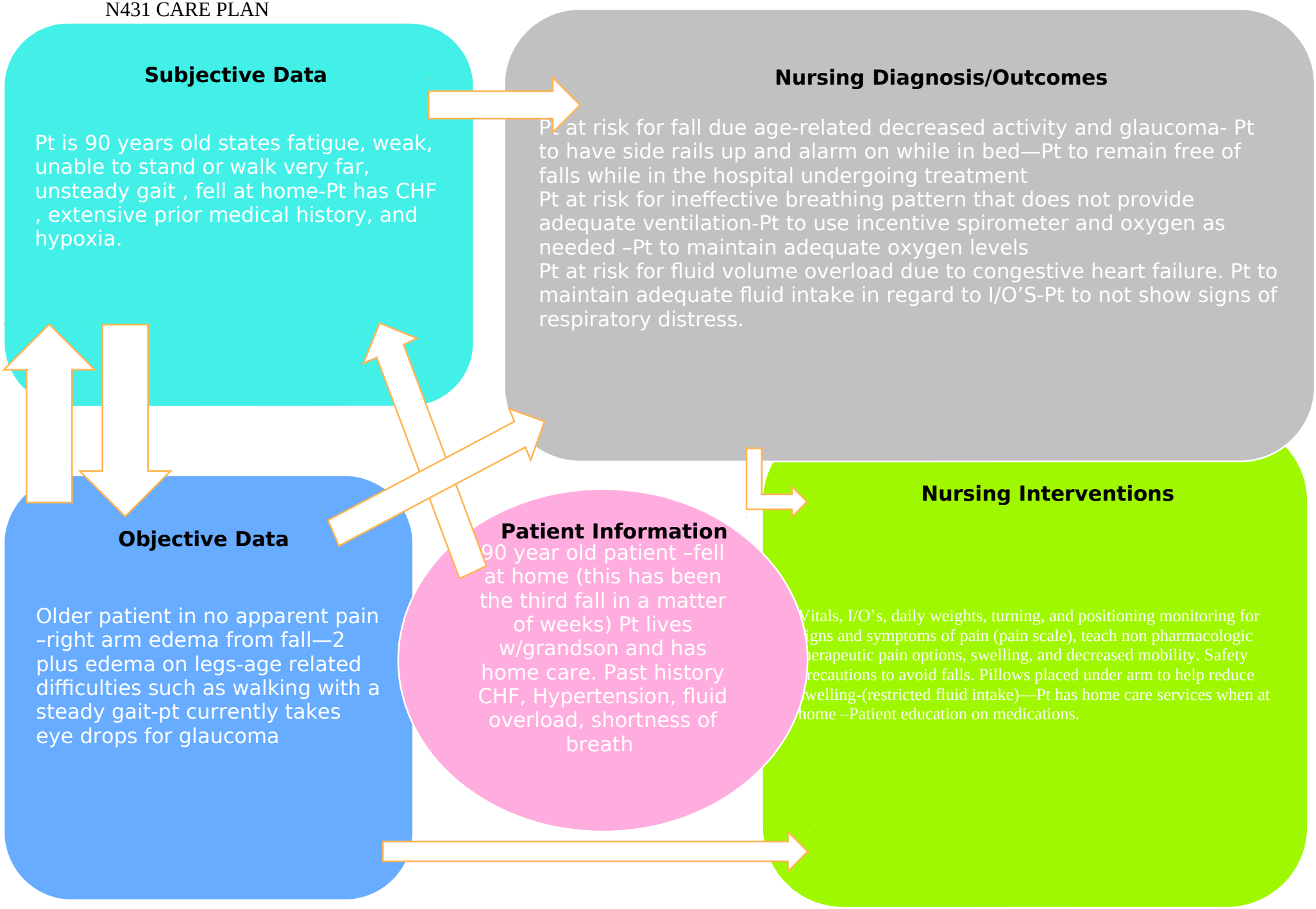
illness		**attitude toward health improvement/increasing social interaction** **4. Pt to have therapy consult (PT/OT) to improve mobility**	**Pt to interact with home activity as tolerated daily**

Other References (APA):

Swearington, P. (2018). *All-In-One Nursing Care Planning Resource.* [S.I.]: MOSBY. St.Louis, Missouri: Mosby, Inc.

Sorenson, M., Quinn, L., Klein, D. (2019). Pathophysiology: concepts of human disease. Hoboken, NJ: Pearson, Education, Inc

Concept Map (20 Points):


Subjective Data
Pt is 90 years old states fatigue, weak, unable to stand or walk very far, unsteady gait , fell at home-Pt has CHF , extensive prior medical history, and hypoxia.
Nursing Diagnosis/Outcomes
Pt at risk for fall due age-related decreased activity and glaucoma- Pt to have side rails up and alarm on while in bed—Pt to remain free of falls while in the hospital undergoing treatment
Pt at risk for ineffective breathing pattern that does not provide adequate ventilation-Pt to use incentive spirometer and oxygen as needed –Pt to maintain adequate oxygen levels
Pt at risk for fluid volume overload due to congestive heart failure. Pt to maintain adequate fluid intake in regard to I/O'S-Pt to not show signs of respiratory distress.
Objective Data
Older patient in no apparent pain –right arm edema from fall—2 plus edema on legs-age related difficulties such as walking with a steady gait-pt currently takes eye drops for glaucoma
Patient Information
90 year old patient –fell at home (this has been the third fall in a matter of weeks) Pt lives w/grandson and has home care. Past history CHF, Hypertension, fluid overload, shortness of breath
Nursing Interventions
Vitals, I/O's, daily weights, turning, and positioning monitoring for signs and symptoms of pain (pain scale), teach non pharmacologic therapeutic pain options, swelling, and decreased mobility. Safety precautions to avoid falls. Pillows placed under arm to help reduce swelling-(restricted fluid intake)—Pt has home care services when at home –Patient education on medications.