N311 Care Plan # 1

Lakeview College of Nursing

Jennifer Rodrigues

Demographics (5 points)

Date of Admission	Patient Initials	Age	Gender
10/8/2020	WA	50	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Psychology professor	Single	No known allergies
Code Status	Height	**Weight**	
Full code	5'11	224.8lbs	

Medical History (5 Points)

Past Medical History: Hypertension, mood disorder related to anxiety and depression, anemia, obesity (morbid), hypothyroid, hyperlipidemia, GERD, gout,

Past Surgical History: Tonsillectomy, no date given or found in chart

Family History: Mother-lung cancer Father- heart disease

Social History (tobacco/alcohol/drugs): Patient states history of tobacco use, no recreational drug use, alcohol consumed rarely. Patient lives at home by himself. He is a psychology professor at Eastern Illinois University, for 14 years. Patient wear glasses. Patient has a boyfriend, dating for just over a year. Boyfriend is very involved in care of patient and present at bedside for most of morning. Boyfriend will be driving patient home, assisting with housework, grocery shopping, picking up medications.

Admission Assessment

Chief Complaint (2 points): Patient arrived at the ER with complaint of dizziness and syncopal episode x 2, once in early AM while in shower and once while walking through house midday.

History of present Illness (10 points): Onset: On October 8, 2020 patient, a 50 y/o single male presented to emergency room at Sarah Bush Lincoln for dizziness and multiple syncopal episodes. **Location:** Patient had full body syncopal episodes, dizziness. **Duration:** For several months, patient has had dizziness and several falls, also related to history of anemia. Recently diagnosed (post 1 week) with colon cancer via patient chart history notes. **Characteristics:** Dizziness without resolve, fainting in shower and with walking, patient and boyfriend decided to seek help. **Aggravating factors:** None listed, as syncopal episodes came on randomly. **Relieving**

factors: None were given/listed. **Treatment:** Patient came to the ER for examination, admitted and scheduled for hemicolectomy.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Primary diagnosis of recently diagnosed colon cancer, notification given October 5, 2020, information listed in patient chart history. Ascending colon resection surgery on October, 12, 2020, specifically "right hemicolectomy of the ascending colon for intra-mucosal adenocarcinoma," per doctor's report.

Secondary Diagnosis (if applicable): Secondary to established colon cancer, patients presents with dizziness, syncopal episodes and increased anemia. Patient has also experienced a weight loss of 15 pounds over the last two weeks.

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

Colon cancer, within the umbrella term of colorectal cancer, is a predominant cancer that can result in death. As stated by Capriotti, "it is the second leading cause of death resulting from cancer." The statistic around colorectal cancer is that about 5% of males will be diagnosed in their lifetime.

The cancer begins as a polyp, a "mass of tissue that bulges or projects upward or outward" (Lippincott, Williams & Wilkins, 2012). Usually, polyps are non-cancerous, but can have the potential to become cancerous, called adenomas. The mass then mutates to become cancerous. Genetic changes allow tumor suppressant genes to become defective. This results in normal cells of the colon to progress to benign adenomas, then to cancerous adenomas. Cancerous adenomas can be categorized into three groups: tubular adenomas that have a mass and stalk coming off the walls of the intestine, villous adenomas that have fingerlike projections that invade into the intestinal walls and tubulovillous adenomas, which have attributes of both prior listed groups (Capriotti, 2020). The cancer is spread intruding into neighboring structures of the body and presenting into the lymphatic system and bloodstream. As stated by Capriotti, "common sites for the cancer to spread are lymph nodes, liver, lungs and bones."

This cancer can be asymptomatic for long durations and then suddenly present. Common symptoms include fatigue, weight loss, anemia, bowel obstruction and weakness (Capriotti, 2020). Anemia is common in patients with colon cancer. Blood slowly seeps into the intestine, causing a drop in WBCs, weakness, fatigue, all symptoms exhibited by the patient. With a prior history of anemia, now being aggravated by further blood loss, weakness, fatigue and dizziness occured in the patient.

