N431 Care Plan #1

Lakeview College of Nursing

Ashley Miller

Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
2/27/2021`	M.K.	76	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Retired	Widowed	Zocar: Stiffness-Mild Sulfa Drugs: Unknown Macrobid: Unknown Fosfomycin: Abdominal Pain-Severe
Code Status	**Height**	**Weight**	
Full	163 cm	70.3 kg	

Medical History (5 Points)

Past Medical History:

MK past medical history consists of abdominal aortic aneurysm (AAA), bacterial in urine, benign essential hypertension, cataract, chronic back pain, dysuria, emphysema with chronic obstructive pulmonary disease (COPD), extended spectrum beta-lactamase (ESBL), facet arthritis of lumbar region, fall risk, history of kyphoplasty, history of gross hematuria, history of bladder cancer, hyperlipidemia, leg edema, mid back pain, myofascial pain, osteoporosis, postop check, primary biliary cirrhosis, vancomycin resistant enterococcus (VRE), gastroesophageal reflux disease (GERD), and a history of contact isolation of vancomycin resistant enterococcus.

Past Surgical History:

MK has a past surgical history of esophagogastroduodenoscopy biopsy (8/4/20) (1/14/20) (12/10/18), phacoemulsification cataract with intraocular lens implantation (7/14/20) (7/21/20), cystoscopy with TURBT (6/8/20) (2/11/19) (8/20/18), cystoscopy (5/19/20) (1/21/20), lumbar facet joint injections medical branch blocks with fluoroscopy (right side)

(3/30/20) (9/27/18), trigger point injections (1-2 muscular groups) (3/30/20), thoracic vertebral augmentation kyphoplasty with fluoroscopy (2/10/20), laparoscopy diagnostic possible laparotomy (7/24/19), colonoscopy with biopsy (6/18/19), hysteroscopy with dilation and curettage (4/15/19), colon resection right or small intestine (6/6/17), injection for bladder x-ray (2/18/14), cervical laminectomy, dilation and curettage, history of appendectomy, orthopedic, surgery, partial colectomy, left oophorectomy, and kyphoplasty of fracture of thoracic spine with fluoroscopic guidance.

Family History:

MK family history consists of

Mother: Diabetes Mellitus, heart attack, and stroke

Father: Heart attack

Brother: Cardiovascular disease

Brother: Diabetes Mellitus

Sister: Diabetes Mellitus, and other

Sister: Colon Cancer

Sister: Cardiovascular Disease

Social History (tobacco/alcohol/drugs): Denies any use of illicit drugs, Former smoker (quit 9/24/19) smoked 1 pack a day, former alcohol user (drank a 24 pack of beer a day).

Assistive Devices: MK uses a walker/ cane at home.

Living Situation: MK lives with her son and daughter-in-law in Newton.

Education Level: MK never finished high school.

Admission Assessment

Chief Complaint (2 points): Abdominal pain

History of present Illness (10 points):

MK stated that her onset of pain started Friday night at around 2300. The location of MK's pain was located in the abdomen. MK stated that the duration of the pain never stopped. Characteristics reported by MK was that the pain felt like a squeezing sensation of the insides. There are no aggravating factors per MK. There are no relieving factors as well, according to MK. For treatment, MK reported to the emergency department and was admitted to the medical unit for treatment. The severity of MK's pain when she came to the emergency department was an eight out of ten.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Small bowel obstruction

Secondary Diagnosis (if applicable): N/A

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

Small bowel obstruction (SBO) can be acute or chronic and partial or complete (Capriotti & Frizzell, 2016**). An acute obstruction has a sudden onset that occurs with adhesions or a herniation of the bowel (**Capriotti & Frizzell, 2016**). A partial obstruction decreases intestinal content flow through the bowel (**Capriotti & Frizzell, 2016**). The primary cause of SBO is postsurgical adhesions, followed by malignancy, Chron's disease, and hernias (**Capriotti & Frizzell, 2016**). Adhesions are bands of connective tissue between tissues and organs, often resulting in injury during surgery (**Capriotti & Frizzell, 2016**). In the abdomen, adhesions commonly bond intestine sections together (**Capriotti & Frizzell, 2016**). Adhesions cause an obstruction and interfere with the intestine's normal function (**Capriotti & Frizzell, 2016**). Intestinal contents cannot move forward through the bowel**

(Capriotti & Frizzell, 2016**). Increased peristalsis and mucus accumulation at the point of obstruction worsens the blockage (**Capriotti & Frizzell, 2016**).**

Signs and Symptoms:

