N431 Care Plan # 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10/5/20	**Patient Initials** A.J.	**Age** 25	**Gender** Female
Race/Ethnicity White	**Occupation** Caregiver	**Marital Status** Single	**Allergies** Morphine
Code Status Full Code	**Height** 170 cm	**Weight** 73 kg	

Medical History (5 Points)

Past Medical History: Pelvic abscess, LLQ pain, nausea, vomiting, diarrhea, abnormal sensory exam, ACL tear, anxiety, headaches, GERD, low back pain, C. diff infection, depression, fatigue, fibromyalgia, history of concussion, migraines, sciatica, tobacco use.

Past Surgical History: Laparoscopy and closure of perforated bowel ulcer, esophagogastroduodenoscopy, knee arthroscopy (left knee), greater occipital nerve block, trigger point injection, spinal tap, cesarean section.

Family History: A.J. states that her mother has hypertension and has had colon polyps. Her father has skin cancer, but she is unsure what type. Both of her parents are still living.

Social History (tobacco/alcohol/drugs): This patient is a current smoker with a 4.5 pack-year history. She states she smokes 10 cigarettes a day and has done so for nine years. She reports drinking small quantities of alcohol only on rare occasions. When she does drink, she states she may have “one or two wine coolers” and that she consumes alcohol “a few times a year.” She smokes marijuana “once or twice a year” but is unable to estimate a quantity that she uses on these occasions. The patient denies the use of any illicit drugs other than marijuana.

Assistive Devices: None.

Living Situation: The patient reports living with her five-year-old son and his father.

Education Level: A.J. has a high school education. Her level of education does not seem to pose any substantial barrier to learning. During our encounter, the client verbalizes an accurate understanding of her medical problems and seems generally well-informed about her present diagnosis.

Admission Assessment

Chief Complaint (2 points): Abdominal pain in left lower quadrant.

History of present Illness (10 points):.

The patient reports that she is experiencing abdominal pain, which started "about two weeks ago." This pain is primarily in her left lower quadrant, but at times radiates across her lower abdomen and in her groin area. The pain has been constant, and gradually worsening since it began, culminating in her visit to the emergency department on the evening of 10/4/20. She describes the sensation of her pain as "gnawing" but adds that it is "sometimes a shooting pain." A.J. adds that she has also experienced nausea and vomiting at times when the pain is particularly intense. Her pain is aggravated with movement or touching her abdomen. She initially denies anything that relieves the pain other than medication but clarifies that laying down and remaining still "maybe helps a bit." When this nurse asks if she had tried anything to treat the pain prior to coming to the hospital, the patient reports that the pain medications she takes at home are ineffective. She also states that she had made a telemedicine appointment with her provider on the Thursday prior to this encounter, and that she was prescribed metronidazole at that time, but that the pain continued to worsen. At the time of the encounter, she rates the severity of her pain as a 10 on the 0-10 scale.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pelvic floor abscess**.**

Secondary Diagnosis (if applicable): N/A

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

An abscess refers to a pus-filled infection that is often, but not always caused by bacteria (Hecht, 2018). Rather than a stand-alone diagnosis, pelvic abscesses are more commonly thought of as a complication of pelvic inflammatory disease (PID) (Hinkle & Cheever, 2018). PID refers to inflammation of the pelvic cavity that may involve the uterus, fallopian tubes, ovaries, and the pelvic peritoneum or vascular system (Hinkle & Cheever, 2018). Commonly, PID occurs secondary to a sexually transmitted infection when the causative organism enters the pelvic organs through the vagina (Higuera, 2019). While gonorrhea and chlamydia are often involved, the condition can also be a complication of an invasive procedure (Hinkle & Cheever, 2018). A.J.'s physicians believe that her pelvic abscess originally occurred secondary to a previous bowel perforation. The diagnosis of PID may involve a pelvic exam, cervical culture to check for infection, and urine tests to check for hematuria (Higuera, 2019). Pelvic ultrasound, endometrial biopsy, and laparoscopy can also be used to assess for the presence of structural or cellular abnormalities (Higuera, 2019). Additionally, a CT scan of the pelvis allows for the visualization of structural abnormalities like cysts, tumors, obstructions, abscesses, or tissue inflammation (Pagana et al., 2019). A.J.'s pelvic abscess was initially discovered using a CT scan after she developed abdominal pain following a bowel perforation repair. During this stay at Sarah Bush Lincoln Health Center, a CT of the abdomen and pelvis with contrast was performed. Based on the results of this scan, A.J.'s gynecologist believes that her pelvic floor abscess was not resolved after the initial treatment of drainage and antibiotics. Furthermore, Dr. Meyer suspects that the

infection has since spread to her ovaries and fallopian tube. A.J. additionally had a urinalysis and CBC performed. The urinalysis revealed elevated RBCs, and the presence of protein and leukoesterase. These findings could potentially indicate a urinary tract infection (Pagana et al., 2019). Her CBC results showed decreased hemoglobin and hematocrit, which may be due to anemia secondary to abnormal bleeding (Pagana et al., 2019).

Several complications may develop as a result of PID. These include pelvic or generalized peritonitis, abscess, strictures, and adhesions (Hinkle & Cheever, 2018). In some cases, structure of the fallopian tubes may lead to ectopic pregnancy or scar tissue may occlude the tube entirely (Hinkle & Cheever, 2018). It may be necessary to remove the uterus, fallopian tubes, and ovaries as a result of chronic pain secondary to adhesions (Hinkle & Cheever, 2018). Symptoms associated with pelvic infection include abnormal vaginal discharge, dysuria, and pain in the lower abdomen (Hinkle & Cheever, 2018). A.J.'s chief complaint during this encounter was pain in her left lower quadrant. Patients may also experience fever, malaise, anorexia, nausea, headache, and vomiting (Hinkle & Cheever, 2018). It was reported by A.J. that she had nausea and occasional vomiting with severe bouts of pain. PID can be managed with antibiotic therapy, but surgery may be necessary if the client does not respond to antibiotics or abscess rupture is a concern (Higuera, 2019). The administration of analgesic medications is indicated for pain relief (Hinkle & Cheever, 2018). A.J.'s pelvic abscess was initially treated with metronidazole. During this stay at Sarah Bush Lincoln, she received piperacillin-tazobactam, doxycycline, and cefotetan. A.J. also has orders for medication to manage her pain, including ketorolac and hydromorphone. However, these medications have not been able to reduce her pain to a level she finds tolerable thus far.

