

N321 Care Plan #2

Lakeview College of Nursing

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**Demographics (3 points)**

<b>Date of Admission</b> 9-21-20	<b>Patient Initials</b> DC	<b>Age</b> 73 years old	<b>Gender</b> Female
<b>Race/Ethnicity</b> White	<b>Occupation</b> Retired	<b>Marital Status</b> Divorced	<b>Allergies</b> House dust, milk, penicillin's, and yeast.
<b>Code Status</b> Full code	<b>Height</b> 5'5"	<b>Weight</b> 240 lbs	

**Medical History (5 Points)**

**Past Medical History:** Metabolic acidosis, moderate dehydration, hypertension, tachypnea, tachycardia, acute cholecystitis, abdominal pain, sepsis, leukocytosis, systemic inflammatory response syndrome, dyspnea.

**Past Surgical History:** Tubal ligation- 2017.

**Family History:** Mother- Diabetes mellitus, heart disease, Hypertension, and cancer.

**Father-** Cancer

**Social History (tobacco/alcohol/drugs):** Pt smoked for 10 years. Quit 30 years ago. Does not drink.

**Assistive Devices:** Cane daily, walker occasionally.

**Living Situation:** Pt lives with daughter and daughter's boyfriend.

**Education Level:** High school.

**Admission Assessment**

**Chief Complaint (2 points):** "Falling apart", abdominal pain, swelling to lower right limb.

**History of present Illness (10 points):** Onset: Abdominal pain began a few days ago.

**Location:** Right upper quadrant of abdomen. **Duration:** Constant, lowers with pain meds.

**Characteristics:** Pain that shoots to the back. Uncomfortable. "feels like a football field is in my stomach". **Associated factors:** Pain is often associated with back pain. **Relieving factors:**

**Medication. Treatment: Pt did not seek treatment until 9-21-20. The patient had O2 stat of 99% with 2L nasal cannula, Pulse of 60, BP of 90/69, RR of 24, and a temp of 96.5.**

### **Primary Diagnosis**

**Primary Diagnosis on Admission (2 points): Acute Cholecystitis**

**Secondary Diagnosis (if applicable): Respiratory failure**

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

**Acute Cholecystitis is inflammation of the gallbladder. This occurs because of biliary stasis and gallstones. Inflammation and spasms of the gallbladder can occur without the formation of stones. 90% of cases are caused by gallstones that lodge in the cystic duct, called calculous cholecystitis and the other 10% of cases occur because of acalculous cholecystitis. Obstruction of the cystic duct by gallstones cause distension of the gallbladder. The distension of the gallbladder irritates the nerves that innervate the wall, causing pain.**

**Some signs and symptoms of acute cholecystitis include; Pain in the abdomen (upper right quadrant), Pain that spreads to your right shoulder or back, tenderness over your abdomen when its touched, nausea, vomiting, fever (Mayo clinic, 2020). Some risk factors for acute cholecystitis include; age greater than 40, high calorie or cholesterol diet, estrogen, female gender, genetic predisposition, obesity, oral contraceptives, and rapid dieting.**

**Laboratory tests used to diagnose acute cholecystitis include; WBC count, ESR, CRP, liver enzymes, and bilirubin. A CT scan is also used to diagnose acute cholecystitis. If acute cholecystitis was suspected, these labs would be elevated, and the CT would show an**

**inflamed gallbladder. The patient came into the ED with these tests ran. Her WBC count was elevated which indicated an infection, Bilirubin was elevated, CRP was elevated, and a CT scan confirmed inflammation of the gallbladder. All these tests were elevated, and the CT showed the gallbladder inflamed which helped make the diagnosis of acute cholecystitis.**

**Treatment of acute cholecystitis includes surgery, dietary management, and medications. The first thing that is done is surgery. The procedure is called a laparoscopic cholecystectomy and it is the removal of the gallbladder that would require a maximum hospital stay of 24 hours (although it is typically outpatient). Dietary management includes avoiding foods high in fat like butter. There are some medications that can help dissolve gallstones to try to avoid surgery. Pain medication may also be administered.**

**Our patient is a 72 year old female who is considered obese and has a high fat / cholesterol diet. These are risk factors for cholecystitis. The patient came into the ED with pain in her abdomen (located in the upper right quadrant). Labs were ran which showed an elevated CRP, WBC, and bilirubin which indicated infection related to her gallbladder. A CT scan confirmed that the patient had acute cholecystitis and was scheduled for surgery. Surgery was postponed because patient had trouble breathing.**