Initial symptoms of a small bowel obstruction usually are crampy pain that is wavelike and colicky due to the persistent peristalsis above and below the blockage (Hinkle & Cheever, 2018**). The patient may pass blood and mucus but no fecal matter and no flatus (**Hinkle & Cheever, 2018**). Vomiting also occurs (**Hinkle & Cheever, 2018**). The signs of dehydration become evident: intense thirst, drowsiness, generalized malaise, aching, and a parched tongue and mucous membranes (**Hinkle & Cheever, 2018**). The patient may continue to have flatus and stool early in the process due to distal peristalsis (**Hinkle & Cheever, 2018**). The abdomen becomes distended (**Hinkle & Cheever, 2018**). The lower the GI tract's obstruction, the more marked the abdominal distention; this may cause reflux vomiting (**Hinkle & Cheever, 2018**). Dehydration and acidosis develop from loss of water and sodium (**Hinkle & Cheever, 2018**). Hypovolemic shock may occur with the continued loss of acute fluid, and septic shock may also occur (**Hinkle & Cheever, 2018**).**

Expected findings:

An expected finding in a patient with small bowel obstruction would be electrolytes are going to be low due to diarrhea and vomiting (Hinkle & Cheever, 2018**). The complete blood count (CBC) will be low in red blood cells, hemoglobin, and hematocrit due to dehydration (**Hinkle & Cheever, 2018**). White blood cells such as neutrophils and lymphocytes will be high due to inflammation and infection (**Hinkle & Cheever, 2018**). The patient will be dehydrated, loss of plasma volume and possible infection are other expected**

findings in a small bowel obstruction (Hinkle & Cheever, 2018**). Other expected findings in small bowel obstruction are previously presented.**

Diagnostic Findings:

Diagnostic findings a person would use for a patient will small bowel obstruction are abdominal x-ray, and CT scan findings include abnormal quantities of gas, fluid, or both in the intestines and sometimes collapsed distal bowel (Hinkle & Cheever, 2018**). When using these tests, the physician is looking for the obstruction and location (**Hinkle & Cheever, 2018**). An abdominal x-ray provides visualization of the area of obstruction and severity of the blockage (**Capriotti & Frizzell, 2016**). An X-ray will show excessive gas in the area of the intestine proximal to the obstruction (**Capriotti & Frizzell, 2016**). CT and ultrasound can also identify the obstruction (**Capriotti & Frizzell, 2016**). A nasogastric tube is inserted to decompress the bowel and remove fluid accumulation within the bowel (**Capriotti & Frizzell, 2016**).**

The patient I assessed had a low sodium count, red blood cells, hemoglobin, and hematocrit levels. Her neutrophils and lymphocyte levels were high during the assessment. She also had a CT on the abdominal and pelvis with contrast performed to show the obstruction and where it is located. RF small bowel was performed to show if there were any abnormalities in the small bowel. The patient also had a nasogastric tube placed to help with the obstruction by decompressing the bowel. Other abnormal labs for this patient were eosinophils, carbon dioxide, BUN and creatine, and glucose.

Treatment:

A nasogastric tube is necessary for all patients with a small bowel obstruction; a nasogastric tube helps decompress the bowel (Hinkle & Cheever, 2018**). Surgical treatment**

of the intestinal obstruction depends on the obstruction's cause (Hinkle & Cheever, 2018**). A hernia and adhesions are the common causes of bowel obstruction and involve surgical repair of the hernia or dividing the adhesion to which the intestine is attached (**Hinkle & Cheever, 2018**). Intravenous fluids are given to assure adequate fluid and electrolyte balance (**Capriotti & Frizzell, 2016 Capriotti & Frizzell, 2016**). The majority of partial small bowel obstructions can resolve medical treatment (**Capriotti & Frizzell, 2016**). Pain management, antiemetic medications, and antibiotics are frequently necessary (**Capriotti & Frizzell, 2016**).**

The patient I was assessing had a nasogastric tube inserted to help decompress the bowel. The patient had acetaminophen and Narcan for pain management. The patient was on lactated ringers to help with adequate hydration and electrolyte balance.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. (1st ed). Philadelphia, PA: F A Davis.

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical perspectives*. F.A. Davis Company.

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	**4.7-6.1**	**3.31**	**N/A**	**Low red blood cell count in patient with small bowel obstruction is that the patient has a dietary deficiency.**

				(Pagana et al., 2019**).**
Hgb	**14-18**	**11.5**	**N/A**	**Low hemoglobin count in a patient with small bowel obstruction is that the patient has a nutritional deficiency. (**Pagana et al., 2019**).**
Hct	**40%-52%**	**33.6**	**N/A**	**Low hematocrit count in a patient with small bowel obstruction is that the patient has a dietary deficiency. (**Pagana et al., 2019**).**
Platelets	**150-400**	**338**	**N/A**	**Normal lab value**
WBC	**5000-10000**	**7.4**	**N/A**	**Normal lab value**
Neutrophils	**55-70**	**76.2**	**N/A**	**High level of neutrophils in a patient with a small bowel obstruction is inflammatory. (**Pagana et al., 2019**).**
Lymphocytes	**20-40**	**14.9**	**N/A**	**Low level of lymphocytes in a patient with small bowel obstruction is infection. (**Pagana et al., 2019**).**
Monocytes	**2-8**	**7.4**	**N/A**	**Normal lab value**
Eosinophils	**1-4**	**0.5**	**N/A**	**Low eosinophils in a patient with a small bowel obstruction is infection. (**Pagana et al., 2019**).**
Bands	**3%-5%**	**N/A**	**N/A**	**N/A**

