N431 Care Plan # 1.3

Lakeview College of Nursing

Rece Doggett

Demographics (3 points)

Date of Admission	Patient Initials	Age	Female
11/07/2020	KT	55	
Race/Ethnicity	Occupation	Marital Status	Allergies
White	Employed – Full time	Married	Penicillin
Code Status	Height	Weight	
Full	5’ 7”	206 lb.	

Medical History (5 Points)

Past Medical History: KT has a history of Diverticulitis. There are no other records of past medical history for other issues.

Past Surgical History: A colonoscopy was performed on 01/16/2018. This was the only surgery listed in the chart.

Family History: KT’s father has a history of osteoarthritis.

Social History (tobacco/alcohol/drugs): KT stated she drinks on occasion, mostly socially, with no previous use of tobacco or drugs.

Assistive Devices: KT wears glasses because she is legally blind.

Living Situation: Client lives at home with husband. She stated that all of her kids have moved out and started their own lives.

Education Level: KT stated she graduated college with her bachelor’s degree.

Admission Assessment

Chief Complaint (2 points): Abdominal pain

History of present Illness (10 points): KT started to experience initial symptoms of abdominal pain and a headache on Friday, November 6th. She continued by saying that the pain continued to get worse throughout the evening and soon was unable to handle the pain come Saturday. The pain started in her left lower quadrant (LLQ) and began to spread to the left flank late Saturday

morning as the flair up progressed. The pain was described as a sharp, stabbing pain which contradicts what was in the chart. The chart stated that the pain was dull and achy. KT stated, "The pain got significantly worse when I took a deep breath." Nothing helped the pain get better which resulted in her driving herself to the emergency department. In the emergency department KT received IV antibiotics and was set to an NPO diet. She was then admitted to the medical-surgical east floor. She denies any pain or discomfort after her 2nd day of admission.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Diverticulitis

Secondary Diagnosis (if applicable): Urinary Tract infection

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

Diverticulitis is defined as the swelling and inflammation of the diverticula which are small, bulging patches that are along the lines of the intestine (Mayo Clinic, 2020). The diverticula usually form in area where the colon is naturally weak. That weak spot may become torn or protruded out of the intestinal wall. The protrusions are pouches about the size of a marble (Mayo Clinic, 2020). Hinkle & Cheever state, "Diverticulitis results when food and bacteria retained in a diverticulum produce infection and inflammation…" (Hinkle & Cheever, 2020, pg. 1297).

Signs and symptoms are listed on Mayo Clinic's website with descriptions of each one. Signs and symptoms include pain, nausea, vomiting, fever, abdominal tenderness, constipation, or diarrhea. KT had experienced abdominal tenderness, pain, and nausea when her flair up began. She stated the pain was very intense to the point where she tried not to move at all. The client was diagnosed with this disease when she was in her mid-40s, so she learned early on how

to take care of herself. Although a risk factor for being diagnosed with diverticulitis before the age of 55 may be related to obesity (Hinkle & Cheever, 2017). Risk factors for this disease include age >55, obesity, smoking, lack of exercise, diet high in fat and low in fiber, and certain medications such as steroids, opioids, and NSAIDS. This client has no history of smoking and the chart makes no mention of a history of obesity, but it did state she was currently overweight according to her BMI.

The testing that is likely to occur are blood and urine tests for infection, in women - pregnancy test, liver enzyme labs, a stool test, and a CT scan to detect inflammation. This client had received a CBC, CMP, BMP, and a CT scan during her stay in the hospital. All of these tests are used to look for the primary source of the pain or infection. The CT is the most accurate test used to diagnose diverticulitis. Treatment includes antibiotics and a liquid diet for a few days. If the attack is more severe IV antibiotics will be used (Mayo Clinic, 2020). KT required IV antibiotics and was started on an NPO diet before she was put on a clear liquid diet. Surgery may be an option if you have frequent GI problems. The two surgeries you may have are primary bowel resection or bowel resection with colostomy. KT did not receive either of these surgeries because she manages her disease very well.