**Pathophysiology References (2) (APA):**

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

**Mayo Clinic. (2020, August 28). *Cholecystitis*. <https://www.mayoclinic.org/diseases-conditions/cholecystitis/symptoms-causes/syc-20364867>.**

**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	3.90-4.98	4.16	3.48	RBC'S are slightly low due to infection (Capriotti and Frizzell, 2016).
Hgb	12.0-15.5	12.5	10.5	Hemoglobin is low from infection and clients shortness of breath (Capriotti and Frizzell, 2016).
Hct	35-45	40.9	33.4	Hematocrit is low due to infection (Capriotti and Frizzell, 2016).
Platelets	140-400	149	147	
WBC	4.0-9.0	10.6	7.1	WBC was high on admission due to infection (Capriotti and Frizzell, 2016).
Neutrophils	40-68%	72.1%	69.2%	Neutrophils are high because of infection (Capriotti and Frizzell, 2016).
Lymphocytes	18-49%	14.6%	15.7%	Lymphocytes are low due to infection (Capriotti and Frizzell, 2016).
Monocytes	3.0-13.0%	10.8%	10.5%	
Eosinophils	0.0-8.0%	0.18	3.5	
Bands				

**Chemistry Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	137	139	
K+	3.5-5	3.7	3.5	

N321 Care Plan

Cl-	95-105	102	110	
CO2	21-31	22	22	
Glucose	70-110 mg/dl	141	108	
BUN	7-25 mg/dL	20	14	
Creatinine	0.50-1.20 mg/dL	16.67	0.79	Creatinine indicates an issue with the kidneys. Levels were high upon admission due to infection (Capriotti and Frizzell, 2016).
Albumin	3.5-3.7 g/dL	4.0	2.6	Albumin is low due to infection (Capriotti and Frizzell, 2016).
Calcium	8.8-10.2 mg/dL	10.0	7.7	Calcium is low due to infection (Capriotti and Frizzell, 2016).
Mag	1.5-2.6 mg/dL	1.7	1.7	
Phosphate	2.5-4.5 mg/dL			
Bilirubin	0.2-0.8 mg/dL	1.0	0.6	Bilirubin was slightly elevated due to complications with gallbladder (Capriotti and Frizzell, 2016).
Alk Phos	32-104 U/L	90	64	
AST	10-40	11	11	
ALT	10-30	13	25	
Amylase	23-85 u/L	22	22	Low amylase levels due to infection (Capriotti and Frizzell, 2016).
Lipase	12-70 u/L	10.0	10.0	Low lipase due to infection (Capriotti and Frizzell, 2016).
Lactic Acid	0.5-1 mmol/L	1.60	1.60	High lactic acid because patients O2 level was low (Capriotti and Frizzell, 2016).

Other Tests **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

N321 Care Plan

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.8-1.4	NA		
PT	10.1-13.1 sec	NA		
PTT	25-36 sec	NA		
D-Dimer	<0.5	NA		
BNP	<100 pg/mL	352.70	183.50	BNP is elevated and heart failure is suspected (Capriotti and Frizzell, 2016).
HDL	>60 mg/dL	43	43	Low levels of HDL indicates not enough good cholesterol in patients body (Capriotti and Frizzell, 2016).
LDL	<100 mg/dL	76	76	
Cholesterol	<200 mg/dL	131	131	
Triglycerides	<150 mg/dL	62	62	
Hgb A1c	<7%	NA		
TSH	0.4-4.0 mu/L	0.67	0.67	

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	Clear yellow	Dark Yellow		Abnormal color can indicate infection (Capriotti and Frizzell, 2016).
pH	4.6-8.0	5.00		
Specific Gravity	1.005-1.030	1.025		
Glucose	Negative	Negative		
Protein	Negative	Negative		
Ketones	Negative	Trace		Ketones in urine can indicate infection (Capriotti and Frizzell, 2016).