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	**136-145**	**135**	**N/A**	**Low level of sodium in a patient with a small bowel obstruction is malabsorption. (**Pagana et al., 2019**).**
K+	**3.5-5.0**	**4.8**	**N/A**	**Normal lab value**
Cl-	**98-106**	**103**	**N/A**	**Normal lab value**
CO2	**23-30**	**22**	**N/A**	**A low carbon dioxide level in a patient with a small bowel obstruction is due to the accumulation of fluid and gases. (**Pagana et al., 2019**).**

Glucose	**74-106**	**129**	**N/A**	**A high glucose level in a patient with small bowel obstruction is acute stress response. (**Pagana et al., 2019**).**
BUN	**10-20**	**29**	**N/A**	**A high level of BUN in a patient with a small bowel obstruction is dehydration. (**Pagana et al., 2019**).**
Creatinine	**0.5-1.1**	**1.17**	**N/A**	**Normal lab value**
Albumin	**3.5-5.0**	**4.4**	**N/A**	**Normal lab value**
Calcium	**9-10.5**	**9.3**	**N/A**	**Normal lab value**
Mag	**1.3-2.1**	**N/A**	**N/A**	**N/A**
Phosphate	**3.0-4.5**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.3-1.0**	**0.5**	**N/A**	**Normal lab value**
Alk Phos	**30-120**	**69**	**N/A**	**Normal lab value**
AST	**0-35**	**17**	**N/A**	**Normal lab value**
ALT	**4-36**	**14**	**N/A**	**Normal lab value**
Amylase	**60-120**	**N/A**	**N/A**	**N/A**
Lipase	**0-160**	**N/A**	**N/A**	**N/A**
Lactic Acid	**5-20: Venous 3-7: Arterial**	**N/A**	**N/A**	**N/A**
Troponin	**<0.1: T <0.03: I**	**N/A**	**N/A**	**N/A**
CK-MB	**3%-5%**	**N/A**	**N/A**	**N/A**
Total CK	**55-170**	**N/A**	**N/A**	**N/A**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	**0.8-1.1**	**N/A**	**N/A**	**N/A**
PT	**11-12.5**	**N/A**	**N/A**	**N/A**
PTT	**30-40 seconds**	**N/A**	**N/A**	**N/A**
D-Dimer	**<250**	**N/A**	**N/A**	**N/A**
BNP	**<100**	**N/A**	**N/A**	**N/A**
HDL	**>45**	**N/A**	**N/A**	**N/A**
LDL	**<130**	**N/A**	**N/A**	**N/A**
Cholesterol	**<200**	**N/A**	**N/A**	**N/A**
Triglycerides	**40-180**	**N/A**	**N/A**	**N/A**
Hgb A1c	**4%-5.9%**	**N/A**	**N/A**	**N/A**
TSH	**2-10**	**N/A**	**N/A**	**N/A**

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	**Yellow/ Clear**	**Yellow/Clear**	**N/A**	**N/A**
pH	**4.6-8**	**6.0**	**N/A**	**N/A**
Specific Gravity	**1.005-1.030**	**1.039**	**N/A**	**Specific gravity elevation in a patient with small bowel obstruction is due to dehydration (**Pagana et al., 2019**).**
Glucose	**50-300**	**Normal**	**N/A**	**N/A**
Protein	**0-8**	**Trace A**	**N/A**	**A protein elevation in a patient with a small bowel obstruction is diabetes mellitus (**Pagana et

				al., 2019**).**
Ketones	**Negative**	**Trace**	**N/A**	**A positive ketones level in a patient with a small bowel obstruction is dietary deficiency (**Pagana et al., 2019**).**
WBC	**Negative**	**8**	**N/A**	**A positive white blood cell count in a patient with a small bowel obstruction is a bacterial infection in the urinary tract (**Pagana et al., 2019**).**
RBC	**<2**	**3**	**N/A**	**A high level of red blood cells in a patient with a small bowel obstruction could be from the patient's history of bladder cancer (**Pagana et al., 2019**).**
Leukoesterase	**Negative**	**Trace 2+**	**N/A**	**A positive leukoasterase in a patient with a small bowel obstruction is a possible urinary tract infection (**Pagana et al., 2019**).**

