N431 Care Plan #1

Lakeview College of Nursing

Matthew Catlett

Demographics (3 points)

Date of Admission 4/6/21	Patient Initials M.K.	Age 59 years old	Gender Female
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Single	Allergies Lipitor
Code Status Full Code	Height 170.2 cm	Weight 108 kg	

Medical History (5 Points)

Past Medical History: The client's past medical history includes COPD, hypertension, type 2 diabetes, neuropathy, and chronic kidney disease.

Past Surgical History: The client's past surgical history includes a hysterectomy, appendectomy, toe amputation, and carotid endarterectomy.

Family History: The client does not know her family history.

Social History (tobacco/alcohol/drugs): The client previously smoked. 80 pack/year. The client does not drink alcohol or consume any drugs.

Assistive Devices: The client does not use any assistive devices.

Living Situation: The client lives alone in a 1st story apartment.

Education Level: The client completed high school but has no further education. The client can understand the information given to her.

Admission Assessment

Chief Complaint (2 points): The client complains of vomiting, diarrhea, and abdominal discomfort.

History of present Illness (10 points): The client is a 59-year-old female presented to the emergency department with vomiting, abdominal pain, and diarrhea. The client states that she vomits with every attempt at eating and has been unable to keep any food ingested for

the past 24 hours. The client states that her abdominal pain is severe and radiates to her flanks bilaterally. No at-home treatments have worked for this client. The client also complains of chills, fever, and a constant, dull headache. The client's symptoms have been persistent throughout without relief.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): The patient is being admitted for gastroenteritis.

Secondary Diagnosis (if applicable): The patient is also being admitted for complications with her chronic kidney disease.

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

Gastroenteritis is the inflammation of the stomach and the small intestines. A viral or bacterial infection can cause gastroenteritis. The most common cause of this infection is rotavirus and norovirus. Other infections can include E. coli and salmonella. When these pathogens invade the gastrointestinal tract, they adhere to the mucosa of the tract and create a disturbance along with toxin production. This creates a shift in fluid within the GI tract and can cause fluid to not be reabsorbed. This results in diarrhea. Other symptoms of gastroenteritis include nausea, vomiting, abdominal pain, fever, and headaches. Gastroenteritis can result in electrolyte imbalances and dehydration (Capriotti & Frizzel, 2016). Patients with gastroenteritis may have increased hematocrit levels due to dehydration, as well as low electrolyte levels. Treatment for this disease includes a liquid diet, as well as a broad-spectrum antibiotic until the cause of the gastroenteritis can be

identified. The client will also need to receive an intravenous saline solution to correct the fluid volume deficit that may occur.

For this client, she received a broad-spectrum antibiotic as well as 0.9% normal saline, ondansetron to treat the client's nausea and vomiting, and acetaminophen to treat the abdominal pain she was experiencing. The client also received an abdominal CT to rule out the possibility of a bowel obstruction or any other gastrointestinal issues that can be identified with a CT scan. The client's complete blood count also shows that she may be suffering from an infection, which could identify her diagnosis of gastroenteritis.

Pathophysiology References (2) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical 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	**3.8-5.3**	**12.6**	**N/A**	**The client's increased RBC may be caused by the client's COPD (Capriotti & Frizzel, 2016).**
Hgb	**12-15.8**	**12.3**	**N/A**	
Hct	**36-47%**	**37.8%**	**N/A**	
Platelets	**140-440**	**216**	**N/A**	
WBC	**4-12**	**12.6**	**N/A**	**Increased white blood cells count is caused by gastroenteritis infection (Capriotti & Frizzel, 2016).**
Neutrophils	**1.6-7.7**	**12**	**N/A**	**Increased neutrophil count is caused by gastroenteritis infection (Capriotti & Frizzel, 2016).**

