N311 Care Plan #3

Lakeview College of Nursing

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Demographics

Date of Admission	**Patient Initials**	**Age**	**Gender**
10/27//2020	K.C.	07/12/69 (51 years old)	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White/ Caucasian	Works at Amarin Corporation	Married (1 son, 2 grandchildren)	Hydrocodone Reaction: itching Start date: 10/22/14
Code Status	**Height**	**Weight**	**Assistive Device**
Full	5'8"	183 pounds (83 kg) BMI: 27.8	None
Primary Language	**Religion**		
English	Christian		

Medical History

Past Medical History:

Patient has a medical history of the following: diverticulitis of colon and intestine (starting in 1/3/20), esophageal reflux, hypercholesterolemia, EOTH abuse, gastroesophageal reflux disease (GERD) 11/4/2019, seasonal allergies. Patient denies any childhood illness or infection. Patient was hospitalized prior once due to complications and flair up of his diverticulitis. Patient denies any past screenings or examinations with the exception of his pap smear in early 2020.

Past Surgical History:

1. Colonoscopy (2/28/2010)
   -Small ascending colon poly removed with the biopsy forceps. Left sided diverticular disease and has significant diverticular stricture at 15-25 cm with inflammation
   - At the age of 40-41
2. EGD (6/18/2015)
   -At the age of 45
3. Sigmoidoscopy (2010)
   - At the age of 41
4. Robotic Sigmoid Colectomy, indecently appendectomy (10/27/20)
   - At the age of 41

Patient denies any other past surgeries (besides the one listed above) or upcoming surgeries. Patient stated he has had dental procedure which included the removal of his wisdom teeth when he was younger.

Family History:

Mom (Alive)- history of Ulcerative Colitis (UC), Mutiple Myeloma and cancer
Dad (Deceased)- alcohol abuse

Social History (tobacco/alcohol/drugs):

Patient reports he never used smokeless tobacco. Patient denies any use of recreational or illicit drug. Patient is a light tobacco smoker. Patient states he smokes one fourth of a pack of cigarettes a day. Patient states he drinks "a lot" of alcohol. When asked how much, patient stated he drinks roughly 20 shots of liquor a day, depending on what day it is. Patient states on other days he drinks a three to four 12 ounces alcoholic beverages a day. Patient states he has drank in excess for the past 20 years. For living arrangements, patient lives with his wife in Illinois. Patient is sexually active with his partner.

Admission Assessment

Chief Complaint:

Lower abdominal; patient stated "I think I have diverticulitis again"

History of present Illness:

K.C. is a 51 year old Caucasian male with a history of diverticulitis of the colon and intestine, esophageal reflux, hypercholesterolemia, EOTH abuse, gastroesophageal reflux disease (GERD) and seasonal allergies. With multiple attacks of diverticulitis getting worse over 15 years. He has them now every 4 months treated with flagyl and cipro and has a stricture in the sigmoid developing. Patient's current outpatient medications are: icosapent ethyl (vascepa; 1g; taken 2g by mouth twice a daily), meloxicam (mobic; 15 mg tablet), omeprazole (20 mg tablet) and mometasone (50 mcg, 2 sprays by nasal daily).

