N301 Care Plan

Lakeview College of Nursing

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Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
03/05/2019	SJ	56	Male
Race/Ethnicity White, Caucasian	**Occupation** Disabled	**Marital Status** Single	**Allergies** Patient has no known medication allergies and no known food allergies
Code Status Full Code	**Height** 182.8cm	**Weight** 130kg	

Medical History (5 Points)

Past Medical History:.

- Bilateral coronary artery stenosis
- Coronary artery disease (CAD)
- Chronic myeloid leukemia (CML)
- Chest pain, SOB
- Diabetes mellitus and diabetic foot ulcer
- Dyslipidemia
- Diastolic dysfunction
- Edema
- Hypertension
- Cardiovascular disease
- Morbid obesity
- Peripheral artery stenosis
- Status post thoracentesis
- Stented coronary artery

Past Surgical History:.

- Cardiac catheterization, left heart (10/15/2018)
- Angiogram (07/19/2018)
- Stent placement, date not noted
- Total knee arthroplasty, date and knee not noted

Social History (tobacco/alcohol/drugs, pertinent social factors):.

The patient is currently unemployed due to a disability. The patient did not explain his disability. He lives at home with his girlfriend. His girlfriend was not present at the bedside. Patient says that he was a former smoker of over twenty years but stopped smoking at the age of forty-three. Patient denies any drug or substance abuse. Patient states that he consumes alcohol frequently and abuses it at home. Patient denies any use of glasses or hearing aids. Patient's education level includes a college degree. Patient family history includes his aunt having brain cancer and his grandfather having breast cancer.

Admission Assessment

Chief Complaint (2 points):.

- Mild back pain, epigastric pain

History of present Illness (10 points):.

Patient presented to the ED on 03/04/2019 with complaints of mild back pain for the last two days. Patient states that his pain started in the mild of his back but began to radiate to his epigastric region. Pain has been consistent for the last two days. Patient tried to relieve his pain with Tylenol but stated that the medication did not help relieve his pain at all. Patient denies any GI upset such as nausea and vomiting. Patient also denies chest pain, dyspnea, and palpitations. In the ED, the patient was given Dilaudid and Toradol to help relieve his pain. After

administration of the medication, the patient states his pain is relieved. Upon physical examination, a CBC, chemistry profile, urinalysis, and CT scan were ordered to help determined the etiology of the patient's pain. The CBC and chemistry profile were unremarkable. Lipase was in normal range. Glucose was four hundred. UA shows glucosuria and Ketonuria. CT of abdomen and pelvis shows possible mild pancreatitis. The patient was admitted and is on hospital admission day two.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):.

- Acute pancreatitis without necrosis or infection, unspecified

Secondary Diagnosis (if applicable):.

Pathophysiology of the Disease, APA format (15 points):.

Pancreatitis is defined as the inflammation of the pancreas. Pancreatitis is classified into two categories, acute and chronic. Acute pancreatitis cannot lead to chronic pancreatitis but chronic can be characterized by acute episodes. Acute pancreatitis can be considered a medical emergency. Acute pancreatitis is caused by self-digestion of the pancreas by its own proteolytic enzymes (Cheever & Hinkle, 2017). It is typical that most patients have undiagnosed chronic pancreatitis before their first episode of acute pancreatitis. "Gallstones enter the common bile duct and lodge at the ampulla of Vater, obstructing the flow of pancreatic juice or causing a reflux of bile from the common bile duct into the pancreatic duct, thus activating the powerful enzymes within the pancreas" (Cheever & Hinkle, 2017, p. 1441). Once the enzymes within the pancreas are activated it can lead to complications such vasodilation, necrosis, or erosion. There are other less causes of acute pancreatitis as well. Some other causes include; complication of

mumps or viral infection, blunt abdominal trauma, the use of certain medications like corticosteroids, and other conditions such as hyperlipidemia (Cheever & Hinkle, 2017).