Pathophysiology References (2) (APA):

Hecht, M. (2018, October 20). *What's the difference between a cyst and an abscess*? Healthline. https://www.healthline.com/health/cyst-vs-abscess

Higuera, V. (2019, May 1). *Pelvic inflammatory disease (PID)*. Healthline. https://www.healthline.com/health/pelvic-inflammatory-disease-pid

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

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic & laboratory test reference* (14th ed.). Elsevier.

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 (x10^6/mcL)	3.8-5.41	4.61	3.98	N/A
Hgb (g/dL)	11.3-15.2	12.0	10.1	Decreased hemoglobin is associated with antibiotic therapy (Pagana et al., 2019). A.J. has taken several antibiotics over the last month, including an initial treatment with piperacillin and tazobactam at Sarah Bush Lincoln hospital. Additionally, A.J. takes meloxicam for pain management daily, at home and in the hospital. Meloxicam is associated with GI bleed and anemia, and it is advised to monitor hemoglobin and hematocrit while using it (Pagana et al., 2019). Furthermore, decreased hemoglobin is

				associated with blood loss (Pagana et al., 2019). A.J.'s CT scan indicated that tubo-ovarian abscess is possible. This condition is associated with abnormal vaginal bleeding (Tokumaru et al., 2015).
Hct (%)	33.2-45.3%	36.5%	32.0%	Decreased hematocrit is associated with penicillin use (Pagana et al., 2019). A.J. was initially treated with piperacillin and tazobactam at Sarah Bush Lincoln hospital. Additionally, A.J. takes meloxicam for pain management daily, at home and in the hospital. Meloxicam is associated with GI bleed and anemia, and it is advised to monitor hemoglobin and hematocrit while using it (Pagana et al., 2019). Furthermore, decreased hematocrit is associated with blood loss (Pagana et al., 2019). A.J.'s CT scan indicated that tubo-ovarian abscess is possible. This condition is associated with abnormal vaginal bleeding (Tokumaru et al., 2015).
Platelets (k/mcL)	149-393	173	153	N/A
WBC (k/mcL)	4-11.7	8.6	6.6	N/A
Neutrophils (%)	45.3-79	62.4	54.4	N/A
Lymphocytes (%)	11.8-45.9	26.4	33.5	N/A
Monocytes (%)	4.4-12.0	7.1	8.4	N/A
Eosinophils (%)	0.0-6.3	3.1	3.0	N/A
Bands (%)	3-5	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na- (mmol/L)	136-145	141	N/A	N/A
K+ (mmol/L)	3.5-5.1	3.7	N/A	N/A
Cl- (mmol/L)	98-107	112	N/A	Elevated levels of chloride are associated with NSAID use (Pagana et al., 2019). A.J.'s PRN pain medications include ketorolac.
CO2 (mmol/L)	21-31	22	N/A	N/A
Glucose (mg/dL)	74-109	80	N/A	N/A
BUN (mg/dL)	7-25	16	N/A	N/A
Creatinine (mg/dL)	0.7-1.3	0.55	N/A	Low creatinine is associated with debilitation and decreased muscle mass (Pagana et al., 2019). A.J. has several medical problems that cause chronic pain. It is likely that as a result her physical activity levels and muscle mass have decreased.
Albumin (g/dL)	3.5-5.2	4.2	N/A	N/A
Calcium (mg/dL)	8.6-10.3	8.5	N/A	Decreased calcium is associated with vitamin D deficiency (Pagana et al., 2019). While A.J. does not have any vitamin D deficiency noted in her chart, it is worth considering that she does have several problems associated with vitamin D deficiency in adults. For A.J., these problems include fatigue, depression, and back pain. (Cleveland Clinic, 2019).
Mag (mg/dL)	1.6-2.4	N/A	N/A	N/A
Phosphate (mg/dL)	3.0-4.5	N/A	N/A	N/A
Bilirubin (mg/dL)	0.3-1.0	0.2	N/A	Decreased levels of bilirubin are

				associated with penicillin use (Pagana et al., 2019). This client was initially treated with piperacillin and tazobactam at Sarah Bush Lincoln hospital.
Alk Phos (unit/L)	34-104	64	N/A	N/A
AST (unit/L)	13-39	11	N/A	Decreased AST is associated with metronidazole use (LabCorp, 2020). A.J. was treated with metronidazole before coming to Sarah Bush Lincoln hospital.
ALT (unit/L)	7-52	11	N/A	N/A
Amylase (unit/L)	30-220	N/A	N/A	N/A
Lipase (unit/L)	11-82	N/A	N/A	N/A
Lactic Acid (mmol/L)	0.5-2	N/A	N/A	N/A
Troponin (ng/mL)	0.0-0.03	N/A	N/A	N/A
CK-MB (ng/mL)	0.6-6.3	N/A	N/A	N/A
Total CK (Intl Unit/L)	30-223	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.86-1.14	N/A	N/A	N/A
PT (seconds)	11.9-15.0	N/A	N/A	N/A
PTT (seconds)	22.6-35.3	N/A	N/A	N/A
D-Dimer (mcg/mL)	0.0-0.62	N/A	N/A	N/A
BNP (pg/L)	0-100	N/A	N/A	N/A
HDL (mg/dL)	>55	N/A	N/A	N/A

LDL (mg/dL)	<130	N/A	N/A	N/A
Cholesterol (mg/dL)	<200	N/A	N/A	N/A
Triglycerides (mg/dL)	35-135	N/A	N/A	N/A
Hgb A1c (%)	4-5.9	N/A	N/A	N/A
TSH (mcIU/mL)	0.45-5.33	N/A	N/A	N/A