Pathophysiology References (2) (APA):

Diverticulitis - Symptoms and causes. (2020, May 7). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/diverticulitis/symptoms-causes/syc-20371758

Hinkle, J. L., & Cheever, K. H. (2017). *Brunner & Suddarth's textbook of medical-surgical nursing*. LWW.

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	4.4 – 5.8	4.27	3.97	
Hgb	13 – 16.5	13.9	12.9	
Hct	38 – 50	40.8	38.5	
Platelets	140 – 446	267	240	
WBC	4 – 12	14	8.6	High white blood cell counts are common with infection. Both diverticulitis and the UTI are the cause of this abnormality.
Neutrophils	40 – 60	69.9	58.9	
Lymphocytes	18-42	23.4	32.5	
Monocytes	4-12	5.0	6.1	
Eosinophils	0.0 - 5.0	0.6	1.1	
Bands				

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	133 – 144	143	138	
K+	3.5 – 5.1	4.1	3.9	
Cl-	98 – 107	106	104	

CO2	21 – 31	24	25	
Glucose	70 – 99	98	100	
BUN	7 – 25	17		
Creatinine	0.5 – 1.2	0..84		
Albumin	3.5 – 5.7	4.4		
Calcium	8.6 – 10.3	9.9		
Mag				
Phosphate				
Bilirubin	0.2 – 0.8	0.4		
Alk Phos	34 - 104	83		
AST	13 - 39	32		
ALT	7 – 52	24		
Amylase				
Lipase				
Lactic Acid				
Troponin				
CK-MB				
Total CK				

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

Lab Test	Normal	Value on	Today's	Reason for Abnormal

	Range	Admission	Value	
INR				
PT				
PTT				
D-Dimer				
BNP				
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				
TSH				

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	Yellow/Clear		
pH	4.5 – 8.0	6.0		
Specific Gravity	1.003 – 1.030	1.020		
Glucose	Neg	Neg		
Protein	Neg	Neg		
Ketones	Neg	Neg		
WBC	Neg,0 – 2	6 - 10		This is a clinical sign of a UTI.
RBC	Neg, 0 – 2	Neg		
Leukoesterase	Neg	2+		This is a clinical sign of a UTI.

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				
PaO2				
PaCO2				
HCO3				
SaO2				

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	No growth	N/A	No growth x 1 day	
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Hinkle, J. L., & Cheever, K. H. (2017). *Brunner & Suddarth's textbook of medical-surgical nursing*. LWW.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):CT of abdomen and pelvis w/o contrast. Shows two cysts on the right lobe of the liver being 1.3 and 1.5 cm in size. The stomach and bowel findings are

consistent with acute diverticulitis in the mid descending and sigmoid colon. The CT shows inflammation and multiple colonic diverticula according to the report.

Diagnostic Test Correlation (5 points): The CT was used for this patient to see look for reoccurring symptoms of the same disease. CTs are not the only scan the patient could have went through although it was the only one that was needed. If a more in depth picture was needed they may have scheduled an MRI. The reason the MRI was not needed is because the doctors believed the CT scan had shown what was needed to prove the cause of her presenting symptoms.

Diagnostic Test Reference (APA):

Radiological Society of North America (RSNA) and American College of Radiology (ACR). (2019, October 7). *Diverticulitis*. RadiologyInfo.org. https://www.radiologyinfo.org/en/info.cfm?pg=diverticulitis#

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

Home Medications (5 required)

Brand/Generic	Women's multivitamin	Flagyl Metronidazole			
Dose	1 tablet	1 tablet			
Frequency	Daily	PRN			
Route	PO	PO			
Classification	Dietary supplement	Antibiotic			
Mechanism of Action	Provides extra vitamins and minerals to body	Damages the DNA of bacteria			