It is important to recognize the risk factors and clinical manifestations of acute pancreatitis so it can be treated before serious complications arise. Risk factors include; biliary tract disease, alcohol use, increased age, metabolic disturbances, kidney failure or transplant, genetics, trauma, penetrating ulcer, medication toxicity, viral infections, and smoking (Cheever & Hinkle, 2017). Clinical manifestations include; severe abdominal pain, abdominal tenderness and back pain, pain occurring twenty-four to forty-eight hours after eating or ingesting alcohol, abdominal distention, nausea, vomiting, fever, jaundice, mental confusion, agitation, respiratory distress, and hypoxia (Cheever & Hinkle, 2017). The patient, SJ, presented to the hospital with mild back pain radiating to his epigastric region. Epigastric region is the biggest clinical manifestation of pancreatitis. SJ stated that he has a past social history of heavy alcohol abuse. Large consumption of alcohol is one of the bigger risk factors for pancreatitis. The past medical history and social history of the patient, SJ, put him at a high risk of developing pancreatitis.

There are multiple diagnostic tests can be run to be helpful in the diagnosis of pancreatitis. Some of the bigger tests include urinalysis, x-rays, CT scans, and serum levels (Cheever & Hinkle, 2017). Upon physical examination in the ED for SJ, a CBC, chemistry profile, urinalysis, and CT scan were ordered and performed. SJ's CBC and chemistry profile were unremarkable. Lipase levels was within normal range. SJ's glucose was elevated highly at four hundred. The urinalysis showed Ketonuria and glucosuria. The CT scan of SJ's abdomen and pelvis showed possible mild pancreatitis. To treat this diagnosis, SJ was put on an NPO diet until he is pain free. A NPO diet helps decrease the irritation and inflammation of the pancreas. Other treatment options include; administering IV fluids and electrolyte replacements, analgesics

and other medications, and surgery as a last option. There are different surgeries that can be used to treat pancreatitis such as; cholecystectomy, sphincterotomy, and pancreatojejunostomy (Cheever & Hinkle, 2017).

Reference:

Cheever, K., & Hinkle, J. (Eds). (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*: Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins

Laboratory Data (15 points)

CBC: Highlight All Abnormal Labs, Explanations must contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.2-6	4.51	N/A	.
Hgb	11.3-15.2	14.2	N/A	.
Hct	33.4%-45.3%	40.6	N/A	.
Platelets	150,000-400,000	135,000	N/A	The patient's platelet count may be low because of thrombocytopenia or thrombocytosis. Both have been associated with acute pancreatitis. There has not been much research on why it is present in pancreatitis (US National Library of Medicine National Institutes of Health, 2014).
WBC	4,000-11,000	7,500	N/A	.
Neutrophils	45.3-79	69.5	N/A	.
Lymphocytes	11.8-45.9	19.1	N/A	.
Monocytes	4.4-12.0	7.8	N/A	.
Eosinophils	0.0-6.3	3.0	N/A	.
Bands	N/A	N/A	N/A	.

Chemistry: Highlight Abnormal

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na+	135-145	130	136	Severe cases of pancreatitis can possibly cause dehydration. If the patient is experiencing severe acute pancreatitis, then he may be experiencing dehydration. He is also NPO which also can affect his hydration status. A disruption in hydration leads to a disruption in electrolyte levels (Cheever & Hinkle, 2017).
K+	3.5-5	4.0	4.0	.
Cl-	98-107	99	100	.
CO2	22-29	22	25	.
Glucose	70-100	400	223	.
BUN	8-25	10	12	.
Creatinine	0.6-1.3	0.98	1.05	.
Albumin	3.5-5.2	3.8	N/A	.
Calcium	8.6-10	8.9	8.8	.
Mag	1.5-2	N/A	N/A	.
Phosphate	0.8-1.5	N/A	N/A	.
Bilirubin	< 1.5	0.5	N/A	.
Alk Phos	50-100	87	N/A	.
AST	10-30	N/A	N/A	.
ALT	10-40	N/A	N/A	.

Amylase	30-125	N/A	N/A	.
Lipase	10-150	55	38	.
Cholesterol	3-5.5	N/A	N/A	.
Triglycerides	<150	N/A	N/A	.
Lactic Acid	0.5-2.4	N/A	N/A	.

Other Tests Highlight Abnormal

Lab Test	Normal Range	Value on Admission	Today's Value	Reason For Abnormal
INR	0.9-1.2	N/A	N/A	.
PT	11-14 sec	N/A	N/A	.
PTT	20-40 sec	N/A	N/A	.
D-Dimer	<250	N/A	N/A	.
BNP	0.5-30	N/A	N/A	.