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	**7.35-7.45**	**N/A**	**N/A**	**N/A**
PaO2	**80-100**	**N/A**	**N/A**	**N/A**
PaCO2	**35-45**	**N/A**	**N/A**	**N/A**
HCO3	**21-28**	**N/A**	**N/A**	**N/A**
SaO2	**95-100**	**N/A**	**N/A**	**N/A**

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	**Negative**	**Positive**	**N/A**	**A positive urine culture in a patient with a small bowel obstruction is a possible UTI (**Pagana et al., 2019**).**
Blood Culture	**Negative**	**N/A**	**N/A**	**N/A**
Sputum Culture	**Negative**	**N/A**	**N/A**	**N/A**
Stool Culture	**Negative**	**N/A**	**N/A**	**N/A**

Lab Correlations Reference (1) (APA):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- **CT abdominal/pelvis with contrast was used to determine if the patient had a bowel obstruction (**Pagana et al., 2019**). The test was ordered for MK due to her coming to the hospital for having a small bowel obstruction.**
- **RF small bowel is used to identify abnormalities in the small bowel (**Pagana et al., 2019**). The test was ordered for MK due to her having a small bowel obstruction.**
- **X-ray of chest nasogastric tube was used to check placement of the nasogastric tube that was placed on the twenty-seven of February (**Pagana et al., 2019**). The chest x-ray was ordered to check for placement of the nasogastric tube.**

Diagnostic Test Correlation (5 points):

- **CT abdominal/pelvis with contrast showed negative results of an obstruction in MK abdominal and pelvis area.**
- **RF small bowel showed negative results of an obstruction in MK small bowel area.**

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	**Albuterol Sulfate/ AccuNeb**	**Cipro/ Ciprofloxacin**	**Pantoprazole Sodium/ Protonix**	**Prolia/ Denosumab**	**Ursodiol/ Actigall**
Dose	**2.5 mg/ 3mL**	**500 mg = 1 tablet**	**40 mg = 1 tablet**	**60 mg/mL**	**300 mg = 1 capsule**
Frequency	**PRN Q6H**	**Q12H**	**BID**	**Q6 month**	**TID**
Route	**Inhalation**	**Oral**	**Oral**	**Subcutaneous Injections**	**Oral**
Classification	**Adrenergic**	**Fluoroquinolone**	**Proton pump inhibitor**	**Monoclonal antibody**	**Bile acid**

Mechanism of Action	**Albuterol attaches to beta2 receptors on bronchial cell membranes, which stimulates the intracellular enzyme adenylate cyclase to convert adenosine triphosphate (ATP) to cyclic adenosine monophosphate (cAMP). This reaction decreases intracellular levels of (cAMP), as shown.**	**Inhibits the enzyme DNA gyrase, which is responsible for the unwinding and supercoiling of bacterial DNA before it replicates. By inhibiting this enzyme, ciprofloxacin causes bacterial cells to die.**	**Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphate enzyme system, or proton pump, in gastric parietal cells.**	**Binds to RANKL, a transmembrane or soluble protein required for the formation, function, and survival of osteoclasts, the cells responsible for bone resorption. By preventing RANKL from activating its receptor, RANK, on the surface of osteoclasts, osteoclast formation, function, and survival are inhibited. This action decreases bone resorption and increases bone mass and strength in both cortical and trabecular bone.**	**Suppresses biliary secretion, hepatic synthesis, and intestinal reabsorption of cholesterol. Prolonged use promotes dissolution of gallstone.**
Reason Client Taking	**Emphysema/ Chronic obstructive pulmonary disease**	**To treat UTI caused by susceptible organisms**	**To maintain healing of erosive esophagitis and reduce relapse of daytime and**	**To treat her osteoporosis at high risk for fracture**	**Primary biliary cirrhosis**

			nighttime symptoms in patient with GERD		
Contraindications (2)	**High blood pressure; hypersensitivity to albuterol or its components**	**Concurrent therapy with tizanidine; hypersensitivity to ciprofloxacin, quinolones, or their components**	**Concurrent therapy with rilpivirine-containing products; hypersensitivity to pantoprazole, substituted benzimidazoles, or their components**	**Hypersensitivity to denosumab and its components; hypocalcemia**	**Acute cholangitis; hypersensitivity to ursodiol, other bile acids, or their components**
Side Effects/Adverse Reactions (2)	**Anxiety; UTI**	**Atrial flutter; intestinal perforation**	**Anxiety; hepatic failure**	**Atrial fibrillation; thrombocytopenia**	**Hyperglycemia; hypertension**
Nursing Considerations (2)	**Administer pressurized inhalations of albuterol during second half of inspiration, when airways are open wider and aerosol distribution is more effective; be aware that drug tolerance can develop with prolonged use.**	**Obtain culture and sensitivity test results, as ordered, before giving ciprofloxacin; know that ciprofloxacin should not be used in a patient with myasthenia gravis as it may exacerbate muscle weakness.**	**Ensure the continuity of gastric acid suppression during transition from oral to I.V. pantoprazole because even a brief interruption of effective suppression can lead to serious complication; beware**	**Know that preexisting hypocalcemia must be corrected prior to denosumab therapy; do not handle the gray needle cap on the prefilled syringe if allergic to latex.**	**Administer ursodiol with food to increase drug dissolution; expect drug to be discontinued if gallstones have not partially dissolved after twelve months of therapy.**