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	"low-yellow"; "low-clear"	"yellow"; "hazy"	N/A	Decreased clarity of urine is associated with the presence of pus, RBCs, and bacteria (Pagana et al., 2019). In addition to finding elevated RBCs in A.J.'s urine, her CT scan indicates that tubo-ovarian abscess cannot be ruled out. Patients with tubo-ovarian abscess have presented with vaginal discharge (Tokumaru et al., 2015). This discharge could potentially alter the clarity of a urine sample.
pH	5.0-8.0	5.0	N/A	
Specific Gravity	1.005-1.034	1.024	N/A	
Glucose	"Low-normal"	"Normal"	N/A	
Protein	"Low-negative"	1+	N/A	It is noted that contamination with vaginal secretions is a common cause of proteinuria (Pagana et al., 2019). A.J.'s CT scan indicates possible tubo-ovarian abscess. This condition is associated with vaginal discharge (Tokumaru et al., 2015).
Ketones	"Low-negative"	"Negative"	N/A	
WBC (per HPF)	< or = 5	2	N/A	
RBC (per HPF)	0-3	67	N/A	A.J.'s CT scan indicates possible

				tubo-ovarian abscess. This is associated with abnormal vaginal bleeding (Tokumaru et al., 2015). A urine specimen contaminated by vaginal bleeding may show an elevated RBC count (Nall, 2019).
Leukoesterase	Low-Negative	Trace	N/A	Elevations in leukoesterase suggest a possible urinary tract infection (Pagana, 2019). While A.J. has not received a diagnosis of urinary tract infection, her CT scan indicates possible tubo-ovarian abscess. It has been observed in cases of tubo-ovarian abscess that the causative bacteria can be isolated in the urine (Tokumaru et al., 2015). This suggests that development of a urinary tract infection secondary to tubo-ovarian abscess is possible.

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	N/A	N/A	N/A
PaO2 (mm Hg)	80-100	N/A	N/A	N/A
PaCO2 (mm Hg)	33-45	N/A	N/A	N/A
HCO3 (mEq/L)	21-28	N/A	N/A	N/A
SaO2 (%)	95-100	N/A	N/A	N/A

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

Test	Normal	Value on	Today's	Explanation of Findings

	Range	Admission	Value	
Urine Culture	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	**Pending**	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (APA):

Cleveland Clinic. (2019, October 16). *Vitamin d deficiency*. https://my.clevelandclinic.org/health/articles/15050-vitamin-d--vitamin-d-deficiency

GlobalRPh. (2017). *Laboratory values*. https://globalrph.com/laboratory-values/

LabCorp. (2020, September 22). *Aspartate aminotransferase (AST/SGOT)*. https://www.labcorp.com/tests/001123/aspartate-aminotransferase-ast-sgot#:~:text=Other%20enzymes%2C%20including%20alkaline%20phosphatase,to%20overt%20chronic%20alcoholism%3B%20cirrhosis.

Nall, R. (2019, December 2). *Why are there red blood cells in my urine*? Healthline. https://www.healthline.com/health/rbc-in-urine

Pagana, K.D., Pagana, T.J., & Pagana, T. N. (2019). *Mosby's diagnostic & laboratory test reference* (14th ed.). Elsevier.

Sarah Bush Lincoln. (2020). Laboratory values. *Cerner PowerChart*. Cerner.

Tokumaru, T., Shima, Y., Okabayashi, T., Hayashi, K., Yamamoto, Y., Ozaki, K., & Iwata, J. (2015). Emergency surgery for tubo-ovarian abscess identified extended-spectrum beta-lactamase-producing *Escherichia coli*: The first case presentation revealing causative bacteria. *Surgical case reports*, *1*(1), 66. https://doi.org/10.1186/s40792-015-0069-6

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Computerized Tomography Scan with contrast, abdomen and pelvis, Performed 10/4/20

The results of this CT scan were compared against a previous CT taken on 9/10/20 which lead to the initial discovery of the client's pelvic floor abscess. For this CT scan, 100 mL of Omnipaque contrast was used. The radiologist noted bilateral hydrosalpinx, which was worse on the right side compared to A.J.'s previous CT. New fluid accumulation in the left adrenexal region was also noted. The radiologist indicates that this may represent a cyst, but that tubo-ovarian abscess could not be excluded. There is also residual fluid observed posterior to the uterus at the site of A.J.'s previously drained pelvic floor abscess. The radiologist's impression also includes possible cholecystitis and a question of focal enteritis.

Diagnostic Test Correlation (5 points):

Computerized Tomography Scan with contrast, abdomen and pelvis, Performed 10/4/20

The CT scan is a diagnostic imaging technique that involves taking a series of X-rays from varying angles to create cross-sectional images of the structures the provider is interested in evaluating (Ross, 2017). The quality of these images can be enhanced with the use of contrast dye (Pagana et al., 2019). A CT scan of the abdomen and pelvis allows the visualization of abnormalities of the organs in these areas, including tumors, cysts, obstructions, abscesses, and tissue inflammation (Pagana et al., 2019). In the pelvis, a CT scan allows for the evaluation of the uterus, ovaries, and fallopian tubes (Pagana et al., 2019). Given her presentation with abdominal pain, as well as her history of bowel perforation and pelvic floor abscess, this test was indicated for A.J. Based on review of A.J.'s CT scan, Dr. Meyer believes that her previous pelvic

floor abscess was not resolved and that infection has now spread to her ovaries and fallopian tubes.

Diagnostic Test Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic & laboratory test reference* (14th ed.). Elsevier.

Ross, H. (2017, December 19). *What is a CT scan*? Healthline. https://www.healthline.com/health/ct-scan

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

Home Medications (5 required)

Brand/ Generic	Feratab/ ferrous sulfate	Mobic /meloxicam	Inderal /propranolol hydrochloride	Imitrex /sumatriptan succinate	Lyrica /pregabalin
Dose	325 mg	15 mg	60 mg	100 mg	75 mg
Frequency	1 tab every other day	1 tab daily	1 tab TID	1 tab BID PRN	1 capsule BID
Route	PO	PO	PO	PO	PO
Classification	Mineral	Anti-inflammatory	Beta-adrenergic blocker	Serotonin 5-HT1-receptor agonist	GABA derivative
Mechanism of Action	Ferrous sulfate binds hemoglobin or is oxidized and stored as hemosiderin. or aggregated ferritin in the bone marrow, liver, and spleen. It is used in the formation	Meloxicam inhibits prostaglandin production by blocking cyclooxygenase. In this way, the inhibits the inflammatory response and the transmission of pain by	Propranolol is a non-selective beta blocker, and blocks the stimulation of both beta-1 and beta-2 adrenergic receptors. This results in a decreased heart rate, improved myocardial	Sumatriptan is thought to stimulate 5-HT1 receptors. This stimulation causes vasoconstriction of dilated and inflamed cranial blood vessels. This decreases carotid arterial blood flow,	Pregabalin is thought to decrease pain sensation and seizure activity by modulating calcium channel function. Specifically, it is thought to accomplish this by binding to the alpha-2-delta