Urinalysis Highlight Abnormal

Lab Test	Normal Range	Value on Admission	Today's Value	Reason For Abnormal
Color & Clarity	Yellow, clear	Yellow	N/A	.
pH	5.0-8	5.0	N/A	.
Specific Gravity	1.005-1.024	1.030	N/A	.
Glucose	Normal	>500	N/A	Glucose in the urine can indicate serious issues. The patient has uncontrolled diabetes and acute pancreatitis. His uncontrolled

				diabetes can be damaging to the insulin-producing cells in the pancreas which is why the level can be elevated (Cleveland Clinic, 2016).
Protein	Negative-Normal	Negative	N/A	.
Ketones	Negative	2+	N/A	Even though the patient has acute pancreatitis. The patient may be in the early stages of diabetic ketoacidosis (DKA) because he is experiencing high levels of ketones in his urine and has a high blood glucose level. This is indicative of his uncontrolled diabetes (American Diabetes Association, 2015).
WBC	<5	< 1	N/A	.
RBC	0-3	1	N/A	.
Leukoesterase	Negative	Negative	N/A	.

Cultures

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
Urine Culture	Negative	N/A	N/A	.
Blood Culture	Negative	N/A	N/A	.
Sputum Culture	Negative	N/A	N/A	.

Lab Correlations Reference (APA): .

American Diabetes Association. (2015). DKA (Ketoacidosis) & Ketones. Retrieved March 6, 2019, from http://www.diabetes.org/living-with-diabetes/complications/ketoacidosis-dka.html

Cheever, K., & Hinkle, J. (Eds). (2017). *Brunner's & Suddarth's Textbook of Medical-Surgical Nursing*: Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins

Cleveland Clinic. (2016). Pancreatitis. Retrieved March 6, 2019, from https://my.clevelandclinic.org/health/diseases/8103-pancreatitis

Kefeli, A., Basyigit, S., Yeniova, A., Kucukazman, M., Nazligul,Y., & Aktas, B. (2014). Platelet Number and Indexes during Acute Pancreatitis. *US National Library of Medicine National Institutes of Health*, 4(2).

Other Diagnostic Tests (EKG, Echocardiogram, Xrays, CT scan, etc) (5 points): .

- **Complete Blood Count (CBC)**

  Patient presented to the emergency room with mild back pain that begin to radiate to his epigastric region. A CBC was ordered to help determine the etiology of his epigastric pain. A CBC is a blood tests that helps determine a patient's overall health and is used to help detect, or monitor, multiple different conditions (Mayo Clinic, 2018). A CBC is not a definitive test but is used to guide health care providers in the right direction to treat a patient. Upon examination, the patient's CBC was unremarkable. The only abnormality within the CBC was a slightly lowered platelet count.

- **Chemistry Profile**

  A chemistry profile, also known as blood chemistry panel, consists of multiple tests that test for a variety of things. It includes kidney function, blood glucose, fasting lipid, protein, electrolytes, liver, and thyroid tests (John Hopkins Medicine, n.d.). Similar to the patient's CBC, it was unremarkable. There was only an abnormality with the

patient's sodium levels. It was slightly lowered than usual upon admission. As of today, the patient's sodium levels are back to normal.

- **Urinalysis**

  A urinalysis (UA) tests a patient's urine to identify things such as infections, kidney disease, diabetes, or liver disease. The patient's UA showed that he had glucosuria and Ketonuria. Glucosuria is the excretion of glucose in the urine. Ketonuria is a medical condition where a patient has ketone bodies present in their urine. This occurs when the body is using fat for energy (Global Diabetes Community, n.d.). This is indicative that the patient's diabetes is uncontrolled and poorly managed.

- **CT Scan**

  A CT scan takes a series of x-rays at different angles to get a better, more detailed picture of bones, blood vessels, and soft tissue (Mayo Clinic, 2018). A CT scan is used for multiple different reasons. It is used to diagnose conditions, guide procedures, monitor conditions, and monitor the effectiveness of treatments. The patient's CT scan of his abdomen and pelvis showed possible mild pancreatitis. The patient was diagnosed with acute pancreatitis.