			that a symptomatic response to the drug does not rule out the presence of a gastric tumor.		
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Review client's potassium level because albuterol may cause transient hypokalemia.**	**Monitor client for blood glucose level for signs and symptoms of changes in blood glucose levels.**	**Monitor client for diarrhea from C. difficile which can occur with or without antibiotics in patients taking pantoprazole.**	**Monitor patient for signs and symptoms of infection, because denosumab increases the risk, especially if patient is receiving immunosuppressant therapy or has an impaired immune system.**	**Monitor client's liver enzymes every month for three months after ursodiol therapy is begun and then every six months thereafter, as ordered. If elevation occurs, notify prescriber as drug may have to be discontinued.**
Client Teaching needs (2)	**Advise patient to wait at least one minute between inhalations if dosage requires more than one inhalation; instruct patient to wash**	**Urge patient to complete the prescribed course of therapy, even if she feels better before it is finished;**	**Instruct patient to swallow pantoprazole tablets whole and not to chew or crush them; advise patient to**	**Tell patient to stop taking denosumab and seek immediate emergency care if allergic reactions occur; advise patient to notify**	**Tell patient to take ursodiol with meals; Urge patient to take aluminum-containing antacids at least one**

	mouthpiece with water once a week and let it air-dry if patient is using a Proair HFA device.	**tell patient not to take drug with calcium-fortified juices or dairy products.**	**expect relief of symptoms within two weeks of starting therapy. Tell patient to notify prescriber if she has a suboptimal response to drug or an early symptomatic relapse.**	**prescriber if signs and symptoms of infection occur, such as drainage, fever, pain, redness, or swelling.**	**hour before or four hours after ursodiol to support absorption.**

Hospital Medications (5 required)

Brand/Generic	**Tylenol/ Acetaminophen**	**Benzonatate / Tessalon**	**Naloxone Hydrochloride/ Narcan**	**Zofran/ Ondansetron Hydrochloride**	**Promethazine Hydrochloride/ Pentazine**
Dose	**1000mg**	**100mg**	**0.4 mg**	**4 mg**	**12.5 mg**
Frequency	**Q6H PRN**	**TID PRN**	**PRN**	**Q6H**	**Q4H PRN**
Route	**IV Piggyback**	**Oral**	**IV Push**	**IV Push**	**Intramuscular**
Classification	**Nonsalicyate, para-aminophenol derivative**	**Antitussives**	**Opiod antagonist**	**Selective Serotonin receptor antagonist**	**Phenothiazine**
Mechanism of Action	**Inhibits the enzyme cyclooxygenase, blocking prostaglandi**	**Anesthetizes cough or stretch receptors in vagal nerve**	**Briefly and competitively antagonizes mu, kappa,**	**Blocks serotonin receptors centrally in the**	**Competes with histamine for H1-receptor**

	n production and interfering with pain impulse generation in the peripheral nervous system.	**afferent fibers found in lungs, pleura, and respiratory passages. May also decrease transmissio n of the cough reflex centrally** (*Benzonatate | Davis's Drug Guide for Rehabilitatio n Professional s | F.A. Davis PT Collection | McGraw-Hill Medical*, n.d.)	**and sigma receptors in the CNS, thus reversing analgesia, hypotension, respiratory depression, and sedation caused by most opioids.**	**chemorecept or trigger zone and peripherally at vagal nerve terminals in the intestine.**	**sites, thereby antagonizin g many histamine effects and reducing allergy signs and symptoms.**
Reason Client Taking	**To relieve mild to moderate pain**	**Coughing**	**Pain**	**To prevent nausea/ vomiting**	**To prevent or treat nausea and vomiting**
Contraindicatio ns (2)	**Hypersensiti vity to acetaminoph en or its components, sever hepatic impairment, severe active liver disease**	**Severe hypersensiti vity to benzonatate and its components ; cross-sensitivity with other ester-type local anesthetics** (*Benzonatate	Davis's Drug Guide for Rehabilitatio*	**Hypersensiti vity to naloxone or its components; hypotension**	**Concomitant use of apomorphin e, congenital long QT syndrome, hypersensiti vity to ondansetron or its components**	**Angle-closure glaucoma; pyloroduod enal obstruction**