Primary Diagnosis

Primary Diagnosis on Admission: Diverculitis Stricture

Secondary Diagnosis: ETOH abuse

Pathophysiology of the Disease, APA format: Diverculitis

In diverticulosis, the bowel wall was multiple weakened areas that form small outpouchings called diverticula. Diverticula often become inflamed, at which point the conditions becomes diverticulitis. This is a common condition that increases with age. Of these patients who has diverticulosis, it is said that “80% to 85% remain symptomatic (Capriotti, 2020). The complications include abscess formation. Patients with diverticulitis who do not have surgery have a recurrence rate of 20% to 35% (Capriotti, 2020). Both females and males are equal to getting this disease. Two main factors of diverticular disease is weakness of the bowel wall and increase intraluminal pressure. This occurs when intestinal contents block the diverticulum, thus cutting off the blood supply and providing an environment where infection can occur (Strate & Morris, 2019). The most significant risk factor for diverticular formation is an individual who has a diet that is low in fiber. It is said to be linked to low fiber diet and obesity. There are also genetic factors as those with a family history tend to have an increased risk of diabetes. Weakness in the bowel muscles can occur where blood supply is at and enter the colonic wall which creates an area for bowel protrusion during periods of increased intra-abdominal pressure (Strate & Morris, 2019). When the bowel does not drain effectively, the contents becomes trapped inside and collect which then causes a mass to form which leads to an obstruction and irritation to occur within the bowel. This all thereby leads to diverticulitis. This happening for an expended amount of time can cause scarring and narrowing of the bowel. The signs and symptoms that are typically for a patient to present with depends on the how serve the

inflammation is. It can be a dull, episodic or a steady left quadrant or middle abdominal pain. A fever, tachycardia, constipation, diarrhea, increased flatus and anorexia can also occur. On the other hand, a patient with this can also present with no physical signs on examinations. A tall tell sign of diverticulitis is left lower quadrant abdomen tender, fever and nausea. Hidden blood is the stool is also observed in patients with this. An x-ray, CT scan, ultrasound or MRI is used to confirm cases of diverticulitis. Colonoscopy can also visualize the location of diverticula within the colon; however, it should not be done during acute diverticulitis (Capriotti, 2020). Treatment for this disease includes resting the bowel with a liquid diet and gradual reintroduction of a soft diet. Seven to ten days of antibiotic therapy and pain medications are also used. Recurrent attacks may result in progressive fibrosis and scarring causing the formation of a stricture. This is what my patient had which resulted in him needing to get surgery. The aim of surgery is to remove the diseased colonic segment while attempting to preserve the colonic integrity by creating a connection between two segments of the bowel (Capriotti, 2020). My patient developed diverticulitis and chronically due to smoking and ETOH abuse due to the nicotine weakening the bowel walls and alcohol causing the vessels in the bowel to tighten and constrict which can ensure have a negative effect on his blood pressure which is has. This patient has elevated blood pressure readings on multiple occasions while being hospitalized, one of which is 178/92.

Pathophysiology References (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives 2nd Edition* (2nd ed., p. 562). Philadelphia: F A Davis.

Strate, L. L., & Morris, A. M. (2019). Epidemiology, Pathophysiology, and Treatment of Diverticulitis. *Gastroenterology*, *156*(5), 1282-1298.e1. https://doi.org/10.1053/j.gastro.2018.12.033

Laboratory Data

COMPLETE BLOOD COUNT

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RED BLOOD CELLS (carry oxygen)	M: 4.7-6.1	5.2	**4.13**	Heavy drinking is linked to a decrease in red blood cell production, as well as the loss of existing red blood cells from damage to the heart, internal inflammation, and lowered immune system. Smoking can lead to deranged morphology of red blood cells which result in reduced oxygen caring capacity of the blood.
HEMOGLOBIN (oxygen-carrying protein in RBCs)	M: 13.8-17.2	17.1	13.8	
HEMATOCRIT (the proportion of RBCs to the fluid component, plasma in your blood)	M: 41-50	48.9	**38.6**	Low hematocrit levels due to an insufficient supply of health RBCs most likely caused by chronic alcohol abuse for this patient. It can induce premature red blood cell destruction. Since the body is under stress when constantly fighting against the inflammation and damage of tobacco, it causes an increased number of RBCs.
PLATELETS (help with blood clotting)	150,000-400,000	245,000	243,000	
WHITE BLOOD CELLS (fight infection)	4,000-10,000	6.10	4.13	
NEUTROPHILS (type of WBC that the bone marrow creates; travel into blood stream and move to areas of infection and neutralize that area)	40-60	**64.2**	**83.2**	This patient has an increased neutrophils level due to infection, injury and chronic inflammation to the diverticula. With smoking, the white blood cells stay high to help defend the body from infections.
LYMPHOCYTES (B cells: produce antibodies to attack bacteria T-cells: kill infected cells	20-40	**18.8**	**7.1**	Due to this patient being a chronic smoker for an extended amount of time, it decreased lung function which increases exacerbation. This is all due to infection and inflammation and illness.