Diagnostic Test Correlation, APA Format & References (5 points):.

Global Diabetes Community. (n.d.). Ketonuria. Retrieved March 6, 2019, from https://www.diabetes.co.uk/diabetes-complications/ketonuria.html

John Hopkins Medicine. (n.d.). Blood Chemistry Panel. Retrieved March 6, 2019, from https://www.hopkinslupus.org/lupus-tests/screening-laboratory-tests/blood-chemistry-panel/

Mayo Clinic. (2018). Complete blood count (CBC). Retrieved March 6, 2019, from https://www.mayoclinic.org/tests-procedures/complete-blood-count/about/pac-20384919

Mayo Clinic. (2018). CT scan. Retrieved March 6, 2019, from https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675

Current Medications (10 points, 1 per completed med))

Home Medications (5 required)

Brand/Generic	**Basaglar Kwikpen (insulin glargine)**	**GlipiZIDE (Glucotrol)**	**Isosorbide Mononitrate (monoket)**	**Potassium Chloride (kolyum)**	**Sprycel (dasatinib)**
Dose	90 units	5mg	120mg	20mEq = 1 tab	40mg = 2 tabs
Route	Subcutaneous, QD	PO, BID	PO (every 6-8hrs.)	PO, BID	PO, QD
Classification	Long-acting insulin	Antidiabetic	Antianginal, vasodilator	Electrolyte replacement	Kinase inhibitors
Action	Replaces the insulin that is normally produced by the body and helps move sugar from the blood into other body tissues where it is used for energy	Stimulates insulin release from beta cells in pancreas	Improves cardiac output by reducing mainly preload but also afterload	Acts as the major cation in intracellular fluid, activating many enzymatic reactions including nerve impulse transmission and cardiac and skeletal muscle contraction	Blocks the action of an abnormal protein that signals cancer cells to multiply.
Reason Client Taking	Patient is a Type 2 diabetic	Patient is a Type 2 diabetic	Patient has a past medical history of chest pain	Patient had a low sodium level upon	Patient has chronic myeloid leukemia

				admission	(CML)
Contraindications (2)	ACE inhibitors Other antidiabetic medication	Ketoacidosis Diabetic coma	Angle-closure glaucoma Concurrent use of phosphodiesterase inhibitors	Acute dehydration Disorders that may delay drug passing through GI tract	Anticoagulants Herbal products, especially St. John's wort
Side Effects/Adverse Reactions (2)	Hypoglycemia Lipodystrophy	Abnormal gait Darkened urine	Syncope, weakness Diplopia	Throat pain when swallowing Hyperkalemia	Swelling, redness, and pain inside the mouth Black and tarry stools
Nursing Considerations (2)	Monitor closely for signs of hyperglycemia and hypoglycemia Monitor for signs of fluid retention and heart failure	Monitor patient's CBC closely Check blood glucose level at least three times daily for a patient switching from insulin n to glipizide.	Use cautiously in patients with hypovolemia or mild hypotension. Monitor for increased hypotension Give drug 1 hour before or 2 hours after meals	Administer with or immediately after meals Regularly assess patient for signs of hypokalemia and hyperkalemia	Monitor closely for any adverse effects If patient is taking an antacid, give drug 2 hours before or 2 hours after
Client Teaching needs (2)	Do not operative heavy machinery until the side effects are known Do not drink alcohol or take OTC medicines	Do not skip doses or increase doses Urge patients to carry identification indicating that he has	Notify provider about blurred vision, fainting, increased angina attacks, rash, and severe or persistent headaches Urge patient to avoid alcohol consumption	Teach patient how to take her radial pulse and advise her to notify provider about significant changes in heart rate or rhythm	Keep the medication stored at room temperature and away from excess heat and moisture Unneeded medication

	that contain alcohol	diabetes		Urge the importance of keeping follow-up laboratory appointments	should be given back to a medicine take-back program

Hospital Medications (5 required)