		n Professionals | F.A. Davis PT Collection | McGraw-Hill Medical, n.d.)			
Side Effects/Adverse Reactions (2)	**Hepatotoxicity; pulmonary edema**	**Headache; constipation** (*Benzonatate | Davis's Drug Guide for Rehabilitation Professionals | F.A. Davis PT Collection | McGraw-Hill Medical*, n.d.)	**Seizures; ventricular fibrillation**	**Hypotension; arrhythmias**	**Seizure; respiratory depression**
Nursing Considerations (2)	**Use acetaminophen cautiously in patients with hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypovolemia, or severe renal impairment; use parenteral drug within six hours once**	**Assess frequency and nature of cough and lung sounds; monitor for signs of hypersensitivity reactions.** (*Benzonatate | Davis's Drug Guide for Rehabilitation Professionals | F.A. Davis PT Collection | McGraw-Hill Medical*,	**Administer parenteral Narcan brand by I.V. route whenever possible; Expect patient with hepatic or renal dysfunction to have increased circulating blood naloxone level.**	**Place disintegrating tablet or oral soluble film on patient's tongue immediately after opening package. It dissolves in seconds; Use calibrated container or oral syringe to measure dose of oral solution.**	**Give I.V. injection at no more than 25 mg/min; rapid I.V. administration may produce a transient drop in blood pressure; be aware that patient should not have intradermal allergen tests within 72 hours of receiving promethazi**

	vacuum seal of glass vial has been penetrated or contents transferred to another container.	n.d.)			**ne because drug may significantly alter flare response.**
Key Nursing Assessment(s)/Lab(s) Prior to Administration	**Monitor the end of a parenteral infusion to prevent possibility of air embolism.**	**Assess dizziness that might affect gait, balance, and other functional activities to keep patient safe from falls.** (*Benzonatate | Davis's Drug Guide for Rehabilitation Professionals | F.A. Davis PT Collection | McGraw-Hill Medical*, n.d.)	**Monitor client in postoperative setting who have received naloxone because of abrupt postoperative reversal of opioid depression after using naloxone may cause serious adverse effects.**	**Monitor client closely for signs and symptoms of hypersensitivity to ondansetron because hypersensitivity reactions, including anaphylaxis and bronchospasm, may occur.**	**Monitor patient's hematologic status as ordered because promethazine may cause bone marrow depression, especially when used with other known marrow-toxic agents. Assess patient for signs and symptoms of infection or bleeding.**
Client Teaching needs (2)	**Caution patient not to exceed recommended dosage or take other drugs containing acetaminophen at the same time because of risk of liver damage;**	**Advise patient to minimize cough by avoiding irritants; advise patient that any cough lasting more than one week or accompanied by fever,**	**Inform patient or family that naloxone will reverse opioid-induced adverse reactions; instruct family on how to administer naloxone by**	**Advise patient to use calibrated container or oral syringe to measure oral solution; advise patient to immediately report signs of**	**Tell patient to use a calibrated device to ensure accurate doses of promethazine syrup; teach patient correct administration**

	teach patient to recognize signs of hepatotoxicity, such as bleeding, easy bruising, and malaise, which commonly occurs with chronic overdose.	**chest pain, persistent headache, or skin rash warrants medical attention.** (*Benzonatate | Davis's Drug Guide for Rehabilitation Professionals | F.A. Davis PT Collection | McGraw-Hill Medical*, n.d.)	**nasal spray, if prescribed for emergency use at home.**	**hypersensitivity, such as rash.**	**technique for suppository, if needed.**

(2020 Nurse's drug handbook, 2020)

Medications Reference (1) (APA):

2020 Nurse's drug handbook. (2020). Jones and Bartlett learning

Benzonatate /Davis's Drug Guide for Rehabilitation Professional / F.A. Davis PT Collection / McGraw-Hill Medical. (n.d.). Fadavispt.mhmedical.com. https://fadavispt.mhmedical.com/content.aspx?bookid=1873&ionid=139002900.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**The patient was awake and oriented to person, place, time, and situation (x4). The patient was responding to the questions and answered appropriately. She looked well nourished and in a good mood. Patient was not showing an =y signs of distress. Overall appearance was**

	appropriate to place.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☐** **Type:**	**Skin was appropriate for ethnicity, intact, warm, and dry to touch with skin turgor being loose due to dehydration. There was no presence of bruising or wounds. There are no signs of a rash.** **No drains presence.** **Braden Score: 19**
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Patient's head and neck were symmetrical and no deviations. The trachea was midline. The patient's eyes were PERRLA and six cardinal fields of gaze bilaterally. The tympanic membrane was pearly gray, and intact bilaterally. No signs of drainage from the ears or nose. There was no deviated septum, equal turbinates, bilaterally. The oral mucosa is pink, moist, and intact. Patient has top dentures only, cannot wear bottoms.**
CARDIOVASCULAR (2 points): **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:**	**S1 and S2 were heard with regular heartbeat. No presence of S3 and S4. Normal sinus rhythm. Pedal pulses were strong bilaterally with a grade of 3+. Capillary refill was less than three seconds. No presence of neck vein distention. No presence of edema.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	**The patient's respirations were 18 breaths per minute with anterior and posterior all lobes expiratory wheezes.** **Patient received a breathing treatment and her anterior and posterior all lobes were clear.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:**	**Height: 163 cm** **Weight: 70.3 kg** **Last BM: 2/28/2021** **The patient's diet at home was regular; during hospital stay the patient was on a clear liquid diet and then upgraded to a soft diet. The patient's abdomen was firm and non-tender. Bowel sounds were hyperactive and heard in**