	of hemoglobin, myoglobin, enzymes including catalase, cytochromes, and peroxidase. It is needed to normalize RBC production, catecholamine metabolism, and normal neutrophil function.	prostaglandins from the periphery to the spinal cord.	contractility, decreased blood pressure, and reduced myocardial oxygen demand.	which in turn relieves acute migraines or cluster headaches.	site of calcium channels in the CNS tissue.
Reason Client Taking	The client does not have a diagnosis of anemia or iron deficiency in her history. However, the only indications provided for ferrous sulfate are iron supplementation and the treatment of anemia.	The client takes meloxicam for relief of her back pain.	Propranolol is indicated for the treatment of hypertension and the treatment of migraines. A.J. reports having a history of both hypertension and migraines.	The client takes sumatriptan to manage her migraine headaches.	The client is taking pregabalin as a treatment for her fibromyalgia.
Contraindications (2)	Two contraindications to ferrous sulfate are hemolytic anemias and hemosiderosis.	Two contraindications to meloxicam are a history of bronchospasm or asthma.	Propranolol is contraindicated in patients with an AV block greater than 1st degree and in patients with asthma.	Sumatriptan is contraindicated in clients with ischemic heart disease or uncontrolled hypertension.	Pregabalin is contraindicated in patients with a hypersensitivity to pregabalin or its components. No other contraindications are provided for pregabalin. However, the use of ACE inhibitors with pregabalin increases the risk of pregabalin-induced angioedema.
Side Effects/ Adverse Reactions (2)	Two adverse reactions to ferrous sulfate are constipation	Two adverse reactions to meloxicam are GI bleed and	Two adverse reactions to propranolol are sinus	Two adverse reactions to sumatriptan are anxiety and	Two adverse reactions to pregabalin are vertigo and

	and nausea.	chest pain.	bradycardia and dyspnea.	colonic ischemia.	thrombocytopenia.
Nursing Considerations (2)	First, iron tablets and capsules should be given with a full glass of water. Second, giving iron salts 1 hour prior to or 2 hours after meals increases absorption.	Meloxicam should be used with extreme caution in patients with a history of GI bleed. Monitor CBC for decreased hemoglobin and hematocrit.	Propranolol should be taken at the same time each day. Stopping this drug abruptly can have severe consequences including myocardia ischemia, myocardial infarction, ventricular arrhythmias, and severe hypertension.	Sumatriptan should not be given within 24 hours of other 5-HT1 receptor agonists. Doing so increases the risk of serious adverse reactions. Encourage patients to lie down in dark, quiet rooms after taking to compliment the drug's effects.	Pregabalin therapy should be done over at least one week to decrease the risk of seizure activity, headache, insomnia, and GI symptoms. Monitor patient closely for suicidal behavior or thinking, especially when therapy is initiated or dosage is changed.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Monitor patient for signs of iron overdose. Symptoms include abdominal pain, diarrhea which may contain blood, nausea and vomiting, and sharp abdominal cramps.	Patient should be monitored for adequate hydration before initiating therapy due to the risk of renal dysfunction.	Blood pressure, apical and radial pulses, fluid intake and output, daily weight, respirations, and circulation to extremities should be monitored before and during propranolol therapy.	The patient should be monitored for signs or symptoms of serotonin syndrome. These include agitation, coma, diarrhea, tachycardia, hyperreflexia, hyperthermia, incoordination, labile BP, and vomiting. If these symptoms are present, notify provider immediately.	This medication can cause leukopenia, thrombocytopenia, and renal failure. Thus, it is advisable to check leukocytes, platelets, and kidney function before beginning therapy and to monitor these labs throughout therapy.
Client Teaching needs (2)	Advise patient to eat food high in vitamin C to improve absorption. Advise patient that it is expected that their stool turn dark green to black while	The client should be advised to avoid other NSAIDs, aspirin, or products containing aspirin while using meloxicam. The client	If the client is a smoker, they should notify their provider if they intend to stop smoking while taking propranolol. This is because smoking increases the metabolism of	Patients should avoid using this drug for more than 10 days in a month and should notify their provider if their need for the drug increases. Patients taking	The patient should avoid stopping pregabalin abruptly. The patient should notify their provider if they experience changes in vision or

	taking iron, and that if it does not, they should contact their provider.	should be advised to contact their provider if they develop dark yellow or brown urine, fatigue, fever, itching, lethargy, nausea, or jaundice. These are signs of hepatic dysfunction.	the propranolol, and they may require a dose adjustment. The patient should notify their provider immediately if they develop shortness of breath.	sumatriptan for prolonged periods should receive yearly ophthalmologic examinations.	unexplained muscle pain, tenderness, or weakness; particularly if these symptoms are accompanied by fever or malaise.

Hospital Medications (5 required)

Brand/Generic	Cefotan /cefotetan disodium	Vibramycin /doxycycline	Dilaudid / hydromorphone hydrochloride	Protonix /pantoprazole	Toradol /ketorolac tromethamine
Dose	2 g .	100 mg	1 mg	40 mg	30 mg
Frequency	Every 12 hours	Every 12 hours	Every 2 hours PRN	1 tab daily	Every 6 hours PRN
Route	IV piggyback	IV piggyback	IV	PO	IV
Classification	Cephalosporin	Oxytetracycline derivative.	Semisynthetic opioid derivative	Proton pump inhibitor	Anti-inflammatory
Mechanism of Action	Cefotetan interferes with bacterial production of cell walls by inhibiting peptidoglycan cross-linkage. Without this cross linkage, bacterial cells rupture.	Doxycycline has bacteriostatic effects against gram-positive and gram-negative organisms. Its relatively high lipophilic characteristic allow it to pass through the lipid bilayer of bacterial cells	Hydromorphone is thought to bind with opioid receptors in the spinal cord and higher levels of the CNS. By binding to kappa and mu-opioid receptors, this medication decreases	Pantoprazole inhibits the activity of the hydrogen-potassium-adenosine triphosphatase system of gastric parietal cells and interferes with gastric acid secretion. Specifically,	Ketorolac inhibits prostaglandin synthesis by blocking cyclooxygenase. Prostaglandins are responsible for mediating the inflammatory response and promoting pain