To diagnose colon cancer, a combination of diagnostic tests and lab tests are performed. A colonoscopy is a forefront diagnostic tool, when a camera is inserted into the colon and intestines to look for masses. This procedure requires both pre and post procedural care, as the patient must empty bowel before and will be consciously sedated, needing observation after (Hopkins, 2015). Ultrasound, MRI and CT can also be used. Lab tests include a CBC, serum iron test, liver enzymes and stool samples. The patient did have a CBC upon admission. The CBC showed several lab values that were affected: low RBC, low hemoglobin, low hematocrit.

Treatment of colon cancer primarily is surgery, as in the case of this patient, to remove the cancerous portion of the bowel. For some patients, chemotherapy and radiation can be recommended and used. It was not established yet what further treatment would be occurring for this patient, such as radiation or chemotherapy. The rate of survival depends on the stage of the cancer, how much of the colon is affected and amount of metastasis in the body.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia, PA: F.A. Davis.

Hopkins, T. B. (2015). *Lab notes: Guide to lab and diagnostic tests*. Philadelphia, PA: F.A. Davis Company.

Stedman, T. L. (2012). *Stedman's medical dictionary for the health professions and nursing*. Philadelphia, PA: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Laboratory Data (20 points)
If laboratory data is unavailable, values will be assigned by the clinical instructor

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

All lab value "normal ranges" taken from Sarah Bush Lincoln Hospital patient chart, per instructor's request, unless stated otherwise/not attainable in patient chart system.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4.28-5.56	4.16	3.34 x10^6/mcl (L)	Patient has history of anemia. Anemia is defined as "decreased RBC mass" (Capriotti, 2020). A deficit of RBCs can be seen in a CBC when hemoglobin and hematocrit values are low as well.
Hgb	13-17	11.6 (L)	9.6 g/dL (L)	Hemoglobin is lowered due to a deficient amount of RBC in the body (Capriotti, 2020). There can also be a lower value due to blood loss and anemia. Patient has history of anemia.
Hct	38.1-48.9	34.8 (L)	28.3% (L)	Hematocrit is the percentage of blood that is made up of RBCs. It can be decreased in anemia, chronic disease, blood loss, excess fluid volume. (Capriotti, 2020) Patient has history of anemia.
Platelets	149-393	353	246 K/mcl	
WBC	4.0-11.7	12.4	9.8 K/mcl	
Neutrophils	45.3-79	75.3	91.5% (H)	High neutrophils can stem from gout, acute infection, acute stress, trauma. (Hopkins, 2015). The patient has a history of gout and has just undergone an acute stressful situation of abdominal surgery.
Lymphocytes	11.8-45.9	15.6	4.7% (L)	Decreased lymphocytes can stem from a decreased production in the bone marrow. It can also stem from acute infections, sepsis, renal failure or radiation sickness (Capriotti, 2020).
Monocytes	4.4-12.0	7.5	3.8% (L)	Low monocyte count can stem from high dose steroids or malignancy (Capriotti, 2020). The patient was diagnosed with malignancy of the colon.
Eosinophils	0.0-6.3	Not collected	1.0%	
Bands	0-10%	Not collected	Not collected	(Normal value from Capriotti, 2020)

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-	136-145	132 (L)	136 mmol/L	Sodium losses normally stem from dehydration, losses from kidney or GI tract (Capriotti, 2020). Patient has been on limited fluid intake and NPO diet per orders for surgery.
K+	3.5-5.1	3.6	4.3 mmol/L	
Cl-	96-106	97	103 mmol/L	
CO2	21-31	25	26 mmol/L	
Glucose	70-99 (fasting)	100	120 mg/dL (H)	High fasting blood glucose is usually correlated with diabetes (Hopkins, 2015). Patient has medical history of pre-diabetes.
BUN	7-25	Not collected	10 mg/dL	
Creatinine	0.70-1.3	Not collected	0.86 mg/dL	
Albumin	3.5-5.2	3.9 g/dL	Not collected	
Calcium	8.6-10.3	9.1	8.2 mg/dL (L)	Low calcium can be correlated with lack of Ca2+ in diet, vitamin D deficiency, hypoparathyroidism or renal disease. (Capriotti, 2020). The patient has a history of hypothyroidism.
Mag	1.5-2.5	Not collected	Not collected	(Lab value from *Lab Notes*, Hopkins)
Phosphate	2.5-4.5 mg/dL	Not collected	Not collected	(Lab value from *Lab Notes*, Hopkins)
Bilirubin	0.3-1.0	0.4 mg/dL	Not collected	
Alk Phos	34-104	65 unit/L	Not collected	

