

N311 Care Plan #4

Lakeview College of Nursing

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Demographics (5 points)

Date of Admission 11/18/20	Patient Initials P.H.S	Age 96	Gender F
Race/Ethnicity White/Caucasian	Occupation Retired	Marital Status Widowed	Allergies Morphine (swelling), Penicillin
Code Status DNR	Height None charted	Weight 77.0 kg	

Medical History (5 Points)

Past Medical History: Chronic heart failure, Diabetes mellitus Type 2, Gout, Hypercholesterolemia, Hypothyroid.

Past Surgical History: Appendectomy, Hysterectomy, Hernia repair x3.

Family History: Mother and father diagnosed with hypertension.

Social History (tobacco/alcohol/drugs): Denies any use of tobacco, alcohol, and drugs.

Admission Assessment

Chief Complaint (2 points): Abdominal Pain.

History of present Illness (10 points): Pt was sent to the emergency room at St. Anthony's Hospital on Tuesday (11/17) complaining of epigastric/RUQ abdominal pain. Pt. explained that pain started at 1600 after she had her lunch consisting of "cooked carrots, potato, and grilled chicken." Pt. described that the pain was sharp and intermittent accompanying episodes of nausea. Pt. was not able to relieve the pain and took no medications to alleviate it.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Acute Cholecystitis

Secondary Diagnosis (if applicable): N/A

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

Acute cholecystitis is the inflammation of the gallbladder, which functions to store bile. Acute cholecystitis usually occurs due to gallstones or biliary stasis. Women over 40 years old and who's diet consists of mostly fatty food are at higher risk. 90% of cases of cholecystitis are due to cholesterol calculi stones. The gallstone obstructs the cystic duct and impedes blood flow, lymphatic drainage, causing gallbladder distention and mucosal ischemia and possible organ necrosis. Acalculous cholecystitis occurs due to a noncontracting gallbladder which creates concentrated bile causing mucosal irritation. Diminished gallbladder contractility can be attributed prolonged fasting or lack of CCK organ response.

The most common clinical presentation of cholecystitis is abdominal pain in the RUQ. The patient may complain of nausea, vomiting, heartburn, and fever. Patients may also present with Murphey's sign and Cullen sign along with peritoneal inflammation. Diagnosis of this disorder includes laboratory tests and abdominal imaging. Providers may examine WBC, ESR, liver enzymes including bilirubin levels. An ultrasound and CT may be utilized to evaluate the structure of the gallbladder and the presence of any stones or abnormalities. Treatment of cholecystitis depends on its severity. The surgical treatment of choice is a laparoscopic cholecystectomy which is a minimally invasive procedure with low risk of complications. An intracorporeal lithotripsy may be used to fragment retained stones. Other forms of treatment include dietary management and medications. Pt. experiencing a cholecystitis attack should not eat anything by mouth. An NG tube may be utilized to relieve nausea and vomiting. Patients who are able to tolerate food, should limit their dietary fat intake. Medications often used to treat this disorder are analgesics to treat pain. Pt. who have gallstones and are unable to tolerate surgery may be prescribed cholesterol dissolving agents.

This patient is presently on an NPO diet and taking Pepcid to help neutralize and to rest the GI tract. Tylenol and Zofran are used to treat the pain and nausea to alleviate accompanying symptoms. The patient regularly takes Colace as a stool softener due to chronic constipation.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J.P, "Pathophysiology: Introductory Concepts and Clinical Perspectives" (2nd ed.). F.A. Davis Company.

Cholecystitis. (2020, August 28). Retrieved November 22, 2020, from

<https://www.mayoclinic.org/diseases-conditions/cholecystitis/symptoms-causes/syc-20364867>

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.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.90-4.98	***no admission values charted	2.74	
Hgb	12.0-15.5		10.4	Decrease in RBC production due to low erythropoietin levels caused by CHF
Hct	35-45		30.1	Decrease in RBC production due to low erythropoietin levels caused by CHF
Platelets	140-400		246	
WBC	4.0-9.0		84	
Neutrophils	40-70		63	