Distention: **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☐** **Nasogastric: Y ☐ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☐** **Type:**	**all four quadrants. The abdomen showed no signs of incisions, drains, or wounds. The patient's abdomen showed several scars over the abdomen area.** **No ostomy or nasogastric, no feeding tubes/ PEG tube present.**
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	**During assessment, the patient's urine was clear and yellow in color. Quantity of urine was not measured in milliliters, but patient voided six times during assessment period. Patient stated that she had slight pain during urination due to a UTI. No dialysis or catheter during time of assessment. Inspection of genitals were normal for age and ethnicity.**
MUSCULOSKELETAL (2 points): **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 a history of falls.** **Patient was able to perform range of motion with upper and lower extremities bilaterally. Strength was equal with upper and lower extremities. Patient was one assist with cane for transfers and to bathroom.** **Fall Score: 50**
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**MK speaks English as primary language and responds appropriately for age.** **MAEW was present.** **PERRAL was present.** **MK strength was equal bilaterally for all extremities. MK mental status is appropriate for age. MK's sensory and level of consciousness (LOC) are present. Orientation is A/O x4.**
PSYCHOSOCIAL/CULTURAL (2 points):	**MK was calm and cooperative during time of assessment. MK does not have a preference on**

Coping method(s): **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	**religion. MK stated that she lives with her son and daughter-in-law and enjoy one another's company. Most days, MK is home by herself with the two dogs her son and daughter-in-law have. Before her son and daughter-in-law get home from work MK will cook dinner for all them to enjoy together as a family.**

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0735	64 beats per minute	140/78 mm HG	18 breaths per minute	36.8 C	96% RA
1100	77 beats per minute	132/69 mm HG	18 breaths per minute	36.8 C	96% RA

Vital Sign Trends:

The patient's baseline blood pressure is slightly high at rest. RC has a history of benign essential hypertension. The blood pressure went down during the second set of vitals. MK pulse was on the low end during the first set of vitals and came up during the second set of vitals. MK respirations, temperature and oxygen saturation were all within normal limits.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0735	Numeric (0-10)	Patient denies pain	0/10	Patient denies pain	Patient denies pain
1100	Numeric (0-10)	Patient denies pain	0/10	Patient denies pain	Patient denies pain

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20-gauge **Location of IV: Right forearm** **Date on IV: 2/28/2021** **Patency of IV: Patent** **Signs of erythema, drainage, etc.: No signs of erythema, drainage, etc** **IV dressing assessment: Dressing was dry and intact**	**Lactated Ringers 125 mL/hr**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Oral: 490mL **Lactated Ringers: 1000mL** **Total: 1490mL**	**Voided: 6 times in the time I was assessing the patient, voiding was not being measured**

Nursing Care

Summary of Care (2 points)

Overview of care:

The first set of vitals were taken at 0735 for MK. Patient has history of benign essential hypertension and blood pressure was 140/78. The patient baseline heart was 64-77 beats per minute. MK respirations were 18 breaths per minute, with lungs being expiratory wheezes anterior and posterior in all lobes with oxygen saturation of 96% on room air. After MK ate breakfast, a full head to toe assessment was performed at bedside. MK was very cooperative and calm during assessment time and answered questions with full sentences. Patient was open about her medical history when questions were asked. The last

set of vitals were performed at 1100; MK blood pressure came down to 132/69 mm Hg and her pulse went up to 77 beats per minute.

Procedures/testing done:

No procedures or testing were done during time of assessment.

Complaints/Issues:

MK denies pain during time of assessments. MK did not report any complaints or issues during time of assessment.

Vital signs (stable/unstable):

MK's vital signs were stable when compared to the baseline vital signs during time of assessment on the floor. MK did have slight high blood pressure during assessment but came down when second set of vitals were performed.

Tolerating diet, activity, etc.:

MK was on a clear liquid diet during the breakfast hours and was then upgraded to a soft diet during time of assessment. MK received a cheeseburger around 1015 and was tolerating the diet well and when assessed around 1100 to reevaluate diet MK was still doing well with the diet.

Physician notifications:

The doctor did not leave any notifications during time on the floor.

Future plans for patient:

The goal for MK was to discharge to home later that day 3/1/2021.

Discharge Planning (2 points)

Discharge location:

Home with son and daughter-in-law.

Home health needs (if applicable):

MK will need to adhere to her medications when home.