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	Yellow Clear	Not collected	Amber Cloudy	Urine is normally clear or light yellow, without odor. Slight haze may be present. Darker colored urine, such as amber, is an indication of dehydration. Hazy, unclear urine can be a sign

				on infection, with particles in the urine such as proteins, ketones, etc. (Capriotti, 2020). The patient was on limited fluid prior to surgery, NPO diet. Normal saline is now being transfused via IV.
pH	5.0-8.0	Not collected	6.0	
Specific Gravity	1.005-1.034	Not collected	1.025	
Glucose	Normal	Not collected	Normal	
Protein	Negative	Not collected	2+	
Ketones	Negative	Not collected	2+	
WBC	0.0-5	Not collected	9 (H)	High WBC count in a urinalysis can be a sign of infection or inflammation in the urinary tract (Lab Tests Online, 2020).
RBC	0-3	Not collected	5 (H)	RBC count being elevated in a urinalysis can be a sign of infection or inflammation in the urinary tract (Lab Tests Online, 2020).
Leukoesterase	Negative	Not collected	Negative	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative/No growth	Not collected	Not collected	
Blood Culture	Negative/No growth	Not collected	Not collected	
Sputum Culture	Negative/No growth	Not collected	Not collected	
Stool Culture	Negative/No growth	Not collected	Not collected	

Lab Correlations Reference (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives*. Philadelphia, PA: F.A. Davis.

Hopkins, T. B. (2015). *Lab notes: Guide to lab and diagnostic tests*. Philadelphia, PA: F.A. Davis Company.

Urinalysis. (n.d.). Retrieved October 15, 2020, from https://labtestsonline.org/tests/urinalysis

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

1. EKG: 12 view of the heart's electrical activity, rate, rhythm
    - 10/8/2020 Sinus Tachycardia, viewable on EKG report
    - 10/9/2020 Normal Sinus Rhythm, viewable on EKG report
    - Patient not on cardiac monitoring in room.

2. X-ray: plain film of the chest
    - 10/8/2020 Chest x-ray, 1 view, "no acute cardiopulmonary process" per doctor's report

3. Echocardiogram: ultrasound of the heart
    - 10/9/2020 "Ejection fraction estimated to be 65-70%" per doctor's report

4. CT: specialized x-ray that takes a picture of tissue
    - 10/8/2020 Abdominal and pelvic CT w/ and w/o contrast
      -"distal ileum thickening, concern for ileitis" per doctor's report
      -"wall thickening, concern for malignancy" per doctor's report
    - 10/8/2020 Brain and head CT, w/ and w/o contrast
      -no acute abnormality

Hopkins, T. B. (2015). *Lab notes: Guide to lab and diagnostic tests*. Philadelphia, PA: F.A. Davis Company.

Current Medications (10 points, 2 points per completed med)
5 <u>different</u> medications must be completed

Medications (5 required)