MONOCYTES (fight infection; help remove dead tissues; destroy cancer cells)	2-8	**13.3**	**9.5**	High levels of monocytes may indicate the present of chronic infection which for this patient is the infection in many of the small pouches in the digestive tract.
EOSINOPHILS (participating in immediate allergic reactions)	1-4	2.5	1	
BANDS (immature form of neutrophils; produced in excess during infection to help fight disease)	3-7	N/A	N/A	

Chemistry

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
NA- (Control BP and blood volume; needed for muscle and nerves to work)	135-145	136	137	
K+ (helps your nerves to function and muscles to contract; heartbeat stay regular; move nutrients into cell and waste products out of cell)	3.5-5.0	4.5	4.1	
Cl- (helps keep the amount of fluid inside and outside of your cells in balance; maintain blood volume, BP and pH)	95-105	98	101	
CO2 (regulates the pH of blood, stimulates breathing, and influences	23-30	30	26	

the affinity hemoglobin has for oxygen)				
Glucose (for energy)	70-110	96	**154**	A reasoning for an increased glucose level could be stress from surgery or just hospitalization. Stress blocks your body from releasing insulin, and lets glucose pile up in your blood. If you're stressed for a long time, your sugar levels will keep building. Alcohol can also be another reason. Beer and wine can increase you blood sugar. Alcohol stimulates your appetite, which can cause you to overeat and may increase your blood sugar. Alcoholic drinks also contain a lot of calories. Nicotine also does not respond to insulin which increases blood sugar levels. Cigarettes harm cells and causes inflammation which makes cells stop responding to insulin.
BUN (measures the amount of nitrogen in your blood that comes from the waste product urea; indicates how well your kidney are working)	10-20	13	**7**	BUN is decreased for this patient due to dehydration. Alcohol can cause dehydration as it is a diuretic. It causes your body to remove fluids from your blood thorough your renal system which includes the kidneys and bladder at a much quicker rate than other liquids. If you do not drink enough water with alcohol, you can become dehydrated quickly.
CREATININE (to be filtered and eliminated in urine)	0.6-1.5	0.96	0.76	
ALBUMIN (helps keep fluid in your bloodstream so it doesn't leak into other tissues)	3.5-5.0	3.5	3.7	
CALCIUM (stored in bones and teeth; supports structure; carries massages between the brain and body parts)	8.5-10.0	9.8	8.8	
MAGNESIUM (required for energy production)	1.5-2.5	N/A	N/A	
PHOSPHATE (build and repair bones and teeth, help nerves function, and	2.8-4.5	N/A	N/A	

make muscles contract)				
BILIRUBIN (orange-yellow pigment that occurs normally when part of your red blood cells break down)	0-0.3	**1.1**	**0.8**	When the liver is badly damaged with high intake of alcohol chronically, it becomes swollen over time. This swelling causes obstruction and blocks the removal of bilirubin, and bilirubin levels than rise in the blood.
ALK PHOS (mostly found in the liver, bones, kidneys, and digestive system. When the liver is damaged, ALP may leak into the bloodstream)	20-90	90	68	

Urinalysis

Lab Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Reason for Abnormal** *An updated urinalysis was not administered to this patient, besides the one taken upon admission to the ED on 10/19/20.*
COLOR & CLARITY	Colorless-Yellow, Clear	Clear, **amber**	Clear, yellow	Alcohol can cause dehydration which can cause a darker colored urine. When you are dehydrated, the color of your urine becomes more concentrated. Severe dehydration can produce urine the color of amber.
pH	6-8.0	6.0	6.0	
SPECIFIC GRAVITY (test compares the density of urine to the density of water; help determine how well your kidneys are diluting your urine)	1.005-1.030	1.020	1.026	
GLUCOSE	Negative	Negative	Negative	
PROTEIN	0-8	0	0	
KETONES (fuels for the body that are made when glucose is in short supply)	Negative	Negative	Negative	