<b>WBC</b>	<b>0-4</b>	<b>3-5</b>		
<b>RBC</b>	<b>0-3</b>	<b>0-3</b>		
<b>Leukoesterase</b>	<b>Negative</b>	<b>Trace</b>		<b>Leukoestrerase in urine can indicate infection (Capriotti and Frizzell, 2016).</b>

Cultures **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

<b>Test</b>	<b>Normal Range</b>	<b>Value on Admission</b>	<b>Today's Value</b>	<b>Explanation of Findings</b>
<b>Urine Culture</b>	<b>Negative</b>			
<b>Blood Culture</b>	<b>Negative</b>			
<b>Sputum Culture</b>	<b>Negative</b>			
<b>Stool Culture</b>	<b>Negative</b>			

**Lab Correlations Reference (APA):**

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

**Diagnostic Imaging**

**All Other Diagnostic Tests (5 points): Troponin. Admission date 9-21-20 there was a level of 0.03. The next day (9-22-20) another troponin test was ran, and the level was 0.02.**

**CRP- C-reactive protein test- >16.00.**

**Diagnostic Test Correlation (5 points): The troponin test indicated that the patient could have had damage to her heart. A CRP high sensitivity test measures the amount of**

**inflammation in the body. The patient's level was high (>16.00) and normal range is 0.02-0.50.**

**A CT was done and this confirmed acute cholecystitis.**

**Diagnostic Test Reference (APA):**

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

**Current Medications (10 points, 1 point per completed med)  
\*10 different medications must be completed\***

**Home Medications (5 required)**

<b>Brand/ Generic</b>	<b>Enteric coated aspirin / Aspirin</b>	<b>Norvasc/ Amlodipine</b>	<b>Tylenol/ Acetamino phen</b>	<b>Ventolin/ Albuterol nebulizer</b>	<b>Microzide/ Hydrochloroth iazide</b>
<b>Dose</b>	<b>81mg</b>	<b>5mg</b>	<b>1,000mg</b>	<b>2.5 mg</b>	<b>12.5 mg</b>

<b>Frequency</b>	<b>1X daily</b>	<b>1X daily</b>	<b>PRN</b>	<b>Every 4 hrs PRN</b>	<b>1X daily</b>
<b>Route</b>	<b>oral</b>	<b>oral</b>	<b>oral</b>	<b>oral</b>	<b>oral</b>
<b>Classification</b>	<b>NSAID, antiplatelet</b>	<b>Calcium channel blocker.</b>	<b>Antipyretic , nonopioid analgesic.</b>	<b>Adrenergic , bronchodilator.</b>	<b>Diuretic.</b>
<b>Mechanism of Action</b>	<b>Blocks the activity of cyclooxygenase, the enzyme needed for prostaglandin synthesis.</b>	<b>Binds to dihydropyridine and nondihydropyridine cell membrane receptor sites on myocardial and vascular smooth- muscle cells and inhibits influx of extracellular calcium ions across slow calcium channels.</b>	<b>Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.</b>	<b>Attaches to beta2 receptors on bronchial cell membrane, which stimulates the intracellular enzyme adenylate cyclase to convert ATP to cAMP.</b>	<b>Promotes movement of sodium chloride and water from blood in peritubular capillaries into nephrons distal convoluted tubule.</b>
<b>Reason Client Taking</b>	<b>To reduce her risk of an MI.</b>	<b>Hypertension.</b>	<b>pain</b>	<b>Dyspnea</b>	<b>Hypertension</b>
<b>Contraindications (2)</b>	<b>Active bleeding or coagulation disorders. Hypersensitivity to aspirin.</b>	<b>Hypersensitivity to amlodipine or its components.</b>	<b>Hypersensitivity to acetaminophen or its components. Severe hepatic impairment .</b>	<b>Hypersensitivity to albuterol or its component.</b>	<b>Anuria, Hypersensitivity to hydrochlorothiazide.</b>
<b>Side Effects/ Adverse Reactions (2)</b>	<b>CNS depression, GI Bleeding.</b>	<b>Arrhythmias, hypotension.</b>	<b>Hypotension, stridor.</b>	<b>Angina, metabolic acidosis.</b>	<b>Hypotension, Renal failure.</b>
<b>Nursing Considerations (2)</b>	<b>Don't crush time released or</b>	<b>Use cautiously in patients with heart</b>	<b>Monitor renal</b>	<b>Monitor serum potassium</b>	<b>Give in the morning and early evening</b>