Reason Client Taking	Health promotion	Diverticulitis flair ups			
Contraindications (2)	Hepatotoxicity, dehydration	Breastfeeding, hypersensitivity to drug or components.			
Side Effects/Adverse Reactions (2)	Abdominal px, nausea	Confusion, depression, chest pain			
Nursing Considerations (2)	Do we have proper dosage, provide water for the client to take capsule.	May interfere with lab values, ensure no drug-drug interactions			
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver enzyme and electrolytes	Liver enzymes, assess neurological status before and after.			
Client Teaching needs (2)	Should not take more than needed, this can not replace food and should be taken daily. (Jones & Bartlett, 2018)	If taking at home take as prescribed, encourage client to complete the full length of the medicine. (Jones & Bartlett, 2018)			

Hospital Medications (5 required)

Brand/Generic	Tylenol Acetaminophen	Lovenox enoxaparin	Norco Hydrocodone-acetaminophen	Levaquin Levofloxacin	Zofran ondansetron

Dose	650 mg	40 mg	5 – 325 mg	750 mg	4 mg
Frequency	PRN Q4	Daily	PRN Q4	Daily	PRN Q12
Route	PO	Sub-Q`	PO	IV	PO
Classification	Non opioid analgesic	Antithrombotic	Opioid analgesic	Antibiotic	Antiemetic
Mechanism of Action	Binds to pain receptors	Prevents blood from clotting	Binds to pain receptors	Interferes with bacterial cell reproduction	Blocks serotonin receptors
Reason Client Taking	Fever, pain	Risk of DVT	Acute pain	infection	Nausea/ Vomiting
Contraindications (2)	Hypersensitivity to components or drug, hepatic impairment	Active bleeding, pork products	Taking with acetaminophen (OD), use caution in those who have abused drugs in the past	Hypersensitivity to drug, myasthenia gravis	Do not use with apomorphine, hypersensitivity to drug
Side Effects/Adverse Reactions (2)	Agitation, anxiety, stridor	Confusion, epistaxis, bloody stools	N/V/D, abdominal pain	Anxiety, confusion, hallucinations	Agitation, drowsiness, arrhythmias
Nursing Considerations (2)	Use cautiously in those with hepatic impairment, monitor renal function, give as prescribed to prevent overdose	Use with caution in clients who have HIT, use caution with those who are at risk for bleeding, don't give IV med with fluids or other drugs running	Ensure proper dosage and administration, Check drug- drug interactions	Use cautiously in those with renal insufficiency Avoid giving drug within 2 hours of antacids	Monitor for hypersensitivity, dilute IV solution in 50 mL of D5W or saline.
Key Nursing Assessment(s)/Lab(s) Prior to	Liver enzymes should be	Liver enzymes, ensure	Liver enzymes, clients	Kidney function, assess for	Electrolyte specifically for

Administration	checked, assess clients pain before giving, don't give with the Norco	client does not have bloody stool or blood in vomit,	neuro and pain should be assessed before administration	signs of infection, check wbc	hypokalemia or hypomagnesemia, ensure no drug-drug interaction
Client Teaching needs (2)	It can be easy to overdose on Tylenol when taking with Norco because it also has the drug in it, take as recommended (Jones & Bartlett, 2018)	Tell client to notify if any adverse symptoms appear, emphasize importance of follow-up appointments (Jones & Bartlett, 2018)	This substance can be addictive, take as prescribed to avoid dependency. (Jones & Bartlett, 2018)	Advice diabetics to monitor blood glucose carefully, tell client to notify provider if severe diarrhea occurs (Jones & Bartlett, 2018)	Instruct client to place tablet under tongue or to swallow depending on what is ordered, take as instructed, follow prescription orders. (Jones & Bartlett, 2018)

Medications Reference (APA):

Learning, J. &. (2018). *2019 nurse's drug handbook*. Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:**	**KT presents to be AO x 4 with no acute distress. She is dressed in a hospital gown and**

