

**De Anza College
Suzie Student
01/01/12**

Critical Thinking Worksheet

Pathophysiology

One of the most common causes of aortic stenosis in geriatric population is senile fibrocalcific degeneration of the aortic valve. Valve becomes thicker and stiffer as a result of lipid deposits, collagen degeneration, fibrosis and calcium deposits. Predisposing factors are hypertension, diabetes mellitus, hyperlipidemia, tobacco abuse, sedentary life style, and advanced age. Aortic stenosis (narrowing of the valve orifice) causes obstruction of blood flow from the left ventricle to the aorta during systole which results in left ventricular hypertrophy and increased myocardial oxygen consumption. When compensatory mechanisms fail, pulmonary hypertension and diastolic heart failure occur as a result of decreased stroke volume and critically decreased cardiac output due to impaired ability of the stiff ventricles to relax and fill during diastole (LHD 880, 822). The decreased cardiac output results in decreased perfusion to the kidneys and causes renal insufficiency. In the presence of diabetes, perfusion to the kidneys is impaired even further due to diabetic nephropathy which is characterized by damaged small blood vessels that supply the glomeruli of the kidney (LHD 1285). Another consequence of cholesterol-lipid-calcium deposits in the walls of arteries is thickening of the walls of arteries resulting in fibrous plaques causing insufficient blood flow to the body organs. The consequences are especially detrimental when fibrous plaques affect coronary arteries obstructing the blood flow to the heart muscle like in a case of complete left anterior descending occlusion. In a case of complete blockage, the result is acute myocardial infarction (Taber's 192).

Developmental

Patient is a 94-year-old female diagnosed with CHF secondary to progressive aortic stenosis and renal insufficiency. According to Erikson's Theory, patient is in the ego integrity vs despair stage of development. She lives in assisted living facility. She has a son who visits her every day while she is in the hospital and who takes a major part in decision making process regarding her health care, code status and financials. She has close relationships with her daughter-in-law who is involved in her care and makes a lot of efforts to keep her two children in touch with their grandmother. Having high education herself and having worked as an office manager until retirement, patient seems to be very proud of her son's and daughter-in-law's working careers and her grandchildren's college achievements. Patient has a lot of friends, especially in her previous assisted living facility, which she left one year before. Patient states that she misses them a lot and calls them often while at home but that she is not in a right mood to call them from the hospital. Patient's personality type and social skills enable her to interact successfully with other people in give-and-take situations and feel self-worth. Patient demonstrates efforts to support her self-concept by trying to look her best before doctors start their rounds in the morning and by

trying to continue to perform her ADLs independently as much as she can. As a diversion activity, she educates herself by reading all pamphlets and reading material supplied by a dietitian and hospital related to her health issues and watching educational programs on TV about heart disease and heart surgeries. She seems to have found meaning in her life and sees the end of her life without despair as the end of an already fulfilled life. These observations seem to suggest that patient has reached ego integrity. Patient is limited code: she wouldn't like mechanical ventilation or chest compression and she refuses dialysis. Patient demonstrates the following age-related changes: grey hair, wrinkled thinned skin, "sagging" appearance, hypothermia, no hair on extremities, grayish yellow brittle nails, sleep disturbances, mild memory impairment, decreased tactile sensitivity in lower extremities, slight hearing and visual acuity loss, decreased muscle mass.

Health deviations

Patient was admitted to the hospital for acute onset of shortness of breath secondary to pulmonary edema. Patient possibly has pneumonia and cellulitis on her left shin. Last time, patient was hospitalized in 11/2009 with heart failure secondary to progressive aortic stenosis, with known diastolic heart failure and chronic renal insufficiency. Patient admits to salt indiscretion. Patient refuses dialysis. She also has a history of ventricular tachycardia, coronary artery disease with known complete left anterior descending occlusion, diabetes with neuropathy and nephropathy, hypertension, hyperlipidemia and prior tobacco abuse.. Patient is unstable on her feet and very weak. She needs assistance x 1 to transfer to a chair and a walker and assistance x 1 to walk. Patient experiences dizziness and shortness of breath during transfer and when she walks to the bathroom. Patient has slight hearing loss and mild visual acuity impairment for which she wears glasses. Prior to hospitalization patient was fairly independent in ADLs and now is very worried that she won't be able to resume them once she is out of hospital. She demonstrates willingness to follow special diet recommendations and is proactive in her desire to restore her pre-hospitalized activity level but she is afraid that it is too challenging to manage in an assisted living facility where she doesn't have enough options to choose from.