	<p><b>controlled release. Ask about tinnitus.</b></p>	<p><b>block, heart failure, impaired renal function, hepatic disorder, or aortic stenosis. Monitor BP.</b></p>	<p><b>function in patient on long term therapy. Store supplies under 26.6 degrees Celsius (80 F)</b></p>	<p><b>level because albuterol may cause transient hypokalemia. Be aware that drug tolerance can develop with prolonged use.</b></p>	<p><b>to avoid nocturia. Assess for evidence of hypokalemia, such as muscle spasms and weakness.</b></p>
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**Hospital Medications (5 required)**

<b>Brand/ Generic</b>	<b>Maxipime/ Cefepime</b>	<b>Magnesium Sulfate</b>	<b>Nuversa/ Metronidazole</b>	<b>0.9% Sodium Chloride</b>	<b>Duramorph/ Morphine</b>
<b>Dose</b>	<b>1g</b>	<b>2g</b>	<b>500mg</b>	<b>150 ml/hr</b>	<b>1mg</b>
<b>Frequency</b>	<b>Every 8 hours</b>	<b>Every 2 hours</b>	<b>Every 8 hours for 5 days</b>	<b>Cont.</b>	<b>PRN- every 3 hours</b>
<b>Route</b>	<b>IV</b>	<b>IV</b>	<b>IV</b>	<b>IV</b>	<b>IV</b>
<b>Classification</b>	<b>anti-infectives</b>	<b>minerals/ electrolytes replacement</b>	<b>anti-infectives</b>	<b>mineral and electrolyte replacements/supplements</b>	<b>opioid analgesics</b>
<b>Mechanism of Action</b>	<b>Binds to the bacterial</b>	<b>Essential for the activity of many</b>	<b>Disrupts DNA and protein</b>	<b>Sodium is a major cation in extracellular</b>	<b>Binds to opiate receptors</b>

	cell wall membrane , causing cell death	enzymes.	synthesis in susceptible organisms.	fluid and helps maintain water distribution, fluid and electrolyte balance, acid-base equilibrium, and osmotic pressure.	in the CNS. Alters the perception of and response to painful stimuli while producing generalized CNS depression
<b>Reason Client Taking</b>	<b>Infection</b>	<b>Replacement of electrolytes.</b>	<b>Infection</b>	<b>Replacing electrolytes.</b>	<b>Pain</b>
<b>Contraindications (2)</b>	<b>Hypersensitivity to cephalosporins; Serious hypersensitivity to penicillins.</b>	<b>Hypermagnesemia; Hypocalcemia.</b>	<b>Hypersensitivity; Hypersensitivity to parabens (topical only).</b>	<b>Fluid retention or hypernatremia.</b>	<b>Hypersensitivity, Significant respiratory depression.</b>
<b>Side Effects/Adverse Reactions (2)</b>	<b>Seizures, rashes.</b>	<b>Arrhythmias, Muscle weakness.</b>	<b>Abdominal pain, Dizziness.</b>	<b>Edema, Hypernatremia.</b>	<b>Confusion, sedation.</b>
<b>Nursing Considerations (2)</b>	<b>Assess patient for infection (vital signs; appearance of wound, sputum, urine, and stool; WBC) at beginning of and throughout therapy. Before initiating</b>	<b>Monitor neurologic status before and throughout therapy. Monitor intake and output ratios.</b>	<b>Assess for infection (vital signs; appearance of wound, sputum, urine, and stool; WBC) at beginning of and throughout therapy. Obtain specimens for culture and sensitivity</b>	<b>Assess fluid balance (intake and output, daily weight, edema, lung sounds) throughout therapy. Assess patient for symptoms of hyponatremia (headache, tachycardia, lassitude, dry mucous membranes, nausea, vomiting, muscle cramps) or hypernatremia</b>	<b>Patients taking sustained-release morphine may require additional short-acting opioid doses for breakthrough pain. Doses of short-acting opioids</b>

	<p><b>therapy, obtain a history to determine previous use of and reactions to penicillins or cephalosporins</b></p>		<p><b>before initiating therapy.</b></p>	<p><b>(edema, weight gain, hypertension, tachycardia, fever, flushed skin, mental irritability) throughout therapy</b></p>	<p><b>should be equivalent to 10– 20% of 24 hr total and given every 2 hr as needed. An equianalgesic chart (see Appendix B) should be used when changing routes or when changing from one opioid to another</b></p>
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**Medications Reference (APA):**