WBC	0-4	Negative	0-5 (trace)	
RBC	0-3	Negative	0-2	
LEUKOESTERASE	Negative	Negative	Negative	

Cultures

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
URINE CULTURE	Negative	None ordered	N/A	
BLOOD CULTURE	Negative	**Trace**	Negative	Alcohol causes changes in the function of the kidneys and makes them less able to filter the blood. When alcohol dehydrates the body, it can affect the kidney's normal function and it can allow blood cells to leak into urine. Large diverticula can result in hematuria.
SPUTUM CULTURE	Negative	None ordered	N/A	
STOOL CULTURE	Negative	None ordered	N/A	

Lab Correlations Reference (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). Mosby's diagnostic and laboratory test reference. St. Louis, MO: Elsevier.

Diagnostic Imaging 10/10

All Other Diagnostic Tests:

CT exam of abdomen pelvis with contrast (6/17/2015)

There is a new 1.8 cm nodule with in the left lung. There are multiple hypo attenuated round lesions involving the liver which statistically represents cysts or hemangiomas in a patient with no known history of malignancy.

Upper GI endoscopy, exam (6/18/2015)

Cancer PSA Screen (11/4/19 @ 0913)

Result: 1.76

Bile ducts: no gross abdominal ductal dilation
Gallbladder: no evidence for gallbladder stone, thickening or pericholecystic fluid
Pancreas: no evidence for peripancreatic inflammation, pancreatic duct dilation or mass
Spleen: normal
Liver: there are multiple hypo attenuated round lesions involving the liver which statistically presents cysts or hemograms
Colon: there are inflammatory changes surrounding the sigmoid colon with diffuse wall thickening of the sigmoid colon worrisome for underlying infections or inflammatory colitis

There is a new 1.7 cm dominant nodule with in the left lung base.

COVID-19 (10/24/20 @ 0905)
Results: not detected

Current Medications

Brand/Generic	**Diphendrydramine (Benadryl)**	**Dexamethasone (Decadron)**	**Enoxaparin (Lovenox)**	**Metoclopramide (Reglan)**	**Naloxone (Narcan)**
Dose	1 capsule (25 mg)	4 mg	40 mg	10 mg	0.5 mg
Frequency	Every 6 hours PRN	Once then PRN	Every 24 hours (scheduled)	Every 6 hours PRN	PRN
Route	Oral	IV	IV	IV	IV
Classification	Antihistamine	Anti-inflammatory	Anticoagulants	Gastroprokinetic	Opioid
Mechanism of Action	Acts as an inverse agonist at the H1 receptor, thereby reversing effects of histamine on capillaries, reducing allergic reaction syndromes. Also acts an intracellular sodium channel blocker, resulting in local anesthetic properties.	Anti-inflammatory effects are complex, but primary via inhibition of inflammatory cells and suppression of expression of inflammatory mediators.	Binds to potentiates antithrombin to form a complex that irreversibly inactivates clotting factor Xa.	Causes antiemetic effects by inhibiting dopamine D2 and serotonin 5-HT3 receptors in the chemoreceptor trigger zone located in the area postrema of the brain	An opioid antagonist that antagonizes opioid effects by competing for the same receptor sites. Reverses the effects of opioids, including respiratory depression, sedation and hypotension.
Reason Client Taking	Itching	Allergies	Prevent blood clot	GERD	Alcoholism
Contraindications (2)	Overactive thyroid glands, high blood pressure, peptic ulcer, urinary bladder	Untreated tb, infection of the eye, infection due to fugus, roundworm	Hypersensitivity, major bleeding such as GI, thrombocytopenia, ulcers	Depression, Parkinson disease, seizures, tardive dyskinesia	hypersensitivity
Side Effects/Adverse Reactions (2)	Dry mouth, dizziness, drowsiness, constipation, chest congestion	Irritability, heartburn, weakness, increased blood sugar levels,	Fever, bleeding, anemia, pain, bruising, swelling in legs	Headache, confusion, dizziness, restlessness, sleepiness	Body aches, fever, sweating, runny nose, sneezing, goose bumps

Medications Reference (APA):