Recommendations for this patient would focus on education and support. Because of patient's physical and mental limitations (mild memory impairment), education should be directed towards not only the patient herself but also toward her primary care giver. They will need to know the signs and symptoms of exacerbation of medical condition she has that require immediate medical attention and measures they can take while waiting for help. They will need to know manifestations of drug toxicity and when to withhold medications. They will also need teaching regarding how to make her environment free of hazards and regarding special diet, exercises and

energy conserving behavior that would fit her multiple health problems and prevent exacerbation of her condition. They will need teaching regarding chronic nature of many of her health problems and the importance of continuing medication therapy even when asymptomatic to keep them under control. They need teaching regarding benefits and risks associated with dialysis and risks of refusal. Since many of these recommendations require 24 hours nursing care, patient would benefit from being placed into a nursing home instead of an assisted living facility.

Critical Thinking Worksheet

Air

1. Breath sounds diminished in RLL, fine crackles before the end of inspiration in LML and LLL. Productive cough. RR 24 -18. Trend ↓ for 2 days. O2 sat. 92-96% on RA. Nasal secretions. T 96.8-98.6 (O). Skin warm, pale, dry.
2. CHF, Admitted with SOB secondary to pulmonary edema, history of tobacco abuse. Possible pneumonia. Nontoxic multinodular goiter. Occasional loose-sounding strong cough productive of thick white-yellowish odorless sputum. More frequent in the morning on rising. Improved since admission. (On admission cough productive of green sputum x 1 day). Moderate amount of clear-whitish, thin nasal secretions. Shortness of breath out of proportion to activity level (during transfer, walking to the bathroom), improved since admission. O2 sat per continuous oxygen therapy (nasal cannula, 2L/min) 90% on 01/08; discontinued per adequate O2 sat on RA 01/10. Symmetrical chest expansion with inspiration, no accessory muscle use. No cyanosis, no clubbing of fingers. Chronically sleeps on 2 pillows to avoid orthopnea. Alert and oriented x 2 (doesn't know the year). Positive MRSA culture in nares. Patient states that upper respiratory infections have been going around her institution. WBC Trend ↓ from 20 (leukocytosis) on admission to 7.6. Lymphocytes 23.7 -L; Monocytes 10.9-12.7-H. Trend ↑. Pulmonary edema presented on admission improved with the Lasix drip per chest X-ray. There are still persistent right basilar infiltrate per chest X-ray. Low-grade temperatures on admission (max 37.9), improved to normal. C/o chills. On antibiotic Zosyn, 2.25 grams IV q 6hrs per possible pneumonia. Daily I & O (01/11): 2055 ml-input, 1304 ml-output, net 751ml; Hgb 10.2-9.1 -L, Trend ↓; Hct. 30.2-27.6-L, Trend ↓; CO2 22-25, Trend ↑. Medications: Lasix.
3. Since diastolic CHF affects gas exchange by causing pulmonary hypertension and pulmonary congestion, assessed for s/s of pulmonary edema (adventitious lung sounds, dyspnea, orthopnea, tachypnea). Assessed for s/s of respiratory infection as a factor that

may exacerbate an already compromised respiratory status of patient (productive cough, nasal discharge, elevated temperature, adventitious lung sounds, chills, positive cultures, leukocytosis) differentiating these s/s from s/s of respiratory complications of CHF (pulmonary edema, SOB). Assessed for other predisposing (smoking history, positive for MRSA in nares, sedentary life style, compromised immunity status post chemotherapy and radiation, age-related changes in thoracic walls resulting in incomplete lung expansion), exacerbating (anemia, nontoxic multinodular goiter, fluid overload, lying flat, ↑activity level) and alleviating factors (HOB↑, Lasix, antibiotic, nasal cannula, adaptive behavior) factors, the degree of respiratory impairment (SOB, skin changes, O₂ sat, respiratory effort, behavioral changes due to possible impaired cerebral perfusion), and any trends in symptoms over time to assess effectiveness of treatment and be able to tune nursing interventions accordingly.