**Jones & Bartless Learning. (2020). *2020 Nurse’s drug handbook* (19<sup>th</sup> ed.). Burlington, MA.**

**Assessment**

**Physical Exam (18 points)**

<p><b>GENERAL (1 point):</b>  <b>Alertness:</b>  <b>Orientation:</b>  <b>Distress:</b>  <b>Overall appearance:</b></p>	<p><b>Pt is alert and oriented X3</b>  <b>Pt was having trouble breathing, even sitting in bed.</b>  <b>Pt was experiencing discomfort in her abdomen.</b>  <b>Appeared well groomed.</b></p>
<p><b>INTEGUMENTARY (2 points):</b>  <b>Skin color:</b>  <b>Character:</b>  <b>Temperature:</b>  <b>Turgor:</b>  <b>Rashes:</b>  <b>Bruises:</b>  <b>Wounds:</b>  <b>Braden Score:</b>  <b>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Type:</b></p>	<p><b>Skin is white and moist.</b>  <b>Warm.</b>  <b>Normal turgor: 2+</b>  <b>No rashes</b>  <b>Mild bruise at formed IV site (right arm).</b>  <b>Redness and swelling on right lower leg/foot.</b>  <b>Braden score: 17</b></p>
<p><b>HEENT (1 point):</b>  <b>Head/Neck:</b>  <b>Ears:</b>  <b>Eyes:</b>  <b>Nose:</b>  <b>Teeth:</b></p>	<p>. Pt's head is symmetrical.          ears clear and pink-no discharge          eyes are symmetrical and responded to light          No nasal deviation          Teeth in good condition.</p>
<p><b>CARDIOVASCULAR (2 points):</b>  <b>Heart sounds:</b>  <b>S1, S2, S3, S4, murmur etc.</b>  <b>Cardiac rhythm (if applicable):</b>  <b>Peripheral Pulses:</b>  <b>Capillary refill:</b>  <b>Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Location of Edema:</b></p>	<p>. <b>S1 and S2 heart sounds present</b>   <b>Cardiac rhythm is normal</b>  <b>Peripheral pulses:2+ symmetric</b>  <b>Capillary refill: less than 3 seconds</b>  <b>No sign of edema</b></p>
<p><b>RESPIRATORY (2 points):</b>  <b>Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/></b>  <b>Breath Sounds: Location, character</b></p>	<p><b>Lung and breath sounds were clear and equal, but patient was experiencing severe dyspnea. Sitting in bed the patient was having trouble breathing. On 2L of nasal cannula oxygen.</b></p>
<p><b>GASTROINTESTINAL (2 points):</b></p>	<p>.</p>

<p><b>Diet at home:</b>  <b>Current Diet</b>  <b>Height:</b>  <b>Weight:</b>  <b>Auscultation Bowel sounds:</b>  <b>Last BM:</b>  <b>Palpation: Pain, Mass etc.:</b>  <b>Inspection:</b>          <b>Distention:</b>          <b>Incisions:</b>          <b>Scars:</b>          <b>Drains:</b>          <b>Wounds:</b>  <b>Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>          <b>Size:</b>  <b>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>          <b>Type:</b></p>	<p><b>Patient is on a normal diet at home.</b></p> <p><b>Hyperactive bowel sounds in the upper right and left quadrants and the right lower.</b>  <b>Pt had a bowel movement 2 days ago and has been experiencing diarrhea all morning.</b>  <b>Patient’s abdomen is tender—specifically in the right upper quadrant.</b>  <b>No distension</b>  <b>No incisions</b>  <b>No scars</b>  <b>No drains</b>  <b>No wounds</b></p>
<p><b>GENITOURINARY (2 Points):</b>  <b>Color:</b>  <b>Character:</b>  <b>Quantity of urine:</b>  <b>Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>  <b>Inspection of genitals:</b>  <b>Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></b>          <b>Type:</b>          <b>Size:</b></p>	<p><b>Dark yellow</b></p> <p><b>Has not been voiding often enough (oliguria).</b></p>
<p><b>MUSCULOSKELETAL (2 points):</b>  <b>Neurovascular status:</b>  <b>ROM:</b>  <b>Supportive devices:</b>  <b>Strength:</b>  <b>ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Fall Score: 85</b>  <b>Activity/Mobility Status:</b>  <b>Independent (up ad lib) <input type="checkbox"/></b>  <b>Needs assistance with equipment <input type="checkbox"/></b>  <b>Needs support to stand and walk <input type="checkbox"/></b></p>	<p><b>.Pt has full ROM</b></p> <p><b>Pt uses a cane daily and a walker PRN.</b></p> <p><b>Pt did need help ambulating to the bedside commode but does not receive help at home (uses cane).</b>  <b>Fall score of 85 according to the morse fall scale.</b></p>
<p><b>NEUROLOGICAL (2 points):</b>  <b>MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/></b>  <b>Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no -</b></p>	<p><b>. Pt moves all extremities well</b>  <b>Pupils equal, round, and reactive to light</b>  <b>Complete orientation</b>  <b>Mental status is excellent</b></p>