Institute for Safe Medication Practices: ISMP Medication Safety Alert

http://www.ismp.org/. Jones & Bartlett Learning. (2019). 2019 Nurse's Drug

Handbook. Burlington, MA

Assessment: ***Physical Exam***

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Patient is a middle aged Caucasian male. He is alert and orientated to situation and person, time and place. Patient does not wear any assistive devices like glasses, contacts or walker. Patient appears to be well groomed and in no acute distress, well-developed and not ill-appeared. Patient was calm and cooperative. Patient appears stated age. **Patient denies fatigue, weight changes, fevers, chills, night sweats.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:**	Patient's skin is warm, pink and dry. Patient has impaired skin integrity related to incision. No rashes or lesions or erythema present other then incision site. Patient has an incision site on abdomen that was placed on 10/27/20 @ 0851. No drainage is present at the site of incision. Transparent film gauze dressing. Incision site is closed, dry and intact with dressing in place. Patient has no bruising to his skin. Patient is not pale or ashy. Patient's nails are without clubbing and cyanosis. Skin turgor normal mobility, quick to return to original state. Patient had no wounds at the time of this assessment. Patient has a JP drain device site in left upper quadrant. It's a collapsible closed device placed at 10/27/20. Drainage is serosanguinous, amount is small. Patient has peripheral IV line single lumen median cubital vein right 18 gauge. Dressing is dry and intact secreted with sterile tape stripes. No signs of phlebitis and infiltration. IV was placed at 10/27/20 @ 0603. When asked patient stated his peripheral IV site does not feel painful or tender. Patient's **Braden score is an 20** (4 – no impairment, 4 – rarely moist, 3 – walk occasional, 3 – slight limited, 3 – adequate, 3 – no apparent problem). Patient states skin was itchy due to medication he is taking, but Benadryl helps along with lotion being apply to his back. **Patient denies dryness, rashes, lesions, non-healing sores, hair changes, purities.**
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Patient's head and neck are symmetrical. Trachea is midline without deviations, thyroid is not palpable, no nodules noted at the time of assessment. Bilateral carotid pulses are palpable and strong. No swollen lymph nodes in the head or neck region. Bilateral sclera white, bilateral cornea clear. Bilateral conjunctiva pink, no visible discharge in eye bilaterally. Bilateral lids are pink and dry without lesion. PERRLA bilaterally, red light reflux

	present bilaterally. EOMs intact bilaterally. Septum is midline. Bilateral frontal sinuses are nontender and to palpation. Bilateral auricles moist and pink without lesions noted. Dentition is good, oral mucous overall is moist and pink without lesions noted. Patient's hair is thick, grey and even distribution. Oropharynx is clear. No discharge present right and left ear. External right and left ear normal. Normal range of motion and neck supple. **Patient denies experiencing headaches, head injury, blurry vision, double vision, earache, drainage, change in hearing, nasal congestion, nose bleeds, nasal drainage, dry mouth, sore throat, swallowing difficulty.**
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:**	Clear S1 and S2 sounds heard without the presence of murmurs, gallops or rubs. PMI at 5th intercostal space at MCL. All extremities warm, pink and dry. Peripheral pulses are 1+ throughout bilaterally. No edema observed or palpated bilaterally though out extremities. Homan's sign is negative bilaterally. Capillary refill less than 3 seconds in fingers and toes bilaterally throughout. No neck vein distention noted in this patient. **Patient denies chest pain, palpitations, diaphoresis, dyspnea, PND, Orthopnea, claudication.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular, even and symmetrical and nonlabored bilaterally. Lung sounds are clear throughout bilaterally. No wheezes, crackles or rhonchi noted. Bilateral equal air entry. **Patient denies wheezing, cough, increase in sputum production. Anterior, lateral, clear and equal bilaterally.**
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:**	Patient is on a full liquid due to surgery and them wanting this bowel to be prep and full cleared. As his recovery progress, patient's tolerance for food can return back to normal and is being closely monitored while in the hospital. Patient states he would describe his eating habits and diet at home to be high in "protein, fiber and low sugar". Patient states either him or his wife prepares his food. Patient states he had a good appetite and no trouble eating. Patient eats well and shows no signs of difficulty eating. Patient uses no assistive devices to aide in eating. Patient does require set up help with each meal. Patient is 5'8". Patient weights 183 pounds. Patient's abdomen is soft, flat, nontender, no masses noted upon light palpation