Brand/Generic	**Aspirin (ancasal, arthrinol)**	**Atorvastatin (lipitor)**	**Furosemide (lasix)**	**Lisinopril (prinivil)**	**Ranexa (ranolazine)**
Dose	325mg = 1 tab	20mg = 1 tab	40mg = 1 tab	20mg = 1 tab	500mg = 1 tab
Route	PO (every 4-6hrs.)	PO, QD	PO (every 6-8hrs.)	PO, QD	PO, BID
Classification	Anti-inflammatory, anti-platelet, antipyretic, nonopioid analgesic	Antihyperlipiedmic	Antihypertensive, diuretic	Antihypertensive vasodilator	Antianginal
Action	Blocks the activity of cyclooxygenase which inhibits prostaglandin synthesis. It also interferes with the production of thromboxane A2	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and	Inhibits sodium and water reabsorption in the loop of Hele and increases urine formation	May reduce blood pressure by inhibiting conversion of angiotension I to angiotension II	Inhibits cardiac late sodium current, but how this action inhibits angina symptoms is also unknown

		breakdown			
Reason Client Taking	Pain control	Patient has a past medical history of dyslipidemia.	Patient has a past medical history of edema	Patient has a past medical history of hypertension	Patient has a past medical history of chest pain
Contraindications (2)	Allergy to tartrazine dye Peptic ulcer disease	Active hepatic disease Unexplained persistent rise in serum transaminase level	Anuria unresponsive to furosemide Alcohol	Hereditary or idiopathic angioedema Concurrent aliskiren use in patients with diabetes or patients with renal impairment	Liver cirrhosis Use of CYP3A inducers or strong inhibitors
Side Effects/Adverse Reactions (2)	Tinnitus/ hearing loss Prolonged bleeding	Abnormal dreams Hypotension	Dizziness Elevated cholesterol and triglyceride levels	Vertigo Abdominal pain	Abnormal coordination Hypotension
Nursing Considerations (2)	Don't crush timed-release or controlled-release tablets unless directed Ask the patient about tinnitus. Monitor closely for this adverse effect.	Use atorvastatin cautiously in patients who consume substantial quantities of alcohol or have a history of liver disease because atorvastatin use increases risk of liver dysfunction Monitor diabetic patient's blood glucose levels because atorvastatin therapy can	Give drug in the morning so patient's sleep won't be interrupted by increased need to urinate Obtain patient's weight before and periodically during therapy to monitor fluid loss	Use cautiously in patients with severe aortic stenosis because symptomatic hypotension may occur Monitor blood pressure often	Monitor patient's QT interval, as ordered, because it can prolong it in a dose-related manner Monitor patient's serum magnesium, potassium, and liver enzyme levels

		affect blood glucose control			
Client Teaching needs (2)	Instruct the patient to not taking ibuprofen if taking because ibuprofen reduces the effect of aspirin. Take aspirin with food or after meals to help prevent GI upset.	Take the drug at the same time each day to maintain its effects Notify provider immediately if they experience unexplained muscle pain, tenderness, or weakness, especially if accompanied by fatigue or fever	Take the drug at the same time every day to maintain therapeutic effects Take the drug with food or milk to help reduce GI distress	Educate that this helps to control, but does not cure, hypertension and that patient may need lifelong therapy Seek immediate emergency treatment if having difficulty breathing or swallowing or notices swelling of her eyes, extremities, face, lips, or tongue	Swallow the tablets whole. Do not chew, break, or crush them Limit the amount of grapefruit and grapefruit juice consumed while taking this drug

Lab Reference (APA Format):.

Vallerand, A. H., Sanoski, C. A., & Deglin, J. H. (2017). *Davis's Drug Guide for Nurses* (15 ed.). Philadelphia, PA: F.A. Davis Company.

Assessment

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0745	84	98/56	14	36.3C	97%
Patient was unavailable	.	.	.	.	.