N321 Care Plan

Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> <b>Orientation:</b> <b>Mental Status:</b> <b>Speech:</b> <b>Sensory:</b> <b>LOC:</b>	Speech is excellent  <b>Pt does not have hearing aids or glasses.</b> <b>Pt is sitting up in bed.</b>
<b>PSYCHOSOCIAL/CULTURAL (2 points):</b> <b>Coping method(s):</b> <b>Developmental level:</b> <b>Religion &amp; what it means to pt.:</b> <b>Personal/Family Data (Think about home environment, family structure, and available family support):</b>	.Pt lives at home with her daughter and daughter's boyfriend. Pt does not smoke or drink. Pt is mature Christian

**Vital Signs, 2 sets (5 points)**

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:00	60	90/69	24	96.5	99%  2L / min  Nasal  cannula
09:45	62	92/75	22	96.7	99%  2L / min  Nasal  cannula

**Pain Assessment, 2 sets (2 points)- Pt is in no pain today.**

Time	Scale	Location	Severity	Characteristics	Interventions
07:00	0-10	NA	0- Pt in no pain	NA	NA
09:45	0-10	NA	0- Pt in no pain. "Just	NA	NA

			<b>feels like there is a football team in my stomach”.</b>		
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**IV Assessment (2 Points)**

<b>IV Assessment</b>	<b>Fluid Type/Rate or Saline Lock</b>
<b>Size of IV:</b> <b>Location of IV:</b> <b>Date on IV:</b> <b>Patency of IV:</b> <b>Signs of erythema, drainage, etc.:</b> <b>IV dressing assessment:</b>	20 gauge Left hand 9-23-20 Clean, dry, intact, flowing continually No sign of redness, drainage, or bruising. 0.9% sodium chloride 150ml/hr Morphine 1g PRN every 3 hours for pain Cefepime 1g every 8 hours Magnesium sulfate 2g every 2 hours Metronidazole 500 mg every 8 hours for 5 days

**Intake and Output (2 points)**

<b>Intake (in mL)</b>	<b>Output (in mL)</b>
<b>2070 ml</b>	<b>200 ml- Loose stool mixed with little urine.</b>

**Nursing Care**

**Summary of Care (2 points)**

**Overview of care: Patient is on 2L/hr per nasal cannula with an O2 stat of 99%. Patient has hypertension and takes 2 medications for that. The patient rated her pain a 0 on a 0-10 scale. She is experiencing dyspnea and “stomach discomfort but no pain right now”. Patient is a fall risk and needs help ambulating to the bedside commode. Patient used a cane daily and a walker as needed.**

**Procedures/testing done:** Patient is scheduled for an outpatient surgery to get gallbladder removed. Patient had a CT scan which confirmed acute cholecystitis as well as CRP, WBC, Bilirubin, and liver enzyme abnormalities. A troponin and BNP was also done, and was abnormal which indicated an issue with the heart (but that is still being diagnosed).

**Complaints/Issues:** Dyspnea, diarrhea.

**Vital signs (stable/unstable):** Stable vitals. BP was slightly low for someone with hypertension so BP medication was held.