Lymphocytes	10-20		18.8	
Monocytes	4.4-12.0		12.0	
Eosinophils	0-6.3		5.3	
Bands	0-5.1		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-	135-145	***no admission values charted	137	
K+	3.5-5.1		4.5	
Cl-	98-107		106	
CO2	22-29		24	
Glucose	70-99		126	
BUN	6-20		10	
Creatinine	.50-1.00		.86	
Albumin	3.5-5.2		3.0	Low albumin due to inflamed gallbladder
Calcium	8.4-10		7.9	Pt. diagnosed with hypothyroid
Mag	1.6-2.5		n/a	
Phosphate	35-105		n/a	
Bilirubin	.3-1.0		1.7	High bilirubin due to obstructed/inflamed gallbladder
Alk Phos	30-120		130	High alk phos due to inflamed gallbladder

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	Pale yellow-deep amber			*** No urinalysis conducted
pH	5-8			
Specific Gravity	1.005-1.034			
Glucose	negative			
Protein	negative			
Ketones	negative			
WBC	negative			
RBC	negative			
Leukoesterase	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	n/a	n/a	*** No cultures conducted
Blood Culture	negative	n/a	n/a	
Sputum Culture	negative	n/a	n/a	
Stool Culture	negative	n/a	n/a	

Lab Correlations Reference (APA):

Lakeview College of Nursing, "Tab: Diagnostics: Lab"

Diagnostic Imaging**All Other Diagnostic Tests (10 points): n/a****Current Medications (10 points, 2 points per completed med)*****5 different medications must be completed*****Medications (5 required)**

Brand/ Generic	Pepcid/ Famotidine	Colace/ Docusate Sodium	Tylenol/ Acetaminophen	Zofran/ Ondansetron	Benadryl/ Diphenhydramine
Dose	20 mg	100 mg	25 mg	2 mL	25 mg
Frequency	Every 12 hrs	BID, PRN	6hr, PRN	Every 6hrs, PRN	Every 6hrs, PRN
Route	PO	PO	PO	IV	PO
Classification	Histamine -2 blocker	Surfactant	Nonsalicylate, Para- aminophenol derivative	Selective serotonin (5- HT3) receptor antagonist	Antihistamine
Mechanism of Action	Famotidine reduces HCl formation by binding to H2 receptors, preventing the acidic breakdown of the intestinal mucosa	Softens stool by decreasing the surface tension between oil and water in feces	Interferes pain impulse by inhibiting cyclooxygenase and blocking prostaglandin production	Reduces nausea and vomiting by blocking serotonin receptors of the vagal nerve terminals in the intestines	Binds to central and peripheral H1 receptor, competing with histamine and preventing it from reaching its site of action
Reason Client Taking	Neutralize gastric hyperactivity	Constipation	Pain	Nausea	Itching

	y				
Contraindications (2)	Hypersensitivity to famotidine Hypersensitivity to H2-repcetors antagonist.	Fecal impaction, hypersensitivity to docusate salts	Hypersensitivity to acetaminophen, severe hepatic impairment	Concomitant use of apomorphine, congenital long QT syndrome	Breastfeeding, Hypersensitivity to diphenhydramine
Side Effects/Adverse Reactions (2)	Arrythmias, laryngeal edema	Dizziness, palpation	Hypotension, hepatotoxicity	Hypotension, bronchospasms	Arrythmias, agranulocytosis

Medications Reference (APA):

Jones & Bartlett Learning. (2019). 2019 Nurse’s Drug Handbook. Burlington, MA

Assessment

Physical Exam (18 points)

GENERAL: Alertness: Orientation: Distress: Overall appearance:	Alert and responsive ANO x4 No visible signs of distress Overall appearance was appropriate
INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:	Skin color usual for ethnicity Moist/intact Warm Elastic turgor No rashes No bruises No wounds 21 n/a
HEENT: Head/Neck: Ears: Eyes:	Normocephalic, no deviation of trachea, lymph nodes are not palpable Ears no drainage, tympanic membrane grey-