Brand/Generic	Zyloprim Allopurinol	Entereq Alvimopan	Lovenox Enoxaparin	Prozar Fluoxetine	Zestril Lisinopril
Dose	100 mg	12mg=1 cap	40mg	20mg	40 mg, 2 tabs
Frequency	Daily	BID	Daily	Daily	Daily
Route	Oral	Oral	Sub-Q shot	Oral	Oral
Classification	Anti-gout drug	GI order agent	Anticoagulant, antithrombic	Antidepressant	Antihypertensive
Mechanism of Action	Reduces uric acid production	Antagonist to GI tract activity	Binds to antithrombin 3 inactivating factors	Inhibits uptake of serotonin in the CNS	Suppresses renin-angiotensin-aldosterone system
Reason Client Taking	Gout	GI motility impairment	Anticoagulant	Anti-depressant, anxiety	Ace inhibitor for blood pressure
Contraindications (2)	1. Contraindicated in patients hypersensitive to drug 2. Those with renal/hepatic disease	1. End stage renal disease 2. Those taking therapeutic opioids doses recently	1. Heparin 2. Active major bleeding	1. Diabetes mellitus 2. Narrow-angle glaucoma	1.Hypersensitivity 2. Angioedema
Side Effects/Adverse Reactions (2)	Rash, drowsiness	Stomach pain, diarrhea	Unusual bleeding, confusion	Insomnia, tremors	High potassium, chest pain

Medications Reference (APA):

Hopkins, T. B. (2015). *Lab notes: Guide to lab and diagnostic tests*. Philadelphia, PA: F.A. Davis Company.

Skidmore-Roth, L. (2020). *Mosby's 2020 Nursing Drug Reference Guide* (33rd ed.). St. Louis, MO: Elsevier.

Assessment

Physical Exam (18 points)

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented to person, place, time and situation. Minimal distress upon movement due to surgical recovery. Well-groomed and appropriately dressed.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	 Pink Dry/normal Warm Normal turgor, good elasticity None Small bruise on L knee from fall None Score of 20 (4 for sensory perception, 4 for moisture, 3 for activity, 3 for mobility: hindered by surgical recovery but patient able to move limbs, neck, etc. freely, 3 for nutrition: currently NPO but being changed to food for lunchtime meal, 3 for friction and shear.)
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head and neck symmetrical, ears symmetrical with no drainage present, eyes PEARRL, patient wearing glasses, nose free of drainage, no missing teeth from those visible while smiling. .
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Heart sounds heard as regular 2+, regular S1 and S2. No murmurs, gallops or rubs auscultated. Capillary refill present, < 3 seconds. Peripheral pulses: felt in brachial and dorsalis pedis. No edema present at time of assessment. No JVD present.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations auscultated as clear, equal lung sounds on anterior chest. No wheezes or crackles noted. Respirations of 20.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:**	Diet at home is regular. Patient currently NPO/"sips and chips" due to post surgery. Lunch was due to be the introduction of some food material. 5'11 224.8lbs Bowel sounds very active. Last bowel movement on 10/12/2020. No distention present. Surgical incision on lower left

Inspection: **Distention:** not present **Incisions: 1 surgical** **Scars: not present** **Drains:** **Wounds: not present** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	abdomen from hemicolectomy. No scars noted on patient. Small amount of drainage present around surgical incision, normal discharge color. Patient wearing abdominal binder. No ostomy present. No NG tube present. No feeding tube/PEG present.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type: French** **Size: 14**	 Amber Cloudy 350ml per output total over 24 hours. Currently, 14 French catheter placed.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☒	Patient has post-surgical weakness. Was ambulated to side of bed and sat in chair for first time post-surgery (performed by care personnel). Limited ROM due to recovery, abdominal binder, but periphery limbs active. Fall risk due to surgery and short recovery time. Score of 13 according to Briggs Healthcare Fall Risk Assessment form (approved by clinical instructor). Needs 1-person assistance to sit up, move to side of bed and ambulate to chair at bedside.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Weakness due to surgery, but able to move arms freely. Legs able to move but limited due to pain and abdominal binder. Pupils equal, round, reactive to light. Arm/ length strength assessed by care personnel. Oriented to person, place, time and situation. Articulate speech, able to converse well. Alert to surroundings and communication. Last LOC with syncopal episode prior to hospital admittance.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home**	Appropriate developmental level for age. Not religious. Patient has boyfriend, at bedside most of morning. Will be assisting patient with transport home, cooking and household chores, delivery of medications, etc. Patient with insurance, mentioned that insurance will cover

environment, family structure, and available family support):	copays for medication.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:15am	75	138/86	20	36.4 C	98% RA

