

N321 Care Plan #3

Lakeview College of Nursing

Olivia Powell

Demographics (3 points)

Date of Admission 4/1/2021	Patient Initials S.J.	Age 42	Gender Male
Race/Ethnicity Caucasian	Occupation Pastor	Marital Status Married	Allergies NKDA
Code Status Full	Height 5'8	Weight 210lbs	

Medical History (5 Points)

Past Medical History: Familial hypertriglyceridemia, Type 2 Diabetes mellitus, essential hypertension, mixed hyperlipidemia, gastroparesis syndrome, binge eating disorder, obstructive sleep apnea syndrome

Past Surgical History: bladder surgery, knee surgery

Family History: Maternal: cervical cancer

Social History (tobacco/alcohol/drugs): Pt denies any use of tobacco, alcohol, or drugs.

Assistive Devices: Pt stated he wear glasses when needed.

Living Situation: Pt stated he lives with his wife and nine children in their home.

Education Level: Master's degree in Divinity

Admission Assessment

Chief Complaint (2 points): Pt complained of abdominal pain and nausea.

History of present Illness (10 points): The patient came to the ED early the morning of April 1st complaining of nausea and abdominal pain. The patient stated that he was having this pain for a while now. He reported that the pain is in his epigastric area and that the pain is always constant. When asked about his pain, he stated it was "piercing". He said when he walks the pain is worse and nothing he does reliefs the pain. He reported that he has had treatment for this before on

March 20th, was discharged home and the pain flared up again so he was readmitted to the unit April 1st.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute pancreatitis

Secondary Diagnosis (if applicable): Type 2 Diabetes Mellitus

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

Acute pancreatitis is inflammation of the pancreas. The inflammation occurs when certain digestive enzymes start to digest the pancreas. There are two types of pancreatitis: acute or chronic. Both are a very serious condition that can lead to serious complications (Pancreatitis, 2020). Acute pancreatitis begins all of a sudden and can subside within a few days after treatment. Unfortunately, chronic pancreatitis does not subside. It progressively worsens and causes permanent damage (Pancreatitis, 2020). Pancreatitis can lead to diabetes mellitus. Diabetes mellitus occurs when there is not enough insulin produced in the body (Pietrangelo, 2018).

The signs and symptoms that correlate with acute pancreatitis include upper abdominal pain, fever, rapid pulse, nausea, and tenderness when touching the abdomen (Pancreatitis, 2020). The signs and symptoms of diabetes mellitus include increased thirst, frequent urination, and extreme hunger (Pietrangelo, 2018).

Diagnostic testing for acute pancreatitis includes a CT scan of the abdomen, amylase test, trypsinogen (Pancreatitis, 2020). Diagnostic testing for diabetes mellitus consists of A1C test, glucose test, and fasting blood glucose test.

The treatment options for acute pancreatitis are pain medications, intravenous fluids, and fasting (Pancreatitis, 2020). Of the possible treatment options listed, the patients' current orders

are to be NPO to fast for a few days and monitor blood glucose levels. The doctor ordered a CT scan of the abdomen and pelvis with and without contrast which showed an enlarged lymph node. The CT scan was ordered to view the inflammation of the pancreas. Due to the inflammation of the pancreas, the patient was in pain. The patient asked for pain medication and hydromorphone was administered during the shift.

Pathophysiology References (2) (APA):

Pancreatitis. (2020, March 05). Retrieved from <https://www.mayoclinic.org/diseases-conditions/pancreatitis/symptoms-causes/syc-20360227>

Pietrangelo, A. (2018, August 20). Diabetes and Your Pancreas: What You Should Know. Retrieved from <https://www.healthline.com/health/diabetes-and-pancreas#pancreatic-cancer>

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	4.20-5.40		5.38	
Hgb	12.0-16.0		16.7	
Hct	37.0-47.0		43.1	
Platelets	150-400		233	
WBC	4.3-11.0		17.8	The patient was diagnosed with acute pancreatitis (Capriotti, 2020).
Neutrophils	37.0-85.0		80.9	
Lymphocytes	20.0-45.0		10.9	The patient has inflammation from the pancreas (Capriotti, 2020).
Monocytes	0.0-15.0		4.2	
Eosinophils	0.0-0.6		0.2	
Bands	0.0-2.0		-	