Lymphocytes	**1.3-3.2**	**0.92**	**N/A**	
Monocytes	**0.2-1**	**0.30**	**N/A**	
Eosinophils	**0-0.4**	**0.0**	**N/A**	
Bands	**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-	**133-144**	**136**	**135**	
K+	**3.5-5.1**	**5.1**	**4.0**	
Cl-	**98-107**	**97**	**101**	**The client's chloride levels may be decreased due to frequent vomiting and diarrhea (Capriotti & Frizzel, 2016).**
CO2	**21-31**	**25**	**23**	
Glucose	**70-99**	**369**	**248**	**Increased glucose is caused by the client's diabetes mellitus.**
BUN	**7-25**	**53**	**48**	**Increased BUN is caused by inadequate filtration of the blood by the kidneys (Capriotti & Frizzel, 2016).**
Creatinine	**0.5-1.2**	**1.53**	**1.37**	**Increased creatinine is caused by poor kidney function (ATI, 2016).**
Albumin	**3.5-5.7**	**4.0**	**3.6**	
Calcium	**8.6-10.3**	**9.3**	**8.6**	
Mag	**1.6-2.6**	**1.9**	**1.9**	
Phosphate	**34-104**	**82**	**N/A**	
Bilirubin	**0-0.3**	**N/A**	**N/A**	
Alk Phos	**36-92**	**N/A**	**N/A**	

AST	**0-35**	**N/A**	**N/A**	
ALT	**0-35**	**N/A**	**N/A**	
Amylase	**0-130**	**N/A**	**N/A**	
Lipase	**<95**	**N/A**	**N/A**	
Lactic Acid	**0.5-2.0**	**2.0**	**N/A**	
Troponin	**0-0.04**	**0.122**	**0.135**	**The client's increased troponin levels are caused by kidney damage (Capriotti & Frizzel, 2016).**
CK-MB	**0-7**	**N/A**	**N/A**	
Total CK	**30-135**	**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	**<1**	**N/A**	**N/A**	
PT	**11-13 sec.**	**N/A**	**N/A**	
PTT	**25-35 sec.**	**N/A**	**N/A**	
D-Dimer	**<300 ng/mL**	**N/A**	**N/A**	
BNP	**0-100**	**47**	**N/A**	
HDL	**40-59**	**35**	**N/A**	
LDL	**<100**	**70**	**N/A**	
Cholesterol	**<200**	**153**	**N/A**	
Triglycerides	**<150**	**431**	**N/A**	**Client's increased triglycerides is caused by obesity and poorly managed diabetes (Capriotti & Frizzel, 2016).**
Hgb A1c	**<7**	**7.5**	**N/A**	**The client's increase Hgb A1c is**

				caused by her poorly managed diabetes (Capriotti & Frizzel, 2016).
TSH	**0.5-5.0**	**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	**Light yellow/ colorless; clear**	**Yellow; clear**	**Yellow; clear**	
pH	**5-9**	**5**	**N/A**	
Specific Gravity	**1.003-1.030**	**1.013**	**N/A**	
Glucose	**Negative**	**1+**	**N/A**	
Protein	**Negative**	**2+**	**N/A**	
Ketones	**Negative**	**Negative**	**N/A**	
WBC	**Negative**	**Negative**	**N/A**	
RBC	**Negative**	**Negative**	**N/A**	
Leukoesterase	**Negative**	**Negative**	**N/A**	

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**	

PaO2	**75-100**	**N/A**	**N/A**	
PaCO2	**35-45**	**N/A**	**N/A**	
HCO3	**22-26**	**N/A**	**N/A**	
SaO2	**94-100%**	**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**	**Negative**	**N/A**	
Blood Culture	**Negative**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**N/A**	**N/A**	

Lab Correlations Reference (1) (APA): ATI. (2016). *RN Adult Medical Surgical Nursing* (10.0 ed., Content Mastery Series)

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): The client also received a chest x-ray and an abdominal CT scan.

Diagnostic Test Correlation (5 points):

The client received a chest x-ray to determine if any infiltrates are present in the client's lungs. The chest x-ray showed no infiltrates or secretions present. The abdominal

CT was conducted to determine if the client had any identifiable causes, such as a bowel obstruction, that would cause the client's frequent vomiting. The abdominal CT returned unremarkable.