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:20	Numerical 0-10	Abdomen	9/10	Sharp, sudden spasm with shortness of breath to accompany	PAC morphine at bedside, given to patient. Ativan delivered from nurse for anxiety. Change of bed position per patient request.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
1585ml from 24 hour total consisting of: Normal saline Medications Morphine	350 ml from 24 hour total: Catheter output

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

1. Patient experiencing acute pain related to abdominal operation, as evidenced by facial grimace and verbal outcry from patient, during abdominal area spasm. States 9/10 pain during spasm. Patient has incisional wound with post-op drainage.	Speaking with patient about pain level and being in the room to experience when patient had painful spasm, chose acute pain as a primary diagnosis that would require nursing intervention.	1. Administer pain medication around the clock, as needed by patient. 2. Change of position for patient from bed to chair by lunch.	1. Goal met: PAC button with morphine placed at bedside. Additional pain and anxiety medication given by nurse. 2. Goal met: Patient had position adjusted from supine in bed to sitting on side of bed. Then he progressed to sitting in chair. Patient seemed more alert to be sitting up, stated "it felt good to get out of bed."
2. Patient at risk for infection, related to impaired skin integrity, as evidenced by surgical incision.	Having an interest in wound care, observed wound check with nurse and questioned about drainage, recovery time, dressings applied/ used. Hospital acquired infections can easily come from soiled dressings, exposure to infectious agents, etc. Routine care and cleaning must be performed.	1. Routinely checking wound for changes in drainage color/consistency. 2. Changing wound dressings regularly and re-securing abdominal binder.	1. Goal met: Wounds checks by nurse and student to assess for drainage amount, color, consistency. Found to be minimal discharge, clear, expected consistency. 2. Goal met: Wound dressings changed at discretion of nurse, abdominal binder checked and tightened upon found being loose.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Patient is recovering from hemicolectomy. Some pain with movement, as evidenced by outcry from patient and facial grimace upon spasm in abdominal region. States pain "9/10 during the spasm."

Nursing Diagnosis/Outcomes

1. Acute pain related to surgery (post 1 day) as evidenced by facial grimace and outcry during abdominal spasm, affecting abdominal incisional wound. States pain is 9/10 upon spasm in abdominal region, requests PAC morphine drip at bedside for usage.
-Goal met: Patient given PAC with morphine, self-dosing, pain decreased within half hour. States pain is 2/10 after receiving morphine and anti-anxiety medication from nurse.
-Goal met: Patient changed to several new positions, side of bed and then seated in room chair. States "feels good to be sitting up and out of bed."

2. Risk for infection related to patient's impaired skin integrity, as evidenced by abdominal surgical incision.
-Goal met: Wound check performed by nurse and student to assess for drainage. Found to be minimal drainage, not amount for concern.
-Goal met: Wound dressings changed at discrepancy of nurse. Abdominal binder re-secured upon found being loosened from movement.

Objective Data

Chief complaint of dizziness and multiple syncopal episodes. Diagnosed with colon cancer within the last week.
Vitals
BP: 138/86
HR: 75
RR: 20
Temp: 36.4 C
SpO2%: 98
Pain:
-9/10 with abdominal spasm
-2/10 after PAC morphine and anxiety medication administered

Patient Information

0 y/o male, presents with dizziness and multiple syncopal episodes. Recent diagnosis of colon cancer. EKGs show ST and NSR. Abdominal CT shows distal ileum thickening, concern for malignancy. Brain/head CT shows no acute abnormality. Chest XR, 1 view, shows no acute cardiopulmonary concern. Echocardiogram shows EF estimated at 65-70%.

Nursing Interventions

1. Administer pain medication to reduce patient pain assessment.

2. Change position of patient from supine to seated at dge of bed to sitting in chair at the bedside.

. Check wound for drainage, watch for increase wound seepage outside of the circle drawn on dressing.

4. Change wound dressings as needed and re-secure abdominal binder if loosened.