Orientation: **Distress:** **Overall appearance:**	**sitting in a chair watching TV.**
INTEGUMENTARY (2 points): **Skin color: Pink** **Character: Dry** **Temperature: Warm** **Turgor: rapid recoil** **Rashes: None** **Bruises: None** **Wounds: None visible** **Braden Score: 22** **Drains present: Y☐ N ☒** **Type:**	
HEENT (1 point): See right **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**KT is normocephalic and has no audible, visual, or oral abnormalities. Smile is even on both sides and has no teeth missing. Overall KT has proper hygiene in every aspect.**
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable): Normal** **Peripheral Pulses: 2+ throughout** **Capillary refill: Rapid <3 seconds** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: None**	**S1 and S2 heart sounds audible with no S3 or S4 sounds present.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Client appears to breath in a normal pattern with clear lung sounds bilaterally.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height: 5' 7"** **Weight: 206lb** **Auscultation Bowel sounds: normoactive** **Last BM: Shortly after waking.** **Palpation: Pain, Mass etc.:** **Inspection: See right** **Distention:** **Incisions:**	**Diet is restricted for those who have diverticulitis. They are to be on a low-fiber diet. During flair ups antibiotics and a clear liquid diet is recommended (Mayo Clinic, 2019)** **There were no abnormalities while assessing the client's abdomen**

Scars: **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY (2 Points): **Color: Yellow** **Character: Clear** **Quantity of urine: voided 4x prior to assessment** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Client was dx with a UTI but still claims no pain with urination.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM: Full** **Supportive devices: glasses** **Strength: Strong/ full strength** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 0** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**Client does not display any physical impairments currently.** **KT stated that Saturday she was immobilized from the pain she was experiencing.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation: understanding** **Mental Status: follows commands** **Speech: clear** **Sensory: normal** **LOC: None**	**Client is alert and oriented x4. She is able to understand and follow commands as presented.** **Speaks clearly and at an appropriate tone.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):**	**Client enjoys hunting and fishing w/ their husband. Client has had her disease for over 10 years and has found the best ways of**

Developmental level: **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**managing it.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400	**78**	**121/70**	**16**	**98.8 Oral**	**99% RA**
1510	**76**	**122/77**	**18**	**98.7 Oral**	**100% RA**

Vital Sign Trends: Stable, little to no change throughout shift.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1400	**Numeric 1 – 10**	**N/A**	**0/10**	**N/A**	**None**
1515	**Numeric 1 - 10**	**N/A**	**0/10**	**N/A**	**None**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20G **Location of IV: Right median vein** **Date on IV: 11/7/2020** **Patency of IV: Patent, flushes** **Signs of erythema, drainage, etc.:** **IV dressing assessment: clean dry intact**	Saline lock – not currently in use

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

According to the chart ~ 900 mL	**~ 1200**

Nursing Care

Summary of Care (2 points)

Overview of care: Client has received antibiotics and pain medicines while during hospitalization. KT is currently feeling much better than when she first came in because of the medicine and care provided.

Procedures/testing done: CT of abdomen and pelvis, basic labs as listed in current care plan.

Complaints/Issues: Desire to go home.

Vital signs (stable/unstable): Stable throughout

Tolerating diet, activity, etc.: Currently tolerating ADLs well. She is up & lib and tolerating her diet well.

Physician notifications: Discharge approval if client tolerates normal diet.

Future plans for patient: Monitor symptoms and maintain appointments with PCP.

Discharge Planning (2 points)

Discharge location: Home

Home health needs (if applicable): None

Equipment needs (if applicable): None

Follow up plan: Continue any normal appointments with PCP.

Education needs: None currently. KT is very knowledgeable and informed on her disease and what she needs to do to prevent it. Unfortunately, flair ups are impossible to avoid 100% of the time.