Physical Exam (18 points)

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 awake in bed but appeared to be fatigued. He is A&O x4. Patient says he is fatigued because he did not sleep very well through the night. Patient speaks English at a normal pace. Patient MAEW and his PERLA was intact. His strength is equal bilaterally. Patient does not show any signs of neurological damage.
MUSCULOSKELETAL (2 points): **Neurovascular status, ROM, Supportive devices/strength** **ADL Assistance Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk ☐**	Morse Fall Risk: 45 Patient has active range of motion bilaterally. Patient is a fall risk because of the dilaudid he is given for pain. Patient is up with assistance and to the bathroom x1. Patient has assistance as a precaution. Patient denies the use of any assistive devices such as a walker, wheel chair, or cane at home.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable)** **Peripheral Pulses:** Radial, pedial **Capillary refill:** < 2 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema_____**	Patient is currently on a telemetry monitor. Upon admission, patient was noted to be in normal sinus rhythm. Upon physical examination, heart sounds were auscultated x5. S1, S2 heart sounds were noted. Radial and pedal pulses assess and were bilaterally present, 3+. Patient's capillary refill was less than two seconds. Patient shows no signs or neck vein distention or edema.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Patient's lungs sounds were auscultated both anterior and posterior at each lobe. Patient's lung sounds were clear bilaterally. Patient does not use accessory muscles when breathing. Patient is currently breathing 1L of oxygen through a nasal cannula. Patient denies any shortness of breath and the use of oxygen at home.
GASTROINTESTINAL (2 points): **Diet at home:** Regular	Patient's normal diet at home is a regular diet.

Current Diet: NPO **Height:** 182.8 cm **Weight:** 130kg **Auscultation Bowel sounds:** . **Last BM:** 03/04/2019 **Palpation: Pain, Mass etc** **Inspection: distention, incisions, scars, drains, wounds** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:_____**	Patient's current diet is NPO to prevent further inflammation of the pancreas. Bowel sounds were auscultated and present in all four quadrants. Patient reports pain upon palpation in his epigastric region. Tenderness was noted. No masses or abdominal distention noted. No noted scars, drains, or wounds. Patient has no ostomy, nasogastric tubes, PEG tubes, or drains. Patient's last bowel movement was 03/04/2019. Patient only reports pain in his epigastric region. Patient denies any recent weight loss.
INTEGUMENTARY (2 points): **Skin color** **character, turgor, rashes, bruises:** **wounds:** . **Braden scale : _____** **Drains present: Y☐ N ☒** **Type_____**	Braden Scale: 20 Patient is Caucasian and has a fairer skin tone. Patient has good skin turgor and is warm to the touch. His skin was pink and dry. Rashes and bruises were not noted. Patient is not a skin risk.
HEENT (2 points): **Head:** . **Ears:** **Eyes:** **Nose:** **Teeth**	Patient's head is midline with no deviations. Patient's hair white, grey in color. Patient's ears show no abnormal drainage. PERLA is present. Patient denies the use of glasses or hearing aids. Patient's nose shows no sign of a deviated septum. Patient's oral mucosa is a little dry due to being NPO the last few days. There are no noted abnormalities. Patient's teeth are present and yellow to white in color.
GENITOURINARY (2 Points): **Color, character, quantity of urine, pain,** **Dialysis Y ☐ N ☒** **Inspection of genitals** **Catheter: Y ☐ N ☒** **Type_____**	Patient is able to get up and ambulate to the bathroom x1. Patient has no use of dialysis and does not have a catheter present. Patient did not urinate. Upon on his last urination, patient denies hesitancy or urgency. Patient denies that his urine has an abnormal odor. Patient is on I&Os
PSYCHOSOCIAL/CULTURAL (2 points): **Coping methods,** **Educational level** **Developmental level,** **Ethnicity,** **Religion & what it means to pt.**	Patient presents in a good mood other than feeling fatigued. Patient states that he wishes he was able to sleep better throughout the night but was unable to because of people coming in and out of his room. Patient lives with his girlfriend. His girlfriend was not present at the bedside.

Occupation (previous if retired) Personal/Family Data (Think about home environment, family structure, and available family support)	Patient stated that his girlfriend was going to come visit once she got off work. He appears to have good support from his girlfriend. Patient is currently unemployed due to a disability. When asked about religious preference, patient states that he has no religious preference.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0745	Numerical	Epigastric region	8/10	Severe, uncomfortable	Pain medications were given
Patient was unavailable	.	.	.	.	.