		and bind reversibly to the 30S ribosomal subunit. This inhibits bacterial protein synthesis.	perception of and emotional response to pain.	the drug blocks the exchange of the intracellular hydrogen cation and and extracellular potassium cation. This prevents the hydrogen cation from entering the stomach and forming hydrochloric acid with available chloride anions in the stomach.	transmission from the periphery to the spinal cord. Thus, ketorolac reduces inflammation and pain through its action.
Reason Client Taking	The client is taking this medication for the treatment of her pelvic abscess.	This client is taking this medication for the treatment of her pelvic abscess.	The client is taking this medication to manage severe pain in the LLQ of her abdomen related to her pelvic abscess.	The client is taking this medication as a treatment for her GERD.	The client is taking this medication as a treatment for moderate to severe pain associated with her pelvic abscess.
Contraindications (2)	This medication is contraindicated in patients with hypersensitivity to cefotetan or hypersensitivity to other cephalosporins. No other contraindications are listed. However, the use of aminoglycosides or loop diuretics with cefotetan increases the risk of nephrotoxicity.	This medication is contraindicated in patients with hypersensitivity to doxycycline or hypersensitivity to other tetracyclines. No other contraindications are listed. However, this medication increases the bioavailability of digoxin, which may lead to digitalis toxicity in clients taking digoxin.	Contraindications for this medication include GI obstruction and severe respiratory depression.	Contraindications for this medication include hypersensitivity to pantoprazole or substituted benzimidazoles, and concurrent therapy with products that contain rilpivirine.	Contraindications to ketorolac include GI perforation and cerebrovascular bleeding.

Side Effects/Adverse Reactions (2)	Adverse reactions to this drug include nephrotoxicity and arthalgia.	Adverse reactions to doxycycline include angioedema and pericarditis.	Adverse reactions to hydromorphone include hypertension and respiratory depression.	Adverse reactions to pantoprazole include migraine and hepatitis.	Adverse reactions to ketorolac include hemolytic anemia and cerebral hemorrhage.
Nursing Considerations (2)	Reconstituted solution should be protected from light and may be stored for 24 hours at room temperature or 96 hours under refrigeration. Patients receiving even short term therapy with this drug should be monitored for signs and symptoms of hemolytic anemia.	Patients receiving IV doxycycline should be observed frequently for phlebitis. Doxycycline may cause pseudomembranous colitis. Thus, the patient should be monitored closely for diarrhea. If diarrhea occurs, the nurse should notify the provider and expect to hold doxycycline.	IV administration of hydromorphone should be done over at least 2 minutes. The patient should be monitored for respiratory depression even if the drug is administered as prescribed, especially within 72 hours of starting therapy or increasing dosage. Furthermore, resuscitation equipment and naloxone should be readily available.	Patients taking pantoprazole for longer than 3 years may develop vitamin B-12 deficiency secondary to achlorhydria or hyperchorhydria. If this occurs, treatment for cyanocobalamin deficiency may be needed. Monitor patient for decreased urine output or hematuria. These may be manifestation of interstitial nephritis. If these occur, notify the prescriber.	If given by IV, the medication should be administered over at least 15 seconds. Monitor CBC for decreased hemoglobin and hematocrit because the drug may worsen anemia.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Because this medication can have nephrotoxic effects, BUN, serum creatinine, and fluid intake and output status should be assessed. When administered by IV, the IV	Because this drug is associated with hepatotoxicity, liver function tests should be evaluated. In patients with hepatic disease, dose adjustment is warranted.	Because this drug is associated with respiratory depression, a respiratory assessment including respiratory rate should be performed prior to administration.	The primary contraindication to this drug is hypersensitivity to pantoprazole and drugs like it including omeprazole, lansoprazole, and rabeprazole. Before administration, the nurse	Because this drug is associated with hepatic impairment, liver enzymes should be monitored before initiating therapy and monitored throughout therapy.

	site should be monitored for complications before starting infusion.			should inquire about any past use of these drugs and any potential hypersensitivity reactions to them.	Because this drug can worsen anemia, a CBC should be reviewed to screen for anemia prior to beginning and throughout therapy.
Client Teaching needs (2)	The patient should avoid alcohol during and for three days following cefotetan therapy. If the client develops diarrhea, they should notify their provider immediately.	The patient should be advised that while taking doxycycline they should avoid UV exposure and use sunscreen due to increased photosensitivity and the risk of phototoxicity. Female patients should be advised that doxycycline increases the risk of vaginal candidiasis, and that if they develop vaginal itching or discharge they should contact their provider.	Advise the patient that pain relief is most effective if the drug is administered before pain is severe. The patient should be instructed that the drug may cause drowsiness and sedation. Thus, potentially hazardous activities should be avoided until CNS effects are known.	Patients should be advised to swallow pantoprazole tablets whole, and not to chew or crush them. Women of childbearing age should notify their prescriber if pregnancy is suspected or occurs due to the risk of fetal harm associated with pantoprazole.	The patient should be instructed to immediately report blood in their urine, easy bruising, itching, rash, swelling, or jaundice. The patient should be advised to seek immediate medical attention if they develop abdominal or epigastric pain, black tarry stools, indigestion, or vomiting blood.

Medications Reference (APA):

Drugs.com. (2020, July 13). *Propranolol*. https://www.drugs.com/ppa/propranolol.html