4. Impaired gas exchange r/t fluid collection in the lung alveoli secondary to increased pulmonary venous pressure due to decreased efficiency of left ventricle; immobility, altered oxygen-carrying capacity of blood secondary to iron-deficiency anemia; collection of secretions affecting O₂ exchange across alveolar membrane secondary to inflammatory process **aeb** increased respiratory rate, shortness of breath, dyspnea on exertion, cough productive of moderate amount of thick, white-yellowish sputum.
5. Monitor RR, respiratory effort, O₂ sat, lung sounds q 4 hrs. Patient will experience less dyspnea on exertion by discharge. Collaborate with RT prn. Administer Lasix as ordered. Maintain fluid restrictions.

Water/Food

1. BP 205/105 on admission, 138/72 and 111/67 (Day 1); 148/69 and 152/72 (Day 2). Heart rate 140 on admission, 80 and 83 (Day 1), 78 and 80 (Day 2). Heart rate is regular. Weight 68.0 kg on admission (height 152 cm); 68.4 kg (Day 1), 68.5 kg. (Day2). Trend ↑ 0.5 kg for 5 days. Skin turgor adequate. Moist mucous membranes. 2+ pitting edema on left foot and ankle, 1+ pitting edema on right foot and ankle on admission, improved to 1+ pitting edema on left foot and ankle and no edema on right lower extremity on 01/12. I& O (01/10): 1120 ml intake, 2033ml output, net -913ml. I & O (01/11): 2055 ml-intake, 1304 ml-output of light yellow, clear urine, net 751ml. Trend for output ↓. Good appetite. Ate 98% breakfast and 75% lunch on day 1; ate 80% of breakfast on day 2. No problems with chewing and swallowing, artificial dentures in place. Able to feed herself.

2. CHF, multifactorial due to diastolic heart failure, aortic valve disease, and chronic renal insufficiency. Coronary artery disease with known complete left anterior descending occlusion, negative thallium scan in 2001. History of ventricular tachycardia, on which she is on Amiodarone, 200 mg daily. History of GERD, diabetes mellitus with nephropathy, prior to tobacco abuse, hypertension, hyperlipidemia. No history of alcohol abuse. Chest X-ray on admission reveals cardiomegaly and heart failure. Low-pitched early systolic ejection murmur in the aortic region radiating up to the suprasternal notch along the left sternal border. S1, S2 auscultated, no gallops. Pedal and femoral pulses palpable bilat., no right posterior tibial pulse. No jugular venous distention. Bowel sounds active X 4 quadrants, abdomen soft, obese, without any obvious organomegaly or masses. Had been compensated on 60 mg of Lasix per day prior to hospitalization, Switched from continuous Lasix IV drip infusion, 8 mg /hour on admission to intermittent IV Lasix, to PO Lasix 80 mg per day currently. On strict fluid restrictions: 1500 ml of fluids per day.. Patient admits to recent salt indiscretion. Refuses dialysis. Patient demonstrated willingness to follow special diet recommendations, but stated that it might be too challenging for her since she lives in assisted living facility and there she doesn't have a lot of choices to choose from. Patient read all pamphlets provided by a dietitian. The next day she forgot about the dietitian's visit but remembered that she needed to limit salt and sugar intake. Labs: Na 141-N on admission, the following days: 134-141 L-N (Normal range:135-145) Trend ↑; Cl 110-N on admission, the following days: 98-110 L-N (Normal range: 101-111) Trend ↑; Hct 36-27.6% -L(Normal range 35%-47%) Trend↓; BNP 1886-H (Normal range < 100) Trend ↓; Troponin-I 0.09-0.74-H (Normal range: <0.04) Trend ↑. Hgb 10.2-9.1-L. (Normal range 12-15) Trend ↓; BUN 37-78-H (Normal range:10-31 mg/dL) Trend ↑; Creatinine 2.3-3.4-H (Normal range: 0.5-1.1 mg/dL) Trend ↑, GFR 17.1-13.5-L (Normal >30) Trend ↓; Potassium 4.3-3.7 -N (Normal range:3.5-5.0 mEq/L); Glucose (Accucheck) 331-129-H (Normal range: 70-100) Trend ↓ (controlled with insulin Aspart per sliding scale).
3. Since CHF results in poor tissue perfusion, it is imperative to check color, temperature, diaphoresis, hair growth pattern, circumference and pulses in all extremities bilat. for symmetry. Since CHF also affects renal blood flow, decreasing it significantly, assessed for sodium and water retention (lab values, weight changes, I&O, BP, crackles in lungs) and peripheral edema. Assessed for bowel function since decreased blood flow due to CHF can also affect digestive tract. Since decreased cardiac output due to CHF may result in hepatic congestion and edema in abdominal cavity, assessed abdomen for