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		139	
K+	3.5-5.5		4.3	
Cl-	95-110		100	
CO2	23-31		23	
Glucose	70-110		214	The patient has Type 2 diabetes mellitus (Capriotti, 2020).
BUN	8-25		19	
Creatinine	0.70-1.50		0.78	
Albumin	3.5-5.0		-	
Calcium	8.4-10.3		8.6	
Mag	1.6-2.6		1.5	The patient was vomiting upon admission to the unit (Capriotti, 2020).
Phosphate	3.4-4.5		-	
Bilirubin	0.2-0.8		-	
Alk Phos	40-150		56	
AST	16-40		16	
ALT	7-52		19	
Amylase	64-76		-	
Lipase	9-17		55.2	The patient has acute pancreatitis (Case-Lo, 2018).
Lactic Acid	4.5-19.8		-	

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	0.0-1.1		-	
PT	11-13.5		-	
PTT	25-35		-	
D-Dimer	0.0-0.50		-	
BNP	0-100		-	
HDL	40-60		19	
LDL	0-100		0	
Cholesterol	0-200		953	The patient has mixed hyperlipidemia (Capriotti, 2020).
Triglycerides	0-100		7467	The patient has acute pancreatitis (Capriotti, 2020).
Hgb A1c	0-5.7		-	
TSH	0.4-4.0		-	

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	5.5-7.5		6.50	
Specific Gravity	1.015-1.025		1.010	
Glucose	negative		>=1000	The patient has Type 2 diabetes mellitus (Capriotti, 2020).
Protein	negative		negative	

Ketones	negative		negative	
WBC	negative		-	
RBC	Negative		-	
Leukoesterase	negative		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	normal	-	-	
Blood Culture	normal	-	-	
Sputum Culture	normal	-	-	
Stool Culture	normal	-	-	

Lab Correlations Reference (1) (APA):

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

Case-Lo, C. (2018, September 29). Amylase and Lipase Tests: Preparation, Procedure, and Results. Retrieved from <https://www.healthline.com/health/amylase-and-lipase-tests>

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT scan od abdomen/pelvis with and without contrast

Diagnostic Test Correlation (5 points): The patient had a CT scan done of the abdominal and pelvis region with and without contrast. The results from the CT scan showed a mildly enlarged lymph node on the pancreas. The inflammation on the pancreas is consist with acute pancreatitis.

Diagnostic Test Reference (1) (APA):

Pancreatitis. (2020, March 05). Retrieved from <https://www.mayoclinic.org/diseases-conditions/pancreatitis/diagnosis-treatment/drc-20360233>

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

Home Medications (5 required)

Brand/Generic	Adderall/	Alprazolam/ Xanax	Atorvastatin/ Lipitor	Carvedilol/Coreg	Metformin/ Riomet
Dose	30 mg tablet	0.5 mg tablet	20 mg tablet	12.5 mg tablet	1000 mg tablet
Frequency	2x daily	2x daily	Once daily, for 30 days	2x daily, for 30 days	2x daily, for 30 days
Route	Oral	Oral	Oral	Oral	Oral
Classification	Stimulant	antipanic	Antihyperlipidemi c	Antihypertensive	Antidiabetic
Mechanism of Action	Increases the activity of norepinephrine and dopamine in the brain	Increases effects of GABA by binding to benzodiazepine receptors	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA	Reduces cardiac output and tachycardia	Promotes storage of excess glucose as glycogen in the liver
Reason Client Taking	The patient needs a stimulant to keep up activities.	The patient is anxious.	The patient has mixed hyperlipidemia.	The patient has essential hypertension.	The patient has Type 2 diabetes mellitus.
Contraindications (2)	Tourette's, suicidal thoughts	Acute angle glaucoma, hypersensitivity	Pregnancy, hypersensitivity	Asthma, Stevens-Johnson syndrome	Advanced renal disease, hypersensitivity
Side Effects/Adverse Reactions (2)	Dry mouth, stomach upset	Agitation, tremor	Amnesia, abdominal pain	CVA, hypotonia	Headache, metallic taste
Nursing Considerations (2)	Provide rest periods, monitor for behavior change	Expect to give a higher dose is unexpected panic attack occurs, Warn pt not to stop abruptly	Expect to monitor lipid levels 2-4 weeks after the start of therapy, Expect liver function tests	Use with caution in pt's with peripheral vascular disease, Monitor pt's glucose levels	Expect to measure pt's estimated glomerular filtration rate, Administer with food