Jones & Bartlett Learning. (2019). *2019 nurse's drug handbook* (18th ed.). Jones & Bartlett Publishers.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** Alert **Orientation:** Oriented to time, place, person, and situation. **Distress:** The client is visibly in apparent distress. She cries intermittently and grimaces with movement. **Overall appearance:** A.J. appears to be her stated age.	The client is A/O x4 and appears to be distressed. Specifically, she cries intermittently and grimaces when she moves. The client attributes her distress to her pain, which she rates as a 10 on the 0-10 scale. Her demeanor is pleasant, and she enjoys talking about her son. A.J. appears to be her stated age.
INTEGUMENTARY (2 points): **Skin color:** Pale-pink. **Character:** Clean, dry, and intact. **Temperature:** Warm to the touch. **Turgor:** Elastic. **Rashes:** No rash is noted. **Bruises:** No bruising is noted. **Wounds:** A.J. has a surgical scar from her laparoscopy and bowel repair. The scar appears pink, is 7 cm long, and is located along the midline of her upper abdomen. **Braden Score:** 19 **Drains present: Y☐ N ☒** **Type:** N/A	A.J.'s skin is pale-pink in color and is clean, dry, and intact. Her skin is warm to the touch, and features elastic turgor. No bruising or rashes were noted. The client has a 7 cm surgical scar to the midline of her upper abdomen. She explains that the scar was from the repair of a bowel perforation. No drains are present. This client has a Braden Score of 19. A.J. has no sensory deficits, and her skin remained dry through the shift. However, while she is able to get up ad lib, in practice her pain has impacted her activity and mobility. She spends the shift in bed and makes only slight changes in body position. Her pain has furthermore affected her appetite. For breakfast, she ate only a small bag of potato chips.
HEENT (1 point): **Head/Neck:** Trachea is midline. Oral mucosa is moist and intact. Head appears normocephalic. Uvula is midline. No tonsil exudate noted. Tongue appears moist and	A.J.'s head is normocephalic. Her trachea is midline. Oral mucosa is moist and intact. Uvula is midline. No tonsil exudate is noted. Her tongue appears moist and pink in color. Dentition is intact, with some yellowing of the teeth noted.

pink. **Ears:** Tympanic membranes appear pearly grey bilaterally. **Eyes:** PERRLA. Sclera appear white. No conjunctival inflammation or drainage noted bilaterally. **Nose:** Septum is midline. **Teeth:** Dentition is intact, with some yellowing of teeth.	Tympanic membranes are visible and appear pearly grey bilaterally. Nasal septum is midline. No epistaxis noted. PERRLA. Sclera appear white bilaterally. There is no conjunctival inflammation or drainage noted bilaterally. .
CARDIOVASCULAR (2 points): **Heart sounds:** S1, S2 heart sounds auscultated. **Cardiac rhythm (if applicable):** Rhythm is regular. **Peripheral Pulses:** Radial and pedal pulses are 2+ bilaterally. **Capillary refill:** Unable to assess capillary refill. Client wears false cosmetic nails that obscure the nail bed. **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:** N/A	Auscultated S1, S2 heart sounds. Heart rhythm is regular. Radial and pedal pulses are 2+ bilaterally. No JVD is noted. Upper and lower extremities feel warm to the touch bilaterally. There is no edema to the upper or lower extremities bilaterally. Unable to assess capillary refill; A.J. wears cosmetic false nails that obscure the nail bed.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds:** Breath sounds are clear throughout all lobes bilaterally. A.J. denies any shortness of breath or dyspnea. Respiratory rate is	Lung sounds are clear throughout all lobes. A.J. denies any respiratory distress. Her respiratory rate is 18 respirations per minute. Respirations are regular in rhythm, even, and appear non-labored. No use of accessory muscles was observed.
GASTROINTESTINAL (2 points): **Diet at home:** Regular **Current Diet:** Regular **Height:** 170 cm **Weight:** 73 kg **Auscultation Bowel sounds:** Bowel sounds are active in all four quadrants. **Last BM:** A.J. reports having a loose bowel movement the evening of 10/4/20. **Palpation: Pain, Mass etc.:** The client's abdomen is very tender in the LLQ. A.J. exhibited guarding when near this area, and reported that even auscultation with a stethoscope was painful. The LRQ was non-tender, but palpation caused	A.J reports a poor appetite, which she attributes to her abdominal pain. Her last bowel movement was on the evening of 10/4/20, which she describes as loose. Bowel sounds were active in all four quadrants. The LLQ of A.J.'s abdomen is tender. She exhibited guarding and complained of pain with only the weight of the stethoscope over the area. Her LRQ was not tender, but palpation of the area caused discomfort in the LLQ. LUQ and RUQ were non-tender. No masses were palpated, and the abdomen is not distended. A.J. has a 7 cm surgical scar to her upper abdomen, midline. The scar is pink in color. Client states this scar is from her laparoscopic bowel perforation repair. She has no drains, wounds, or

discomfort in the LLQ. **Inspection:** **Distention:** non-distended **Incisions:** N/A **Scars:** 7 cm surgical scar to upper abdomen, midline. Scar is pink in color**.** **Drains:** n/a **Wounds:** n/a **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** n/a **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** n/a	ostomy present. No NG tube or feeding tube is present.
GENITOURINARY (2 Points): **Color:** Unknown **Character:** Unknown **Quantity of urine:** n/a **Pain with urination: Y ☒ N ☐** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** n/a **Size:** n/a	A.J. did not get up to urinate this shift. Consequently, no urine was observed. The client denies difficulty producing urine, but experiences pain in her LLQ with urination. A.J. is not receiving dialysis, and has not had a catheter placed.
MUSCULOSKELETAL (2 points): **Neurovascular status:** Pedal and radial pulses are 2+ bilaterally. Skin at extremities is warm bilaterally. Color of skin is pale-pink in hands and feet. A.J. denies any pain or tingling in her extremities. **ROM:** A.J. demonstrates functional AROM in her arms and legs. **Supportive devices:** n/a **Strength:** 5/5 in upper and lower extremities bilaterally. **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 0** **Activity/Mobility Status:** **Independent (up ad lib) Y ☒** **Needs assistance with equipment ☐ NO** **Needs support to stand and walk☐ NO**	A.J. is up ad lib, but has remained in bed this shift due to severe LLQ pain. During our physical assessment, she demonstrates a functional active range of motion in her upper and lower extremities bilaterally. Pedal and radial pulses are 2+ bilaterally. Skin is warm to the tough in the upper and lower bilaterally. Color of skin is pale-pink in the upper and lower extremities bilaterally. A.J. denies any pain or tingling sensations in her extremities. Muscle strength is 5/5 in arms bilaterally. Because the client complained of pain in LLQ with movement of her legs, strength in the legs against resistance was not assessed. However, she was observed to be able to move her legs against gravity. A.J.'s Morse fall score is 0.

NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** Oriented to person, place, time, and situation. **Mental Status:** Appropriate. No apparent deficit in memory or confusion. Client's thoughts are rational and ordered. **Speech:** Clear. **Sensory:** Sensorium is intact. **LOC:** Alert	This client demonstrates that she is able to move all extremities normally. PERRLA. Strength in arms is equal. Did not assess strength in legs due to client's severe LLQ pain being exacerbated with movement. A.J. is alert and oriented to person, place, time, and situation. She speaks in clear and coherent English. There is no apparent deficit in memory or confusion. The client is able to articulate her thoughts in a clear, rational, and ordered manner. Sensorium is intact. Facial expressions are symmetrical.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** A.J. feels that she has a good family support network including her family and boyfriend that she can rely on for emotional support. **Developmental level:** The client is at an appropriate developmental level for her age. **Religion & what it means to pt.:** The patient states that she is not religious. **Personal/Family Data (Think about home environment, family structure, and available family support):** The client feels that her relationship with her parents is healthy and supportive. She lives at home with her boyfriend and son, and reports that her mother can watch her child while her boyfriend works.	This client feels that she has a supportive family and boyfriend that she can rely on to talk through her problems with. She lives with her boyfriend and son, and states that her mother can help with childcare if necessary. A.J. denies any religious affiliation or beliefs. However, this nurse has concerns about the client's ability to cope with an unfavorable treatment outcome. During her gynecology consult, Dr. Meyer raised the possibility that surgery may be necessary if antibiotic therapy fails, and that as a result she may be infertile or fertile only by in vitro fertilization. A.J. seemed to struggle with this and began crying. Because of the emotional toll an unfavorable outcome could have on the client, particularly with her history of depression, this nurse believes that referral to a counselor or support group may be indicated to supplement her family support and help the client develop coping skills.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	64 beats per minute	126/80 mm Hg	18 respirations per minute	36.8 degrees Celsius	98% on room air

1100	55 beats per minute	133/88 mm Hg	14 respirations per minute	36.8 degrees Celsius	99% on room air

Vital Sign Trends:

Between the two sets of vitals, there was a decrease in pulse of 9 beats per minute. This change is explicable by the client taking her scheduled dose of propranolol, which lowers heart rate through its action (Jones & Bartlett Learning, 2019). A.J.'s systolic and diastolic blood pressure were increased on the second set of vitals. The client reports that she has a history of hypertension. Furthermore, this set of vitals was obtained shortly after performing a physical assessment which involved movement that the client found painful and a gynecology consultation that A.J. was emotionally distressed by. It is known that blood pressure can increase because of stress (Capriotti & Frizzell, 2016). Moreover, hypertension is a noted adverse reaction to hydromorphone (Jones & Bartlett Learning, 2019). Respirations decreased from 18 per minute to 14 per minute. This change is likely attributable to her use of hydromorphone, as opiates can decrease the respiratory rate (Jones & Bartlett Learning, 2019). Her temperature remained stable this shift, and the increase between her first and second O2 saturation readings was modest.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	0-10	LLQ of abdomen	10	"Gnawing"	Administered hydromorphone 1 mg by IVP.
1100	0-10	LLQ of abdomen	8	"Gnawing"	A.J. will receive a PRN dose of hydromorphone

					when her nurse is able to do so.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 ga. **Location of IV:** Right forearm **Date on IV:** 10/4/20 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** None. **IV dressing assessment:** Clean, dry, and intact.	0.9% NaCl at 75 mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
120 mL, Sprite 100 mL, doxycycline 1mg/mL solution by IV 150 mL. 0.9% NaCl by IV **Total: 370 mL**	**0 mL**

Nursing Care

Summary of Care (2 points)

Overview of care:

For this client I administered scheduled and PRN medications, performed a head to toe assessment, obtained vital signs, and offered emotional support during her gynecology consult with Dr. Meyer.

Procedures/testing done:

No procedures or testing are performed this shift, however the client is awaiting the results of a blood culture, which was drawn on the previous shift.

Complaints/Issues:

A.J. voices no complaints with the care she is receiving, but her pain is an ongoing problem for her. An order to increase the frequency of her hydromorphone to every two hours as needed is obtained. The effectiveness of this change is not yet known.

Vital signs (stable/unstable): There were significant changes to the client's vital signs this shift. Between the initial and final set of vitals taken A.J.'s pulse decreased, her blood pressure increased, and her respirations decreased. The changes to her pulse and respirations are likely a result of her medications, respectively propranolol and hydromorphone. The change in her blood pressure is attributable to emotional stress.

Tolerating diet, activity, etc.:

The client's oral intake is poor, which she attributes to her pain. She eats a bag of potato chips, and drinks one-third of a can of Sprite on this shift. She is up ad lib but found getting up or even making small movements in bed extremely uncomfortable.

Physician notifications:

Dr. Bukhari was contacted twice regarding A.J.'s pain. On the first occasion, he ordered hydromorphone 1 mg/1mL give 1 mg by IV push now. On the second occasion, he

ordered another 1 mg dose of hydromorphone by IV push. He additionally ordered that A.J.'s hydromorphone order be changed to 1 mg by IV push every two hours as needed.

Future plans for patient:

The client had a consult with Dr. Meyer today, and is awaiting a consult with Dr. Green. At this point, Dr. Meyer believes based on her CT scan that A.J.'s infection has spread to her fallopian tubes and ovaries, and that it is appropriate to attempt treating the infection with antibiotics. If antibiotic treatment fails, surgical intervention may be necessary. Thus, A.J.'s course of treatment and duration of stay will primarily depend on two factors. First, the results of her blood culture will inform her physicians whether the antibiotics she is receiving are appropriate. Second, whether A.J. will require surgery depends on her response to antibiotic therapy.

Discharge Planning (2 points)

Discharge location:

Whether she receives surgical treatment or not, is likely to be discharged to home. She feels that her parents and boyfriend can adequately assist her with recovery.

Home health needs (if applicable):

The patient is unlikely to require home health services. She has access to reliable transportation to and from follow up any needed appointments. Moreover, with instruction, she is likely capable of identifying signs or symptoms that warrant contacting her provider or returning to the emergency department.

Equipment needs (if applicable):

At this time, it is not clear that any equipment will be needed.

Follow up plan:

The client will need follow up appointments with her primary care provider and gynecologist regardless of her course of treatment. If A.J. does have surgery, she will additionally need to follow up with her surgeon. Nurses should verify that she is attending these appointments. During her gynecology consult, Dr. Meyer discussed with the client that it was possible surgical treatment would render her either infertile or fertile only by in vitro fertilization. A.J. found this information difficult to hear. It may be appropriate for the client to receive a referral to a counselor or support group. If she does choose to attend, a nurse should check to see if A.J. feels that attendance is helpful.