hepatomegaly and ascites; assessed appetite for anorexia. It is also important to assess for cardiovascular risk factors (elevated serum lipids, hypertension, tobacco use, sedentary life-style, diabetes mellitus, high salt intake, anemia) to be able to put them under control and minimize their possible contribution to deterioration of patient's health condition (by diabetic, low-sodium, low triglyceride, high-iron content diet, minimizing stress and anxiety, exercise plan) . Assessed for any changes in vital signs, diagnostic studies and lab values over the period of hospitalization to measure the effectiveness of treatment and interventions. Since patient in on diuretic therapy and has chronic renal insufficiency, it is important to assess for s/s of dehydration (dry mucous membrane, poor skin turgor, low BP) and potassium depletion. Assessed patient's compliance with diabetic and low-sodium diet and medication therapy prior to hospitalization and her willingness and ability to comply with treatment regimen after discharge from the hospital to plan interventions regarding education and support accordingly.

4. Decreased cardiac output r/t altered myocardial contractility secondary to aortic stenosis and diastolic dysfunction, cardiac structural changes aeb tachycardia, decreased urine output, increased BP, diminished lung sounds bilaterally, dependent edema of lower extremities, SOB and tachypnea on exertion.
5. Monitor BP, heart rate, lung sounds, respiratory effort q 4 hrs. Patient's c/o fatigue will decrease by discharge. Administer Lasix, heart medications as ordered. Monitor K+, blood glucose, I/O. Collaborate with a dietician as ordered. Daily weights. Maintains fluid restrictions as ordered.

Elimination

1. Bowel sounds active X 4 quadrants, abdomen soft, obese, without any obvious organomegaly or masses. Able to control bowel movement. Moderate amount of loose, brown stool x2 (Day1), x1 (day2). I& O (01/10): 1120 ml intake, 2033ml output, net - 913ml. I &O (01/11): 2055 ml- intake, 1304 ml-output of light yellow, clear urine, net 751ml per Foley catheter. Trend for output ↓. Ate 98% breakfast and 75% lunch on day 1; ate 80% of breakfast on day 2.
2. Diastolic heart failure, chronic renal insufficiency, diabetes mellitus with nephropathy and neuropathy, history of GERD, hypertension, hyperlipidemia. Weight 68.0 kg on admission (height 152 cm); 68.4 kg (Day 1), 68.5 kg. (Day2). Trend ↑ 0.5 kg over 5 days' period. Skin turgor adequate, moist mucous membranes. 2+ pitting edema on left foot and ankle, 1+ pitting edema on right foot and ankle on admission, improved to 1+ pitting

edema on left foot and ankle and no edema on right lower extremity on 01/12. Had been compensated on 60 mg of Lasix per day prior to hospitalization. Switched from continuous Lasix IV drip infusion, 8 mg /hour on admission, to intermittent IV Lasix, to PO Lasix, 80 mg per day, currently. On strict fluid restrictions: 1500 ml of fluids per day. Patient admits to recent salt indiscretion. Refuses dialysis. Patient demonstrated willingness to follow special diet recommendations, but stated that it might be too challenging for her since she lives in assisted living facility and there she doesn't have a lot of choices to choose from. Patient read all pamphlets provided by a dietitian. The next day she forgot about the dietitian's visit but remembered that she needed to limit salt and sugar intake. Patient is unstable on her feet and very weak. She needs assistance x 1 to transfer to a chair and a walker and assistance x 1 to walk. Patient experiences dizziness and shortness of breath during transfer and when she walks to the bathroom. Patient shows concern about her weakness and inability to resume the same level of activity she did before hospitalization such as walking to the bathroom. Labs: Na 141-N on admission, the following days: 134-141 L-N (Normal range:135-145) Trend ↑; Cl 110-N on admission, the following days: 98-110 L-N (Normal range: 101-111) Trend ↑; Hct 36-27.6% -L(Normal range 35%-47%) Trend↓; BUN 37-78-H (Normal range:10-31 mg/dL) Trend ↑; Creatinine 2.3-3.4-H (Normal range: 0.5-1.1 mg/dL) Trend ↑, GFR 17.1-13.5-L (Normal >30) Trend ↓; Potassium 4.3-3.7 -N (Normal range:3.5-5.0 mEq/L);