Wounds: **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	of all the LUQ, RUQ, RLQ quadrants. Patient did feel tender in LLQ where his incision site was. Deep palpation was not done with this patient due to current surgery and tenderness to the abdomen and incision site. Bowel sounds are normoactive in all four quadrants. There's no abdominal tenderness or guarding or rebound pain beside sin the patient's LLQ. No signs of distention, ostomy or nasogastric feeding nudes/ PEG tubes. Patient swallows food without difficulty and has no indicators of nutrition risks. Patient's last bowel movement was 10/29/20 at 1am. Patient described bowel movement as being brown and loose/ diarrhea. Patient is passing flatus and tolerating full liquids well. **Patient denies nausea, vomiting, diarrhea, abdominal pain, heartburn, jaundice, hematochezia, melena. Last episode of nausea and/or vomiting was "a while ago" according to patient. Patient is passing gas. Patient's last bowel movement was 10/29/2020. Patient's bowel movement was described as being brown and diarrhea. _____**
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:**	Patient's urine appears to be yellow, clear and absent of foul odor. Patient has a normal stream of urine and consent flow. Patient's genitals appear to be intact, no abnormalities noted. Patient does have a catheter at the time of this assessment. Patient voids spontaneous without difficulty. Patient voided 1, 525 ml in total during my shift on 5 different occasion (4 of which is through the foley and once in the urinal). Patient's urine was clear yellow, no malodor and not cloudy. Patient described his urine production as being good. Patient stated he did notice an increase in frequency of urination but believes it is due to the IV he is taking. Patient has an 18g indwelling catheter. Patient's foley catheter was removed during the shift at 10a. Patient voided 300 mL in the urinal afterwards. Patient stated there was difficulty in urinating. **Patient denies burning or pain, hematuria, incontinence, flank pain while urinating.**
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☐ N☒**	Patient appeared to be alert LOC. Patient arousal level was she opened his eyes spontaneously. Patient is a one assist with stand by assist. Patient demonstrated active range of motion bilaterally throughout. Patient fall risk score is a 5 (1 – male, 2 – mobility deficit/ weakness, 2 – altered elimination). Patient's bed alarm, fall reduction program maintained, non-skid shoes/ slippers, when out of

Fall Score: **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐ **X**	bed, ambulated encouraged and dorsiflexion/ plantar flexion and anticoagulant therapy initiated. Patient maintains good balance with a stand by assist and gait belt. Patient ambulated 100 feet in the hallway during the shift. Patient tolerated ambulation well. This was the first time the patient has ambulated extensively since surgery 2 days ago. Patient showed no signs of difficulty breathing. Patient is a stand by assist. Patient needed no cueing and set up assistance. Patient was encouraged to engage in as much as he can independently; all personal objects within reach. Patient's general motor response was normal.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Patients speech was logical, well-paced, spontaneous and clear. Patient's mood and behavior was cooperative, calm and talkative. Patient's memory was normal. PERRLA bilaterally. Patient's hand grip and ankle strength were strong bilaterally. Patient is alert and orientated to situation and person, time and place. Patient is full concisions and alert. Patient displays no signs of confusion. CAM score negative. No acute, inattention, altered LOC, disorganized thinking.
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Patient states he copes with different stressor in his life by drinking alcohol a majority of the time, but this is an unhealthy habit he is trying to change. Instead he wish spending time with his wife and grandchildren were a way he could cope with his stressors. Patient's CAGE score was a 0, however I feel like if the patient was truly being honest, it would be much higher. Patient's developmental level is appropriate for his age. Patient stated he is a Christian. Patient states he desired a prayer stating he always accepts positive thoughts coming his way. Patient also wanted prayers for healing as well as elderly in general knowing they are struggling with isolation due to COVID. Patient states his main support team consist of his wife and her son.