<p>Nose: Teeth:</p>	<p>pink, no hearing aid Eyes no drainage, symmetrical, pink conjunctiva Nose no septum deviation, polyps, turbinate Teeth intact no visible cavities, moist pink mucosa, use of dentures</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	<p>Normal S1/S2 heart sounds heard No murmur or gallops heard Normal steady rate and rhythm Peripheral pulses 3+ Capillary refill 2 sec n/a Left and right ankles</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>No use of accessory muscles Respiration pattern is regular Bronchovesicular breath sounds Equal lung aeration</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Regular diet at home Current diet NPO No height charted 77.0 kg Bowel sounds are active in all 4 quadrants Last BM yesterday (11/18) RUQ tender to palpation No distention No incision 2 old surgical scars No drains No wounds</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Pale-yellow Clear No urine output charted/observed n/a</p>

<p>Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>n/a n/a n/a</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: 45 Activity/Mobility Status: Independent (up ad lib) <input checked="" type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input checked="" type="checkbox"/></p>	<p>Nail bed pink, normal capillary refill. Mobility in feet and toes, All extremities are warm. Active ROM Strength 3+ active motion against gravity Fall Score: 45 Pt. able to stand and walk with walker Walker used for support</p>
<p>NEUROLOGICAL: MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input checked="" type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>ANO x4 Normal cognition Speech is clear All sensory perceptions are normal; no numbness or tingling sensations Pt. alert & awake and able to answer appropriately</p>
<p>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):</p>	<p>Family support Mature Christian Pt.'s family takes turn to care and visit her home</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
9:15 am	68 bpm	115/68 mmHg	16 bpm	37.2 C	93%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:15 am	Numeric	n/a	0	n/a	n/a

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
n/a (not charted/none observed)	n/a (not charted/none observed)

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	Rational <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	Intervention (2 per dx)	Evaluation <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
Acute pain related to inflamed gallbladder, as evidenced by RUQ pain.	Patient is admitted due to severe abdominal pain from cholecystitis	1. Administer prescribed analgesics (Tylenol, Zofran) 2. Manage dietary restrictions (NPO status, IV fluids, Pepcid)	1. Pt.’s pain diminished after the administration of prescribed analgesic 2. Pt’s pain was lowered due to dietary restrictions. Pt’s NPO status and prescription of Pepcid helped neutralize and ease gastric acidity and contractility. IV fluids were administered to prevent dehydration.
Risk for impaired liver function related to diagnosis of cholecystitis as	Patient’s inflamed gallbladder may be due to gallstones and	1. Be alert to abdominal distention, tenderness, and	1. Pt.’s health improved as consistent monitoring prevented gallbladder perforation.

evidenced by high bilirubin and low albumin levels.	may lead to the obstruction of common bile duct interfering with liver function	rigidity. 2. Monitor skin, sclera, urine, and stool	2. Pt.'s health improved as they were consistently monitored for any signs jaundice and liver dysfunction
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Other References (APA):

Swearingen, P. L., & Wright, J. D., (2019). All-in-One Nursing Care Planning Resource: Medical-Surgical, Pediatric, Maternity, and Psychiatric-Mental Health (5th ed.). Grand Rapids, MN: Elsevier

Concept Map (20 Points)

Subjective Data

Nursing Diagnosis/Outcomes

1. Acute pain related to inflamed gallbladder, as evidenced by RUQ tenderness, epigastric pain, and NPO status. Pt. denies pain after she ate cooked carrots, potato, and grilled chicken.
2. Risk for impaired liver function related to diagnosis of cholecystitis as evidenced by high bilirubin and low albumin levels.
 - Pt.'s health improved as consistent monitoring prevented gallbladder perforation.
 - 2. Pt.'s health improved as they were consistently monitored for any signs jaundice and liver dysfunction

Objective Data

Patient Information

Nursing Interventions

1. Administer prescribed analgesics (Tylenol, Zofran)
Pt. was presented to the emergency room at St. Anthony's due to severe abdominal pain (11/17). They were later admitted to Sarah Bush where they were diagnosed with cholecystitis.
2. Manage dietary restrictions (Pepcid)
Vitals: BP: 115/68 mmHg RR: 16 bpm Temp: 37.2 C SpO2: 93%
3. Pt.'s health improved as consistent monitoring prevented gallbladder perforation.
4. Pt.'s health improved as they were consistently monitored for any signs jaundice and liver dysfunction.
Both of Pt.'s parents have hypertension. Pt. denies any use of alcohol, drugs, and tobacco.