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. Acute pain related to diverticulitis as evidenced by patient stating they were in pain and inflammation shown in CT	Pain management is essential to provide proper patient care regardless of what their condition is.	1.Ask client if she would like a warm blanket to help with pain 2.Assess pain via verbal and nonverbal cues.	Client responded well to pain interventions. She did not have much pain during my visit but the warm blanket was comforting. She made no mention of being in acute pain or showed no nonverbal signs of pain.
2. Electrolyte/Diet imbalance related to diet restriction as evidenced by diverticulitis and inability to tolerate certain foods.	The client has a restricted diet and is limited to what they can eat. This may cause electrolyte or diet imbalances.	1. Note exact weight without estimating to assess weight loss or gain. 2.Take a nutritional history with participation of those involved with preparing meals.	Client stated she had already been informed about this and provided teach back as proof of understanding. Client also mentions that she records what she eats just in case something new causes a flair up.
3. Ineffective protection of the body related to repeated flair ups as evidenced by multiple hospital	The client has a hx of diverticulitis and more than one hospital admission.	1.Monitor for signs of infection and early detection of disease symptoms. 2Assess immunization status and history of the	KT is currently feeling free of infection or pain as we observe normal vitals and absence of signs or symptoms. Early recognition allows for quick treatment which will result in less pain.

admissions.		client.	Client states immunizations are up to date and keeps up with her health hygiene.
4. Noncompliance related to patient refusing lovenox as evidenced by client verbalization and MAR records	Deep vein thrombosis (DVT) is a common risk for all people who are hospitalized due to lack of activity. Lovenox is a medication to prevent this.	1.Assess the client's knowledge about their health condition and wellbeing. 2. Assess client's viewpoint and knowledge in the refusal or noncompliance.	The client is very knowledgeable about her condition. She knew every detail she needed to know about diverticulitis. Although this medicine was not for that. This medicine is to prevent DVT which she is at risk for.

Other References (APA):

Imbalanced nutrition: Less than body requirements – Nursing diagnosis & care plan. (2017, September 23). Nurseslabs. https://nurseslabs.com/imbalanced-nutrition-less-body-requirements/

Swearingen, P. L., & Wright, J. (2018). *All-in-One nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Mosby.

Risk for infection – Nursing diagnosis & care plan. (2019, March 20). Nurseslabs. https://nurseslabs.com/risk-for-infection/

Concept Map (20 Points):

Subjective Data

Client states she has had diverticulitis for about 10 years. She stated this flair up occurred late Friday evening and caused some pain then. She continued to get worse and decided to be seen.

Nursing Diagnosis/Outcomes

Acute pain – Client is no longer experiencing pain after the first initial day of admission. This is a positive outcome for our client since she is not dependent on the pain medication.
Electrolyte/diet imbalance – Client was NPO and went to clear liquid diet. She is not on a soft diet and the next step is to see how she does with her normal diet. This outcome is still in progress but improving.
Ineffective protection – Client has a good understanding of her disease and has very few readmissions for her disease. Although, the flair ups still occur. This outcome is ever ongoing in attempts to reduce the amount of flare-ups.
Noncompliance – KT has refused to take her Lovenox when asked by the nurse. She does not believe she needs it because she is still up and moving around. This outcome will be determined by overall health even though the drug is for prevention. (Not a good outcome)

Objective Data

CT scan shows inflammation of diverticula. Labs show signs of infection which is common with Diverticulitis and UTI. KT had an elevated WBC count upon admission and leukocytes were found in her urine which is also a sign of infection.

Patient Information

KT is a 55 YO white female who has a history of diverticulitis. She was also diagnosed with a UTI.

Nursing Interventions

Acute pain – assess and identify pain, gave warm blanket to reduce pain
Diet imbalance – Review and record nutritional intake, take weight daily at the same time every day
Ineffective protection – assess for and teach client for early signs of infection and preventative methods to protect from infection.
Noncompliance – assess clients understanding of disease/ complication and their own wellbeing, assess clients viewpoint as to why they refuse or are noncompliant.