Hospital Medications (5 required)

Brand/Generic	Lisinopril/	Acetaminophen	Hydromorphone	Ondansetron	Sodium
----------------------	--------------------	----------------------	----------------------	--------------------	---------------

	Prinivil	/ Abenol	/ Dilaudid	/Zofran	Chloride
Dose	40 mg	650 mg	1 mg push	4 mg	125 ml/hr
Frequency	daily	PRN every 8 hours	PRN every 3 hours	PRN every 6 hours	Continuou s
Route	oral	Oral	IV	IV	IV
Classification	ACE inhibitor	Antipyretic	Opioid analgesic	Antimetic	Isotonic
Mechanism of Action	Reduces blood pressure by inhibiting conversion of angiotensin I to angiotensin II	Inhibits cyclooxygenase which blocks prostaglandin production	Binds with opioid receptors in the spinal cord and levels in the CNS	Serotonin receptors are blocked to help reduce nausea and vomiting	Source of electrolytes and water
Reason Client Taking	The patient has essential hypertension.	The patient has pain.	Patient is experiencing pain.	Patient was vomiting upon admission to the unit.	The patient has a NPO status.
Contraindications (2)	Hereditary or idiopathic angioedema, hypersensitivity	Severe liver disease, hypersensitivity	Acute asthma, paralytic ileus	Hypersensitivity, congenital long QT syndrome	Congestive heart failure, renal impairment
Side Effects/Adverse Reactions (2)	Depression, irritability	Wheezing, jaundice	Hallucinations, diaphoresis	Tachycardia, dry mouth	Edema, confusion
Nursing Considerations (2)	Monitor blood pressure especially within the first 2 weeks, monitor for anaphylaxis	Monitor renal function, use with caution in patients with hepatic impairment	Give IV form over a 2-minute span, Give before pain becomes intense	Monitor patient for symptoms of hypersensitivity, Dilute drug in 50 mL of D5W or normal saline	Do not administer unless solution is clear, monitor for fluid volume overload

Medications Reference **(1)** (APA):

2020 nurses drug handbook. (2020). Burlington, MA: Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: A&Ox3 Orientation: Orientated to person, place, time Distress: No apparent distress. Overall appearance: Well-groomed</p>	
<p>INTEGUMENTARY (2 points): Skin color: Appropriate for race Character: Dry, moist Temperature: Warm Turgor: Less than 3 seconds Rashes: none noted Bruises: none noted Wounds: none noted Braden Score: 0 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	
<p>HEENT (1 point): Head/Neck: Head and neck midline Ears: Auricle was pink, moist, with no lesions or rashes noted. Eyes: PEERLA Nose: Septum midline. No bleeding or drainage noted. Teeth: Overall good dentition</p>	
<p>CARDIOVASCULAR (2 points): Heart sounds: Clear S1 & S2 sounds S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Normal sinus rhythm Peripheral Pulses: 84 bpm Capillary refill: less than 3 seconds Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema: None noted.</p>	
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character Clear in all lobes</p>	
<p>GASTROINTESTINAL (2 points):</p>	

<p>Diet at home: Patient stated he is on a 19 g fat diet but does not follow it. Current Diet: low-fat diet Height: 5'8 Weight: 210 lbs Auscultation Bowel sounds: Bowel sounds present in all four quads. Last BM: 3/31/2021 Palpation: Pain, Mass etc.: tenderness in epigastric area Inspection: Distention: none noted. Incisions: none noted. Scars: left knee and midsection Drains: none noted. Wounds: none noted. 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>GENITOURINARY (2 Points): Color: yellow Character: clear Quantity of urine: 825mL Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> 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>MUSCULOSKELETAL (2 points): Neurovascular status: Alert ROM: Active ROM bilaterally in both upper and lower extremities Supportive devices: none noted. Strength: Equal strength bilaterally in lower and upper extremities ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Score: 0 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>X</p>