Equipment needs (if applicable):

MK will continue to use her can with up and walking and up her diet as tolerated.

Follow up plan:

MK will follow up with her primary care provider one week after her discharge.

Education needs:

MK will need education on how to stay hydrated, move around to keep bowels moving, and report any signs of reoccurring bowel obstructions. MK will need education to continue taking medications as prescribed.

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 the client being admitted to the medical unit for abdominal pain as evidenced by a small bowel obstruction.	**The patient presented to the medical unit with abdominal pain.**	**1. Give analgesics as ordered, evaluating their effectiveness, and observing for any signs and symptoms of untoward effects.** **2. Assess pain characteristic.**	**- The patient will have a therapeutic effect while using analgesics.** **- Goal is to have the patient explain the characteristics of her pain, so that the nurse can manage the pain properly.**
2. Risk for	**The patient has**	**1. Administer**	**- The patient is**

electrolyte imbalance related to the patient having a small bowel obstruction as evidenced by the patient's skin turgor being loose and having lactated ringers.	**a small bowel obstruction, so electrolytes are not being absorbed as they should be.**	**balanced electrolyte intravenous solutions as prescribed.** **2. Monitor serum electrolyte levels.**	**tolerating her lactated ringers' therapy well and exhibits no signs of adverse effects during this shift.** **- The patient's electrolyte levels will be within normal ranges on the next lab with drawl.**
3. Imbalanced nutrition: less than body requirements related to insufficient dietary intake as evidenced by patient being on a clear liquid diet.	**Patient is on a clear liquid diet, which means the patient is not getting adequate nutritious to meet the body's nutritional needs.**	**1. Monitor laboratory values that indicate nutritional well-being or deterioration.** **2. Encourage exercise.**	**- The patient's CBC levels will be within normal ranges on the next lab drawl.** **- Encourage patient to exercise to utilize the nutrients when patient is discharged home.**
4. Diarrhea related to malabsorption of the bowel as evidenced by the patient having a bowel obstruction.	**The patient has a small bowel obstruction and presents with abdominal pain and loose stools.**	**1. Assess for abdominal pain, cramping, and hyperactive bowel sensations.** **2. Assess hydration status.**	**- Is to limit the number of loose stools that the patient is having.** **- To keep the patient well hydrated and electrolytes balanced.**

(Gulanick & Myers, 2017**)**

Other References (APA):

Gulanick, M., & Myers, J. L. (2017). Nursing care plans: diagnoses, interventions, & outcomes (9th ed.). Elsevier.

Concept Map (20 Points):

Subjective Data

Patient complains of abdominal pain during time of being admitted to the hospital. Patient states that she lives with her son and daughter-in-law at their home.

Nursing Diagnosis/Outcomes

1. Acute pain related to the client being admitted to the medical unit for abdominal pain as evidenced by a small bowel obstruction.
   - The patient will have a therapeutic effect while using analgesics.
   - Goal is to have the patient explain the characteristics of her pain, so that the nurse can manage the pain properly.
2. Risk for electrolyte imbalance related to the patient having a small bowel obstruction as evidenced by the patient's skin turgor being loose and having lactated ringers.
   - The patient is tolerating her lactated ringers' therapy well and exhibits no signs of adverse effects during this shift.
   - The patient's electrolyte levels will be within normal ranges on the next lab with drawl.
3. Imbalanced nutrition: less than body requirements related to insufficient dietary intake as evidenced by patient being on a clear liquid diet.
   - The patient's CBC levels will be within normal ranges on the next lab drawl.
   - Encourage patient to exercise to utilize the nutrients when patient is discharged home.
4. Diarrhea related to malabsorption of the bowel as evidenced by the patient having a bowel obstruction.
   - Is to limit the number of loose stools that the patient is having.
   - To keep the patient well hydrated and electrolytes balanced.

Objective Data

Sodium level low
RBC level low
Hgb level low
Hct level low
Neutrophils and lymphocytes levels were high
Glucose level was high
BUN and creatine level was high
BP: 140/78 (1st set), 132/69 (2nd set)
Pulse: 64 (1st set), 77 (2nd set)
Respirations: 18
Oxygen saturation: 96%
Fall score: 50
Braden Score: 19

Patient Information

M.K. is a 76-year-old white widowed female who is retired and presented to the emergency department on 2/27/2021 with abdominal pain that started Friday night at 2300. M.K. lives her son and daughter-in-law. She was admitted to the medical unit for a small bowel obstruction.

Nursing Interventions

1. Give analgesics as ordered, evaluating their effectiveness, and observing for any signs and symptoms of untoward effects.
2. Assess pain characteristic.
3. Administer balanced electrolyte intravenous solutions as prescribed.
4. Monitor serum electrolyte levels.
5. Assess for abdominal pain, cramping, and hyperactive bowel sensations.
6. Assess hydration status.