3. Since CHF affects renal blood flow, decreasing it significantly due to decreased cardiac output, assessed for sodium and water retention (lab values, weight changes, I&O, BP, crackles in lungs) and peripheral edema. Assessed for bowel function since decreased blood flow due to CHF can also affect digestive tract. Since decreased cardiac output due to CHF may result in hepatic congestion and edema in abdominal cavity, assessed abdomen for hepatomegaly and ascites; assessed appetite for anorexia. Since CHF causes fatigue due to decreased cardiac output, impaired perfusion to vital organs, and decreased oxygenation to tissues assessed patient's ability to tolerate walking to the bathroom and her willingness to do it. Assessed for constipation since strain during defecation associated with constipation may cause additional stress on the heart. It is important to assess for any trends in lab values reflecting renal sufficiency and fluid balance to evaluate the effectiveness of the interventions and treatment since the older adults cannot tolerate dehydration and fluid overload due to decreased ability to concentrate urine.

4. Excess fluid volume r/t sodium/ water retention secondary to cardiac failure, age-related glomerular sclerosis aeb breath sounds diminished in RLL, fine crackles before the end of inspiration in LML and LLL., weight gain, hypertension, pitted edema on lower extremities, dyspnea on exertion, decreased urine output.
5. Continue to monitor daily weights, I& O, creatinine level, Na⁺, K⁺, Cl⁻ level. Monitor BP, heart rate, hydration status, I & O q 4 hours. Patient will improve his fluid balance by discharge. Monitor bowel status (BM's)- number and quality.

Activity /rest

1. Patient is unstable on her feet and very weak. She needs assistance x 1 to transfer to a chair and a walker and assistance x 1 to walk. Patient experiences dizziness and shortness of breath during transfer and when she walks to the bathroom. Patient is able to perform simple tasks of ADLs such as brushing her hair, washing her hands, do mouth care, open all food packages and eat by herself. Prior to hospitalization she was fairly sedentary. Slightly decreased ROM in lower extremities. Full ROM in neck. Significant loss of muscular mass and strength. Able to roll in bed by self, not able to sit up in bed by self. c/o not being able to sleep at night. Takes several naps during the day.
2. CHF, pulmonary edema, possible pneumonia, left anterior occlusion, hypertension, chronic renal insufficiency, CAD with known complete history of carpal tunnel, nontoxic multinodular goiter, gout, anemia. C/o lower back pain while walking 3(10), c/o weakness in legs while walking. Chronically sleeps on 2 pillows to prevent orthopnea. Prior to hospitalization patient was fairly independent in ADLs and now is very worried that she won't be able to resume them once she is out of hospital. She is proactive in her desire to restore her pre-hospitalized activity level.
3. Since fatigue is one of the earliest signs of CHF, assessed for fatigue associated with activities that normally have not been tiring for patient before hospitalization. Assessed the patient's tolerance to activities to set up a base line for evaluating effectiveness of interventions and treatment. Assessed for factors contributing to patient's fatigue to be able to put them under control and minimize their affect . Assessed patient's willingness to resume her prior activity level to be able to plan for valued or desired activities.
4. Activity intolerance r/t fatigue secondary to cardiac insufficiency, imbalance between oxygen supply and demand secondary to pulmonary congestion aeb dyspnea on exertion, shortness of breath out of proportion to activity level, weakness.

5. Teach patient to organize tasks before beginning, perform slower purposeful movements and eat small meals to conserve energy and oxygen. Patient will use energy conserving techniques by discharge. Collaborate with PT. Measure O2 sat with activity. May benefit from/ need supplemented O2 with activities.