IV Assessment (2 Points)

Site Location, Patency/Condition & Date	Fluid Type/Rate or Saline Lock
Peripheral IV (Peripheral R hand) 20g Date established: 03/05/2019 Right hand peripheral IV is stable, patent with no complications. Patient denies any pain at insertion site. There is no evidence of erythema, drainage, or swelling.	Lactated Ringer's drip Continuous Infusion 1,000mL 100mL/hr

Intake and Output during Your Shift (2 points)

Intake	Output
0ml – Patient was NPO	0ml – Patient stated he did not have to use the restroom.

Nursing Care

Summary of care- Narrative of Nursing care provided, patient status throughout the day, any major concerns, etc (2 points): .

Patient was fatigued throughout the morning. Patient asked to be left alone to try to catch up on his sleep. Patient was moved to another floor before the end of shift. Patient did have complains of severe pain around 0745. Patient rated his pain 8/10 on a numerical scale. Patient states that the pain was only in his epigastric region. Pain medication was administered to help with the pain. Patient's vital signs remained stable throughout the shift. Patient's abnormal lab values are due to the possibility of uncontrolled diabetes, acute pancreatitis, and his past medical history. Patient had no pressing concerns.

Discharge Planning- Identify discharge needs, education, home health services/equipment, family involved, etc (2 points): .

Upon discharge, patient will be going home with his girlfriend. Patient often laid in bed throughout the shift. Patient did not want to get up and ambulate. Patient should try to ambulate more at home while using precautions. Patient states that his girlfriend is somebody who will be able to help assist him at home. Patient will not need the use of an assistive device equipment at home. The patient should try to lower the consumption of alcohol and fatty foods to prevent further irritation of his pancreas. The patient should be educated on a low fat diet. The patient should follow-up with his primary care provider in a few days to monitor for an improvement in his pancreatitis.

***The following must be listed in order of priority and must be NANDA approved Diagnosis (18 points Total, 3 points for each complete diagnosis with 2 interventions & Rational, 3 points for correct prioritization)**

Nursing Diagnosis	Rational	Intervention (2 per dx)
1. Risk for electrolyte imbalance related to dietary restrictions as evidenced by a decrease in electrolyte	The patient is at risk for electrolyte imbalance because of the fact he came in with low electrolyte levels and has been receiving Lactated	**1.**. Assess vital signs q2-4h **2.**. Monitor closely for adventitious breath sounds, increased weight, and drop in

levels (Swearingen, 2016).	Ringer's to correct the issue.	Hct without blood loss.
2. Risk for dysfunctional gastrointestinal motility related to bowel dysfunction as evidenced by a lack of bowel movements (Swearingen, 2016).	The patient is at risk for issues with the GI motility because he has been NPO for the last three days. He has not had a bowel movement since before admission. This can have possibly slowed his motility.	**1.** Assess for bowel sounds in all four abdominal quadrants **2.** Following recommencement of fluids and food, monitor for bowel movements and emesis
3. Risk for venous thromboembolism related to lack of physical mobility as evidenced by the patient refusing to ambulate (Swearingen, 2016).	The patient is supposed to ambulating three times a day along with the use of SCDs and Levonox. The patient refuses the medication and ambulation which can lead to the development of a blood clot in his lower extremities.	**1.** Encourage the use of SCDs and explain the importance of them. **2**. Talk to physical therapy and see if together a plan can be developed with the patient to get him ambulating
4. Acute pain related to inflammatory process of the pancreas as evidenced by patient's complaints of pain (Swearingen, 2016).	The patient's complaints of pain have remained consistent since admission. On a numerical scale, the patient rated his pain an 8/10.	**1.** Administer pain medication as prescribed and asses for any changes in pain **2.** Emphasize nonpharmacological pain interventions
5. Risk for increased inflammation related to high glucose levels as evidenced by the patient's blood glucose being in the 200s (Swearingen, 2016).	The patient's blood glucose was 400 upon admission and has remained in the 200s since admission. The high blood glucose levels can be damaging to his pancreas leading to prolonged pancreatitis until it can be controlled.	**1.** Encourage a low-fat diet **2.** Monitor and educate the patient to watch for signs of hyperglycemia such as thirst, nausea, and shortness of breath.

Overall APA Format/Neatness/Grammar (5 point):

Swearingen, P. (2016). *All-in-One Nursing Care Planning Resource* (4th ed.). St. Louis, Missouri: ELSEVIER.

Concept Map Attached (20 points):