<p>NEUROLOGICAL (2 points): 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 type="checkbox"/> Orientation: alert Mental Status: appropriate for age Speech: no slurred speech noted Sensory: Pt is perceptive to touch, temperature, and pain. No sensory deficit noted. LOC: Alert & awake</p>	<p>.</p>
<p>PSYCHOSOCIAL/CULTURAL (2 points): Coping method(s): Patient stated that he will play video games. Developmental level: Appropriate for age Religion & what it means to pt.: Christianity; Patient stated that it is his everyday life as it is his occupation. Personal/Family Data (Think about home environment, family structure, and available family support): Patient stated that his wife and nine kids are his support system. He said his home environment is “very chaotic”.</p>	<p>.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1300	91 bpm RUE	188/89	16	98.7 F	98% RA
1609	84 bpm RUE	191/ 90	18	98.3 F	97% RA

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1553	0-10	epigastric	6	Piercing, constant	Pt repositioned himself in bed.
1601	0-10	epigastric	6	Piercing, constant	Pt requested pain medication and nurse administered Hydromorphone.

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 g Location of IV: right forearm Date on IV: 4/1/2021 Patency of IV: easily flushable Signs of erythema, drainage, etc.: none noted IV dressing assessment: clean, dry, and intact	Sodium Chloride 0.9% @ 125mL/hr

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
600mL	825mL

Nursing Care**Summary of Care (2 points)**

Overview of care: The patient is independent, so he did ADL's on his own time. Pain medications were administered per orders. The doctor is continuing to monitor the patient's triglyceride levels to determine the next step in treatment.

Procedures/testing done: CT of abdomen/pelvis with and without contrast

Complaints/Issues: nausea, abdominal pain

Vital signs (stable/unstable): Stable, unchanged since admission.

Tolerating diet, activity, etc.: Pt is independent and completes activities as tolerated. Pt is also on a NPO status until further notice.

Physician notifications: None during this shift

Future plans for patient: Pt will be discharged home and will follow diet order plans.

Discharge Planning (2 points)

Discharge location: His home

Home health needs (if applicable): Pt will not need home health.

Equipment needs (if applicable): Pt will not need any equipment.

Follow up plan: Pt will need to follow up with his doctor in regard to his triglyceride levels, glucose levels, and acute pancreatitis.

Education needs: The patient needs education on a low-fat diet and his medications.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

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.
<ol style="list-style-type: none"> Acute pain related to inflammation of the pancreas as evidenced by patient reports pain 6/10. 	Patient was admitted for nausea and abdominal pain.	<ol style="list-style-type: none"> Maintain bedrest in a quiet, restful environment. Administer pain medications as ordered. 	Goal met. Patient was placed in a quiet, restful room upon admission to the floor. Goal met. Nurse administered Hydromorphone.
<ol style="list-style-type: none"> Risk for 	Patient is on NPO	<ol style="list-style-type: none"> Administer IV 	Goal met. Nurse inserted

imbalanced fluid volume related to NPO status.	status due to vomiting upon admission.	fluids. 2. Monitor intake and output.	IV to right forearm and started infusing Sodium Chloride 0.9%. Goal met. CNA recorded and reported intake and output to nurse.
3. Deficient knowledge related to multiple episodes of acute pain as evidenced by patient stated he does not always follow his diet plan.	Patient stated he is “not very good at following the diet”.	1. Educate patient on the importance of following a low-fat diet. 2. Encourage follow-up care and review symptoms that need immediate medical attention.	Goal met. Patient was educated on following a low-fat diet. Goal met. Patient was encouraged to follow-up with care and reviewed symptoms requiring immediate attention.

Other References (APA):

Vera, M., By, -, Vera, M., & Matt Vera is a registered nurse with a bachelor of science in nursing since 2009 and is currently working as a full-time writer and editor for Nurseslabs. During his time as a student. (2020, December 05). 8 Pancreatitis Nursing Care Plans. Retrieved from <https://nurseslabs.com/5-pancreatitis-nursing-care-plans/>

Concept Map (20 Points):