Vital Signs

Time	Pulse	B/P	Resp Rate	Temp	Oxygen

0710	76 (right radial)	144/90 (right arm; HOB 30)	16 (unlabored)	98.6 F (oral)	93% (room air)

Pain Assessment

Time	Scale	Location	Severity	Characteristics	Interventions
1125	5 out of 10	Lower abdomen by incision (LLQ area)	Moderate and intermittent pain	Dull and soreness	Patient uses pain pump (PCA) to manage pain. Patient had slight nonverbal indicators present by the patient grimacing. Patient complained of pain and discomfort and was encouraged to manage pain appropriately before it got worse.

Intake and Output

Intake (in mL)	Output (in mL)
200 mL (apple juice) 50% of cream of wheat	All of patient's urine throughout shift was yellow, clear urine, free of foul odor. No bowel movement during shift 0730 – 300 mL (foley) 0815 – 300 mL (foley) 0956 – 375 mL (foley) 0958 – 150 mL (foley) 1030 – 400 mL (urinal; post foley being removed) **TOTAL: 1,525 mL**

Patient is on a full liquid diet due to being postoperative surgery 2 days. For breakfast, patient ate cream of wheat and a cup of apple juice (200 mL). patient ate 50% of cream of wheat. Patient was encouraged to eat as much as tolerable to promote good and healthy wound healing.

Nursing Diagnosis

Nursing Diagnosis	Rational	Intervention	Evaluation
1. infection **related to** inadequate primary defense, indwelling catheter, drains, IV devices, invasive procedures **as evidenced by** broken skin and injured skin was incision was surgery, JP drain in place, foley catheter being used postoperatively for 3 days	Patient was admitted for surgery due to diverticulitis. Patient had an indwelling catheter placed the day of surgery on 10/27/20. Patient currently has an IV in place as well as a JP drain to prevent clotting at the incision site.	1. Maintain free of infection as evidenced by normal vital signs, absence of purulent drainage from incision site and JP drain from 7:30a-12:45pm on 10/29/20. 2. Explain the importance of wash hands with patients and between procedures with the patient by 7:30a-12:45p on 10/29/20.	1. Goal met. Patient maintained free of infection during shift on 10/29/20 from 7:30am to 12:45pm. Patient had an elevated blood pressure of 144/90, but that can be due to the stress of the surgery and being hospitalized. When you're in a stressful situation, your body produces a surge of hormones. These hormones temporary increase your blood pressure by causing the heart to beat faster and your blood vessels to narrow. Patient's incision site had no abnormal drainage. Patient's incision site was covered with a transparent gauze dressing that is dry, closed and intact. Patient drain device site that is in the lower upper quadrant has serosanguinous drainage that was a small amount which is an expected finding 2 days postoperative. 2. Goal met. Patient explained it is important to perform proper handwashing to reduce the risk of infection and transmitting pathogens during shift on 10/29/20 from 7:30am to 12:45pm. Patient stated it will "help me not get anymore further surgeries and go home to my dad and wife sooner".
2. Ineffective individual coping **related to**	K.C. is hospitalized for a fair up in his	1. Patient will verbalize feelings of fears and	1. Goal was met. Patient stated one thing that makes him