Education needs:

Educational needs are partially dependent on the client's eventual course of treatment. If A.J. responds well to antibiotic therapy, she will need instruction on her prescribed medications. If she requires surgery, review of post-operative instructions will be required prior to discharge. In either case, this client would benefit from education on non-pharmacological pain management techniques including guided imagery and deep breathing.

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

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Ineffective protection related to impaired tissue integrity as evidenced by	This client has a pelvic floor abscess. Active infection represents A.J.'s most immediate	**1.**Administer prescribed antibiotics to the client as ordered. **2.**Monitor resident	The patient received all prescribed antibiotics this shift and tolerated them well. She did not display symptoms of sepsis this shift and tolerated

abnormal CT scan.	threat to homeostasis.	for signs and symptoms of sepsis this shift.	physical assessment well. The desired goals of these interventions are that the client's abscess will resolve and that further complication vis a vis sepsis will not occur. These goals are still in progress.
2. Acute pain related to inflammation as evidenced by patient complaint of severe pain in the left lower quadrant of her abdomen.	A.J.'s pain is an active and acute problem for her and is what prompted her to seek treatment.	**1.** Administer PRN hydromorphone as ordered. **2.**Instruct A.J. on use of the 0-10 pain scale.	A.J. was able to understand and use the 0-10 pain scale. She initially ranked her pain as a 10 but following administration of hydromorphone ranked it as an 8. Hydromorphone was administered this shift but was only modestly effective. A.J.'s pain remains more severe than she finds tolerable. In response, her physician changed her hydromorphone order to 1 mg by IV every 2 hours as needed. Whether this will be effective remains to be seen.
3. Ineffective health management related to tobacco use as evidenced by patient statement that she is a current smoker.	Smoking is associated with a variety of health problems, including hypertension (Hinkle & Cheever, 2018). A.J. reports that she has a history of hypertension.	1. Provide education on how smoking can impact the client's health. **2**.Assess client's willingness to discuss smoking cessation.	Goals remain in progress. Ideally, the client would be able to verbalize an understanding of the education provided and would express a willingness to discuss smoking cessation.
4. Ineffective	While this is not	1. Assess the	Goals remain in progress.

coping related to possible infertility as evidenced by observation of patient during and after her gynecology consultation.	an immediate threat to homeostasis, the client would benefit from interventions that improve her ability to cope with her prognosis.	client's current methods of coping. **2.** Discuss attending a support group for infertility with the client, including her willingness to attend.	Currently, the client identifies discussing her problems with her family and boyfriend as a method of coping. The client has not yet been assessed for a willingness to attend a support group. Ideally, the client would be willing to participate in the group.

Other References (APA):

Herdman, T. H., & Kamitsuru, S. (2014). *Nursing diagnoses – definitions & classification 2015-2017*. NANDA International.

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

Concept Map (20 Points):

Subjective Data

Patient reports severe LLQ pain, which has been persistent and worsening for 2 weeks. The pain primarily manifests with a “gnawing” quality.

Patient reports she has experienced nausea and vomiting with particularly intense bouts of pain.

Patient reports being a current smoker that consumes ½ pack of cigarettes daily.

Patient reports a history of hypertension.

Objective Data

Patient rates pain in LLQ of abdomen as a 8 out of 10 on a 0-10 scale following administration of hydromorphone 1 mg by IV.

Patient’s CT scan shows fluid accumulation posterior to the uterus and to the adenexal region and ovaries bilaterally.

Most recent VS: BP 133/88 mm Hg, P 54 bpm, R 14/min, T 36.8 C, O2 sat 99% on room air.

Patient observed crying following her gynecology consult.

Patient Information

This patient is a 25 year old caucasian female presenting [illegible] persistent and worsening over the last two weeks. She has a history of pelvic floor abscess following a laparoscopic bowel repair. She is a current smoker. Her social support system consists of her parents and boyfriend. Her medical history includes Pelvic abscess, LLQ pain, nausea, vomiting, diarrhea, abnormal sensory exam, ACL tear, anxiety, headaches, GERD, low back pain, C. diff infection, depression, fatigue, fibromyalgia, history of concussion, migraines, sciatica, tobacco use

Nursing Diagnosis/Outcomes

sis 1: Ineffective protection related to impaired tissue integrity as evidenced by abnormal CT scan.
Outcome: The patient will remain free from sepsis during this stay at Sarah Bush Lincoln Health Center.
Diagnosis 2: Acute pain related to inflammation as evidenced by patient complaint of severe pain in the left lower quadrant of her abdomen.
Outcome: The patient will identify, achieve, and maintain a level of pain on the 0-10 scale that she finds tolerable during this shift.
Diagnosis 3: Ineffective health management related to tobacco use as evidenced by patient statement that she is a current smoker.
Outcome: The client will identify three ways that smoking can negatively impact her health this shift.
Diagnosis 4: Ineffective coping related to possible infertility as evidenced by observation of patient during and after her gynecology consultation.
Outcome: The client will express a willingness to attend an infertility support group this shift.

Nursing Interventions

Nursing Diagnosis 1

1.Administer prescribed antibiotics to the client as ordered.

2.Monitor resident for signs and symptoms of sepsis this shift.

Nursing Diagnosis 2

1.Administer PRN hydromorphone as ordered.

2.Instruct A.J. on use of the 0-10 pain scale.

Nursing Diagnosis 3

1.Provide education on how smoking can impact the client’s health.

2.Assess client’s willingness to discuss smoking cessation.

Nursing Diagnosis 4

1.Assess the client’s current methods of coping.

2. Discuss attending a support group for infertility with the client, including her willingness to attend.

Nursing Diagnosis 1

1.Administer prescribed antibiotics to the client as ordered.

2.Monitor resident for signs and symptoms of sepsis this shift.

Nursing Diagnosis 2

1.Administer PRN hydromorphone as ordered.

2.Instruct A.J. on use of the 0-10 pain scale.

Nursing Diagnosis 3

1.Provide education on how smoking can impact the client's health.

2.Assess client's willingness to discuss smoking cessation.

Nursing Diagnosis 4

1.Assess the client's current methods of coping.

2. Discuss attending a support group for infertility with the client, including her willingness to attend.