Solitude and Social Interaction

1. Alert and oriented x 2 (doesn't know the year). Clear speech. Slight hearing loss. Cooperative, anxious and irritable when she doesn't get what she needs straight away. Slight memory loss (didn't recall dietitian visit the next day). Pain 3 (10) in lower back while walking. She lives in assisted living facility. She has a son who visits her every day while she is in the hospital and who takes a major part in decision making process regarding her health care, code status and financials. As a diversion activity, she educates herself by reading all pamphlets and reading material supplied by a dietitian and hospital related to her health issues and watching educational programs on TV about heart disease and heart surgeries.
2. History of depression. Increased wariness about her changed health status. Patient has close relationships with her daughter-in-law who is involved in her care and makes a lot of efforts to keep her two children in touch with their grandmother. Patient has a lot of friends, especially in her previous assisted living facility, which she left one year before. Patient states that she misses them a lot and calls them often while at home but that she is not in a right mood to call them from the hospital. Patient's personality type and social skills enable her to interact successfully with other people in give-and-take situations and feel self-worth.
3. Since decreased cardiac output secondary to CHF and impaired gas exchange secondary to pulmonary edema can affect cerebral perfusion, it is important to assess LOC. Assessed for pain level since pain can affect patient's energy level and desire to communicate. Assessed for any physical challenges that can impede good communication to be able to address these barriers. Assessed social interactions since impaired social interaction can lead to depression that is associated with poor recovery. Assessed for anxiety since it may further increase myocardial workload.
4. Anxiety r/t threat to self-concept, change in health status, unmet needs, threat of death and expressed concern due to change in health status, increased wariness.
5. Uses support system effectively and demonstrates problem-solving skills (step by step increasing independence in ADLs) by discharge.

Be available for patient for listening and talking. Spend time with patient. Explain the situation. Help patient to focus on dealing with problems. Teach stress management techniques (relaxation, meditations, praying).

Prevention of Hazards

1. Alert and oriented x 2 (doesn't know the year). Slight hearing loss. Slight visual acuity loss for which she wears glasses. Foley catheter. Negative urinalysis. Unstable on her feet. Requires assistance x 1 to transfer and a walker and assistance x 1 to ambulate. C/o dizziness, SOB, weakness in legs during ambulation. Saline lock site clear of s/s inflammation. Skin pale, dry, warm, intact except blisters, 3mm in diameter, on left shin with erythema around, 4x4 cm, with warmth and tenderness secondary to cellulites, improved on Day 2 –less erythematic. Walker in patient's room. Call light within reach. Side rails up x 2.
2. CHF, peripheral neuropathy, possible pneumonia, cellulites, MRSA in nares. Carpal tunnel, gout, anemia. Medications: Piperacillin and Tazobactam, Amiodarone, Isosorbite mononitrate, Furosemide. WBC Trend ↓ from 20 (leukocytosis) on admission to 7.6. Lymphocytes 23.7 -L; Monocytes 10.9-12.7-H. Trend ↑.
3. Assessed environmental, physical and mental factors that can predispose patient to risk for falls to be able to address them in timely manner. Assessed patients' medications for such side effects as orthostatic hypotension, dizziness, weakness, vertigo, confusion, ataxia, blurred vision, syncope that can predispose patient for risks for falls. Assessed patient for risk of being invaded by pathogenic organisms such as invasive procedures (IV, Folley catheter), broken skin, poor tissue perfusion, poor gas exchange, chronic diseases, immunosuppressive and antibiotic medications.
4. Risk for fall r/t weakness secondary to decreased cardiac output and anemia, decreased cerebral perfusion, decreased sensation in feet secondary to peripheral neuropathy, limited ROM secondary to age-related changes in joints and gout, side effects of medications.
5. Side rails up x 2. Call light within reach in all times. Slippers on before arising from bed. Assist patient in transfer and ambulating. ROM exercises 3 times a day. Patient is free of falls during hospitalization. Skin assessment q. shift. Good skin care- turning q. 2 hrs., keep skin clean and dry etc.

Developmental Self–Care Requisites

1. 94-year-old female, with slight memory, visual acuity, and hearing loss. According to Erikson's Theory, patient is in the ego integrity vs despair stage of development. She

- lives in assisted living facility. She has a son who visits her every day while she is in the hospital and who takes a major part in decision making process regarding her health care, code status and financials.
2. Patient has close relationships with her daughter-in-law who is involved in her care and makes a lot of efforts to keep her two children in touch with their grandmother. Having high education herself and having worked as an office manager until retirement, patient seems to be very proud of her son's and daughter-in-law's working careers and her grandchildren's college achievements. Patient has a lot of friends, especially in her previous assisted living facility, which she left one year before. Patient demonstrates efforts to support her self-concept by trying to look her best before doctors start their rounds in the morning and by trying to continue to perform her ADLs independently as much as she can. As a diversion activity, she educates herself by reading all pamphlets and reading material supplied by a dietitian and hospital related to her health issues and watching educational programs on TV about heart disease and heart surgeries. She seems to have found meaning in her life and sees the end of her life without despair as the end of an already fulfilled life. These observations seem to suggest that patient has reached ego integrity. Patient is limited code: she wouldn't like mechanical ventilation or chest compression and she refuses dialysis.
 3. Since patient and her primary care giver will need to adapt to her changed health status, assessed patient's willingness, cognitive, psychosocial abilities to take care for herself and her support system to be able to address her needs while she is still in the hospital
 4. Powerlessness r/t chronic debilitating conditions, dependency and expressions of frustration over inability to perform previous tasks.
 5. Follows exercise plan by encouraging ambulating 3 times a day and performing ROM exercises. Patient will express a sense of control over the present situation and future outcome.