inadequate coping skills with substitution of drugs **as evidenced by** negative role modeling, impaired adaptive behavior, decreased ability to handle stress resulting in hospitalization, losing time on job, verbalized of inability to cope.	diverticulitis that worsens with cigarettes and alcohol consumption. By this patient's own admission, he abuses ETOH. Patient consumes 12 ounce alcohol beverages, 20 shots of liquor sometime a day and other days he drinks roughly 5-6 drinks a day. Patient also stated he smokes ¼ of a pack of cigarettes a day, but increases his intake on the weekend to 1/5 a pack depending on what's going on. Alcohol abuse and dependence can often arise from the use of alcohol as a failed coping mechanism.	anxiety to help him come to terms with issues and cope effectively by 12:45pm on 10/29/20. 2. Patient will be able to state the importance of learning relaxation skills, guided imagery and visualizations by 12:45pm on 10/29/20.	anxiety and nervous is getting hospitalized again for the same thing due to his drinking by 12:45pm on 10/29/20. Patient stated he was to stop drinking, but finds it extremely difficult to do since he has been engaging in this behavior for an extended amount of time. 2. Goal is met. I assisted the patient in learning and highly encouraged the use of relaxation skills like exercise, mediation, deep breathing and socializing with coworkers or friends or other family members. Also, the important of guided imagery and thinking about things getting better and how potentially his life could be with alcohol and the positive impact it can have with the people close to him to help the patient relax and develop new ways to deal with stress, problem-solve. Patient appeared to understand and verbalized the information back to me by 12:45pm on 10/29/20. Patient stated a way he could relax is playing with his dog in his backyard when he feels overwhelmed and stressed instead of drinking or consuming alcohol.

Other References (APA):

Ackley, B. J., Ladwig, G. B., & Makic, M. B. (2017). Nursing diagnosis handbook: An evidence-based guide to planning care (11th ed.). St. Louis, MO: Elsevier

Concept Map

SUBJECTIVE DATA

- Patient stated it will “help me not get anymore further surgeries and go home to my dad and wife sooner”.
- Patient stated a way he could relax is playing with his dog in his backyard when he feels overwhelmed and stressed instead of drinking or consuming alcohol
- Patient stated he was to stop drinking, but finds it extremely difficult to do since he has been engaging in this behavior for an extended amount of time.

Patient consumes 12 ounce alcohol beverages, 20 shots of liquor sometime a day and other days he drinks roughly 5-6 drinks a day. Patient also stated he smokes ¼ of a pack of cigarettes a day.

NURSING DIAGNOSIS/OUTCOMES

1. 1. infection **related to** inadequate primary defense, indwelling catheter, drains, IV devices, invasive procedures **as evidenced by** broken skin and injured skin was incision was surgery, JP drain in place, foley catheter being used postoperatively for 3 days
- Goal met. Patient maintained free of infection during shift on 10/29/20 from 7:30am to 12:45pm.
- Goal met. Patient explained it is important to perform proper handwashing to reduce the risk of infection and transmitting pathogens during shift on 10/29/20 from 7:30am to 12:45pm.

2. . Ineffective individual coping **related to** inadequate coping skills with substitution of drugs **as evidenced by** negative role modeling, impaired adaptive behavior, decreased ability to handle stress resulting in hospitalization, losing time on job, verbalized of inability to cope.
- Goal was met. Patient stated one thing that makes him anxiety and nervous is getting hospitalized again for the same thing due to his drinking by 12:45pm on 10/29/20.
- Goal is met. Patient appeared to understand and verbalized the information back to me by 12:45pm on 10/29/20. P

OBJECTIVE DATA

- Patient had an elevated blood pressure of 144/90, but that can be due to the stress of the surgery and being hospitalized being that the patient’s blood glucose was also elevated to 156.
- Patient’s incision site had no abnormal drainage. Patient’s incision site was covered with a transparent gauze dressing that is dry, closed and intact. Patient drain device site that is in the lower upper quadrant has serosanguinous drainage that was a small amount

Patient Information

K.C. is a 51 year old Caucasian male with a history of diverticulitis of the colon and intestine, esophageal reflux, hypercholesterolemia, EOTH abuse, gastroesophageal reflux disease (GERD) and seasonal allergies. With multiple attacks of diverticulitis getting worse over 15 years. He has them now every 4 months treated with flagyl and cipro and has a stricture in the sigmoid developing. Patient is currently prescribed outpatient

NURSING INTERVENTIONS

1. Observe patient’s incision site and drainage from JP drain every shift or when there is a change in status.

2. Wash hands between procedures to prevent pathogens from spreading from one area of the body to another.

1. Encourage and motivate the patient to extreme feelings that bring on feelings of fear, anxiety and nervousness.

2.Help patient explore alternative coping strategies to help manage time, feelings and relationships without alcohol and smoking.