Diagnostic Test Reference (1) (APA):

Capriotti, T., & Frizzell, J. P. (2016). *Pathophysiology: introductory concepts and clinical perspectives*. F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	**Plavix/ clopidogrel**	**Ferrous sulfate**	**Lasix/ furosemide**	**Crestor/ rosuvastatin**	**Flonaze/ fluticasone**
Dose	**75 mg**	**325 mg**	**20 mg**	**20 mg**	**50 mcg**
Frequency	**Daily**	**Daily**	**Daily**	**Daily**	**Daily**
Route	**Oral**	**Oral**	**Oral**	**Oral**	**Nasal**
Classification	**Platelet aggregation inhibitor**	**Anti-anemic**	**Diuretic**	**Antilipemic**	**Antiasthamtic/ Anti-inflammatory**
Mechanism of Action	**Binds to ADP receptors on the surface of activated platelets.**	**Binds with hemoglobin and normalizes RBC production.**	**Inhibits sodium and water reabsorption in the loop of Henle.**	**Increases the amount of LDL hepatic receptors, allowing more LDL's to be eliminate**	**Inhibits cells involved in the inflammatory response that causes asthma.**

				from the bloodstream.	**This medication also inhibits the production and secretion of chemical mediators.**
Reason Client Taking	**The client is taking the medication to reduce the risk of future thrombotic events.**	**The client is taking this medication to treat anemia or prevent anemia.**	**The client is taking this medication to reduce edema caused by her renal disease.**	**The client is taking this medication to treat hyperlipidemia.**	**The client is taking this medication to treat seasonal allergic rhinitis.**
Contraindications (2)	**Contraindications include active bleeding and hypersensitivity to clopidogrel.**	**This medication should not be taken by clients with hemolytic anemia or hemochromatosis.**	**This medication should not be taken by clients with anuria or a hypersensitivity to furosemide.**	**Contraindications include active liver disease and mothers who are currently pregnant or breastfeeding.**	**This medication should not be taken by clients with untreated nasal mucosa infection or hypersensitivity to the medication.**
Side Effects/Adverse Reactions (2)	**Side effects include hypotension and thrombocytopenic purpura.**	**Side effects include hypotension and angioedema.**	**Side effects include arrhythmias and hypokalemia.**	**Side effects include hepatic failure and angioedema.**	**Side effects include bronchospasm and adrenal insufficiency.**
Nursing Considerations (2)	**Use cautiously in patients with renal or hepatic disease.** **Use cautiously in**	**Monitor patient's blood pressure with each administration.** **Give tablets**	**Use cautiously in clients with severe hepatic disease.** **Obtain weight**	**Use cautiously in clients who consume large amounts of alcohol.** **Use**	**Use cautiously in clients with untreated systemic infections.** **Monitor**

	patients with peptic ulcer disease.	**with full glass of juice or water.**	**periodically to monitor fluid loss.**	**cautiously in clients who have hepatic impairment.**	**patient closely if the patient has an allergy to milk or milk products.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**A CBC should be obtained before and during usage of this medication.**	**The client's CBC should be obtained before administering this medication.**	**The client's liver function should be evaluated before administration. The client's hydration status should also be evaluated before administration.**	**The client's liver function should be evaluated before administering this medication.**	**Assess client for infections such as pulmonary tuberculosis and other infections.**
Client Teaching needs (2)	**Discourage the use of NSAIDs while taking this medication.** **Instruct client to report unusual bleeding or bruising.**	**Client should eat food high in Vitamin C to improve iron absorption.** **Client should avoid drinking coffee or tea within one hour of iron intake.**	**This medication should be taken at the same time every day.** **Change positions slowly to minimize orthostatic hypotension.**	**Encourage patients to follow a low-fat diet.** **Clients should wait 2 hours after taking antacids before ingesting this medication.**	**Instruct client to use this medication regularly as prescribed.** **When 2 inhalations are administered, wait 1 minute between doses.**

Hospital Medications (5 required)