**Tolerating diet, activity, etc.:** Patient ate 100% of breakfast and is drinking fluids but has diarrhea.

**Physician notifications:** Notified physician about diarrhea.

**Future plans for patient:** Discharge with outpatient at a later date (when breathing is under control).

#### **Discharge Planning (2 points)**

**Discharge location:** Daughters house.

**Home health needs (if applicable):** Pt may need to be on oxygen at home for dyspnea.

**Equipment needs (if applicable):** Cane / walker.

**Follow up plan:** Outpatient surgery on gallbladder.

**Education needs:** Pt needs education on proper diet for acute cholecystitis and even after gallbladder removal.

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

<p><b>Nursing Diagnosis</b></p> <ul style="list-style-type: none"> <li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li> </ul>	<p><b>Rational</b></p> <ul style="list-style-type: none"> <li>• Explain why the nursing diagnosis was chosen</li> </ul>	<p><b>Intervention (2 per dx)</b></p>	<p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• How did the patient/family respond to the nurse’s actions?</li> <li>• Client response, status of goals and outcomes, modifications to plan.</li> </ul>
<p><b>1. Risk of accident related to dyspnea as evidence by needing a walker to walk longer distances.</b></p>	<p><b>Patient is a fall risk because breathing has been rough for her, so walking can be an issue.</b></p>	<p><b>1. Administer O2 per nasal cannula.</b></p> <p><b>2. Administer a breathing treatment when experiencing dyspnea.</b></p>	<p><b>The patient is willing to receive O2 per nasal cannula and the breathing treatment.</b></p> <p><b>Goal: help patients breathing.</b></p> <p><b>Outcome: Patients O2 saturation was 99% and breathing did get better.</b></p>
<p><b>2. Ineffective individual coping strategies related to medical issues as evidence by patients frustration/sadness</b></p>	<p><b>Patient was very frustrated that she was in the hospital and that she didn’t have answers.</b></p>	<p><b>1. Help the patient develop coping strategies. Sit and talk to patient.</b></p> <p><b>2. Talk to the patient about what she can do once she gets home to prevent her from being back in the hospital.</b></p>	<p><b>The patient was willing to listen. Told her to try and stay calm / positive and mentioned better dietary habits to follow once she gets discharged.</b></p> <p><b>Goal: Have patient develop better coping strategies.</b></p> <p><b>Outcomes: Pt understood and seemed to feel better.</b></p>
<p><b>3. Difficulty to stay</b></p>	<p><b>Patient lives</b></p>	<p><b>1. Diet changes</b></p>	<p><b>The patient is willing</b></p>

N321 Care Plan

<b>healthy related to lack of support and conditions as evidence by diet and conditions.</b>	<b>with her daughter and daughter makes her meals. She needs to be on a healthier diet for acute cholecystitis and hypertension.</b>	2. Have daughter try and help the patient stay healthy since she is the one who makes her food.	<b>to change her diet and talk to her daughter about it as well. Goal: make sure patient is keeping a low-fat diet. Outcome: patient is going to try and eat better.</b>
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**Other References (APA):**

Swearingen, P. L., & Wright, J. D. (2020). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier.

**Concept Map (20 Points):**

### Subjective Data

The patient is not experiencing pain today. "No pain"  
She states that "it feels like a football team is in my stomach! It won't stop moving around down there".  
Pt states "I am having trouble breathing, but it is like that every day".  
The patient does not smoke or drink.

### Nursing Diagnosis/outcomes

1. Risk of accident related to dyspnea as evidence by needing a walker to walk longer distances. Outcomes: Patients O2 saturation was 99% and breathing did get better.
2. Ineffective individual coping strategies related to medical issues as evidence by patients frustration/sadness. Outcomes: Pt understood and seemed to feel better. She was sad, but happier after talking.
3. Difficulty to stay healthy related to lack of support and conditions as evidence by diet and conditions. Outcomes: patient is going to try and eat better. She is also going to talk to her daughter about cooking healthier meals for her.

### Objective Data

Height: 5'5"  
Weight: 240 pounds  
Vitals  
Pulse- 60  
BP- 90/69  
RR- 24  
Temp- 96.5  
O2- 99% with 2L/min nasal cannula

### Patient Information

Patient is a 73 year old female admitted on September 21<sup>st</sup> for acute cholecystitis. Surgery was supposed to happen, but she was experiencing respiratory issues so it was postponed.  
Full code  
Allergies include: house dust, milk, penicillin, and yeast.

### Nursing Interventions

1. Administer O2 per nasal cannula. Administer a breathing treatment when experiencing dyspnea.
2. Help the patient develop coping strategies. Sit and talk to patient. Talk to the patient about what she can do once she gets home to prevent her from being back in the hospital.
3. Diet changes. Have daughter try and help the patient stay healthy since she is the one who makes her food.

## N321 Care Plan

## N321 Care Plan