Health Deviation Requisites

1. Patient was admitted to the hospital for acute onset of shortness of breath secondary to pulmonary edema. Patient possibly has pneumonia and cellulites on her right shin. Last time, patient was hospitalized in 11/2009 with heart failure secondary to progressive aortic stenosis, with known diastolic heart failure and chronic renal insufficiency.
2. Patient refuses dialysis and admits to salt indiscretion. She also has a history of ventricular tachycardia, coronary artery disease with known complete left anterior descending occlusion, diabetes with neuropathy and nephropathy, hypertension,

hyperlipidemia and prior tobacco abuse. She demonstrates willingness to follow special diet recommendations and is proactive in her desire to restore her pre-hospitalized activity level but she is afraid that it is too challenging to manage in an assisted living facility where she doesn't have enough options to choose from. Her current health status requires 24 hours nursing care; so patient would benefit from being placed into a nursing home instead of an assisted living facility. Medications: Piperacillin and Tazobactam, Amiodarone, Isosorbite mononitrate, Furosemide, heparin, insulin aspart.

3. Because of patient chronic, debilitating conditions require very complicated treatment regimen, assessed for patient's need for support and education.
4. Ineffective therapeutic regimen management r/t complexity of therapeutic regimen, knowledge deficit, lack of recall of already given information, social support deficit and failure to include diabetic and cardiac treatment regimen in daily routine.
5. Prior to discharge patient and her primary care-giver will consider and arrange for placing patient into a facility with 24-hours nursing care. Vital signs q 4 hours, daily weights, strict I & O, compliance with drug regimen, diet and exercise regimen.

Nursing notes:

Date: 12/25/11

Pt. A.S.

07:30-09:30 a.m. Awake in bed asking to transfer to chair. Transferred with assist. x 1. C/o dizziness during transfer. C/o not sleeping at night. A & O x 3. C/o chills, warm blankets provided. Ambulated to bathroom with walker and assist. x 1. Unstable gait. SOB and tachypnea. C/o lower back pain 3 (10) while walking. No pain once sat on a chair. VS: BP 138/72; T 96.8 (O), P. 80, RR 22; O2 sat. 96% on RA. AP 80, normal rhythm, S1, S2 present, no gallops. Murmurs auscultated. No jugular venous distention. CRT=3 sec on UE & LE bilat. Radial and pedal pulses palpable, equal bilat. Dependent edema, pitting +2 on L ankle and foot. Dependent edema, pitting +1 on R foot. Blisters 3mm with erythema, warmth and tenderness on L shin. Sensation present on feet bilat. Lung sounds diminished in the RML and RLL. Crackles in LLL. Loose-sounding cough productive of moderate amount of thick white-yellowish sputum. Nasal discharge, moderate amount, thin, white. Abd. soft, nontender with active bowel sounds x 4 quads. FS BS 129. PRN Insulin Aspart, 1 unit per sliding scale administered. Ate 98% of breakfast. Asked for additional cup of coffee. Fluid restriction regimen explained. Patient expressed understanding. 150 ml or light yellow, clear urine per Foley catheter..S. Student, SN

10:30-11:45 a.m. Slept in the bed. No abnormal respiratory effort.....S. Student, SN, DAC

12:00 p.m. VS: BP 111/67, T 98.6 (O), P83, R 24. O2 sat. 92% on RA. Up in chair. C/o SOB and extreme weakness in legs .C/o chills, warm blankets provided. Ate 75 % of lunch. Dietitian educator visited, explained low-salt and diabetic diet, left pamphlets. Patient read provided information, stated, "It is very useful information, I'll try to follow their advice, but it's quite challenging to follow in assisted living facility". Urine output 325 ml of clear, yellow urine per Foley catheter.....S. Student, SN, DAC