Brand/Generic	**Tylenol/ acetaminophen**	**Rocephin/ ceftriaxone**	**Lovenox/ enoxaparin**	**Lopressor/ metoprolol**	**Zofran/ ondansetron**
Dose	**650 mg**	**2 g**	**40 mg**	**10 mg**	**4 mg**
Frequency	**Q4H PRN**	**Daily**	**Daily**	**Q12H**	**Q6H PRN**
Route	**Oral**	**IV**	**Subcutaneous**	**Oral**	**IV**
Classification	**Antipyretic/ nonopioid analgesic**	**Antibiotic**	**Anticoagulant**	**Antihypertensive**	**Antiemetic**
Mechanism of Action	**Inhibits the cyclooxygenase enzyme that is involved with prostaglandin production.**	**Interferes with bacterial cell wall synthesis.**	**Stops the action of antithrombin III.**	**Inhibits the stimulation of beta-1 receptor sites.**	**Blocks serotonin receptors in the vagal nerve of the intestines.**
Reason Client Taking	**To reduce pain and inflammation.**	**The client is taking this medication to stop the bacteria that may be causing her gastroenteritis.**	**The client is receiving this medication to reduce the risk of DVT.**	**The client is taking this medication to lower her blood pressure.**	**The client is taking this medication to prevent nausea and vomiting.**
Contraindications (2)	**Contraindications for this medication include hepatic impairment and hypersensitivity to**	**This antibiotic should not be given to those who have a high serum bilirubin or receiving**	**This should not be given to clients who are currently bleeding.** **This should not be given to clients who**	**This should not be given to those who suffer from acute heart failure or those with a pulse less than 45**	**This medication should not be given to clients who suffer from long QT syndrome or are**

	acetaminophen.	**IV infusions that contain calcium.**	**have a history of heparin induced thrombocytopenia.**	**beats per minutes.**	**currently receiving apomorphine.**
Side Effects/Adverse Reactions (2)	**Side effects include hepatotoxicity and hypotension.**	**Side effects include pancreatitis and neutropenia.**	**Side effects include hemorrhage and atrial fibrillation.**	**Side effects include heart failure and cardiogenic shock.**	**Side effects include hypotension and serotonin syndrome.**
Nursing Considerations (2)	**Use cautiously in clients with hepatic impairment.** **Monitor renal function in clients who receive this medication long term.**	**Calcium containing infusions should not be given within 48 hours of administration of this medication.** **Use cautiously in patients who have an allergy to penicillin.**	**Use extreme caution when administering this medication to clients who are at an increased risk of hemorrhage.** **Use cautiously in clients who have a history of peptic ulcer disease.**	**Use cautiously in clients who are currently suffering from angina.** **Patients should be monitored closely if receiving more than 400 mg in a 24-hour period.**	**Hypokalemia and hypomagnesemia should be corrected before administering this medication.** **Monitor clients closely for signs of hypersensitivity.**
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	**Liver function tests should be evaluated before administration.**	**Providers should ensure the client does not have an allergy to this antibiotic before administration.**	**The client's thrombocyte count should be evaluated before administration.**	**The client's vital signs should be checked before administration.**	**The client's potassium and magnesium levels should be evaluated before administering this drug.**
Client Teaching needs (2)	**Follow prescription as intended. Overuse of this drug can**	**Instruct client to report watery, bloody**	**Instruct patient to report any signs of excess**	**Instruct client to take this medication with food at**	**Instruct client to report signs of hypersensiti**

	lead to hepatic damage. **Teach client to identify the signs and symptoms of hepatotoxicity.**	**stools to provider immediately.** **Instruct patient to report any signs or symptoms of hypersensitivity.**	**bleeding to the provider.** **Review safety of disposal of needles with the client after use.**	**the same time every day.** **Instruct client to notify provider if their heart rate goes below 60 beats per minute.**	**vity to the provider.** **Instruct client to use a calibrated measuring device when receiving this medication orally.**

Medications Reference (1) (APA): Jones & Bartlett Learning. (2020). *2020 Nurses drug handbook*.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	**Client is alert and oriented x4.** **The client appears in minor distress.** **The client's overall appearance is**
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:**	**Client's skin is pink, warm to the touch.** **Client has no excess diaphoresis.** **Client's skin turgor is <2 seconds at the clavicle.** **No rashes, incisions, or wounds present.**

Rashes: **Bruises:** **Wounds:** . **Braden Score: 20** **Drains present: Y☐ N ☒** **Type:**	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	**Head and neck are symmetrical.** **No tracheal deviation present.** **Tympanic membranes are pearly gray without inflammation.** **No discharge present from the ear canal.** **Sclera's are white without hemorrhage.** **Client does require glasses.** **Nose is midline without septal deviation.** **Oral mucosa is pink and moist. No sores present.** **Dentition is good.**
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 heart sounds are audible.** **No S3, S4, or murmurs present.** **Peripheral pulses are present in upper and lower extremities, bilaterally.** **Client has mild, 1+ edema present in the lower extremities.**
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	**Client's breath sounds are clear bilaterally in all lobes.** **No wheezes, rhonchi, or crackles present.**
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height: 170.2 cm** **Weight: 108 kg** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:**	**Client's bowel sounds are active in all four quadrants.** **Client's bowel sounds are hyperactive.** **Client follows a regular diet at home.** **Client is currently on a clear liquid diet within the hospital.** **Last bowel movement occurred on 4/7 at 0830.** **Client has no incisions, scars, drains, or wounds present.** **Client has no abdominal distention.**

Ostomy: Y ☐ N ☒ **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Client's urine is yellow, but clear of sediment.** **The client has voided 300 mL in the past 24 hours.** **The client is not experiencing any urgency, frequency, or incontinence.** **The client's genitals are intact without inflammation or sores present.**
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 15** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	**The client can walk independently but prefers assistance when standing from the bed.** **The client does not use a wheelchair, walker, or cane.** **The client has full range of motion in all extremities.** **The client has equal strength in the upper and lower extremities bilaterally.**
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	**The client moves all extremities well.** **The client is oriented x4.** **The client is not suffering from any speech impairment.** **The client does suffer from neuropathy in the lower extremities.**
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and**	The client states that she is not religious. The client states she uses food as a means of coping. The client's attitude and understanding are developmentally correct for her age. The client receives support from her 2 daughters.

available family support):	

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0300	**84**	**133/65**	**16**	**98.1 F**	**100%**
0700	**89**	**150/66**	**18**	**98.2 F**	**98%**

Vital Sign Trends: The client's vital signs stayed the same throughout the clinical experience except the clients systolic blood pressure that increased from 133 to 150.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0600	**Numeric**	**Head/ Abdomen**	**2/10**	**N/A**	**No interventions initiated at this time.**
0700	**Numeric**	**Head/ Abdomen**	**1/10**	**N/A**	**No interventions initiated at this time.**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 24 gauge **Location of IV: Basilic vein** **Date on IV: 4/6/21** **Patency of IV: The IV is intact.** **Signs of erythema, drainage, etc.: No signs of drainage or erythema present.** **IV dressing assessment: Dressing is intact without signs of drainage or bleeding.**	0.9 sodium chloride @ 75 mL/hr.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360 mL	**300 mL**

Nursing Care

Summary of Care (2 points)

Overview of care: The client received assistance with ambulation to and from the restroom as well as assistance with bathing and changing gowns. The client also received blood work from the phlebotomist.

Procedures/testing done: The client's troponin levels were checked twice the day of clinical.

Complaints/Issues: The client complained of her I.V. placement. The nurse was made aware of this complaint.

Vital signs (stable/unstable): The client's blood pressure raised throughout the clinical experience but returned to normal once she received her metoprolol.

Tolerating diet, activity, etc.: The client still suffered from diarrhea on the full liquid diet.

Physician notifications: The physician notified the nurse that the client was being transferred to the OSF location in Champaign-Urbana.

Future plans for patient: The client does not have any future plans at the moment.

Discharge Planning (2 points)

Discharge location: The client's discharge location is still undetermined as she began the transfer from the hospital in Danville to the hospital in Champaign-Urbana.

Home health needs (if applicable): The client does not currently have any home health needs.

Equipment needs (if applicable): The client does not need any equipment currently.

Follow up plan: The client should continue to monitor her glucose and make reoccurring appointments with her primary care provider to monitor her hemoglobin A1C levels and her kidney disease progression.

Education needs: The client should receive education regarding her diet, as well as her diabetes control and insulin administration. The client should also receive education on ways she can slow the progression of her chronic kidney disease as well as information on how to prevent injury regarding her neuropathy.

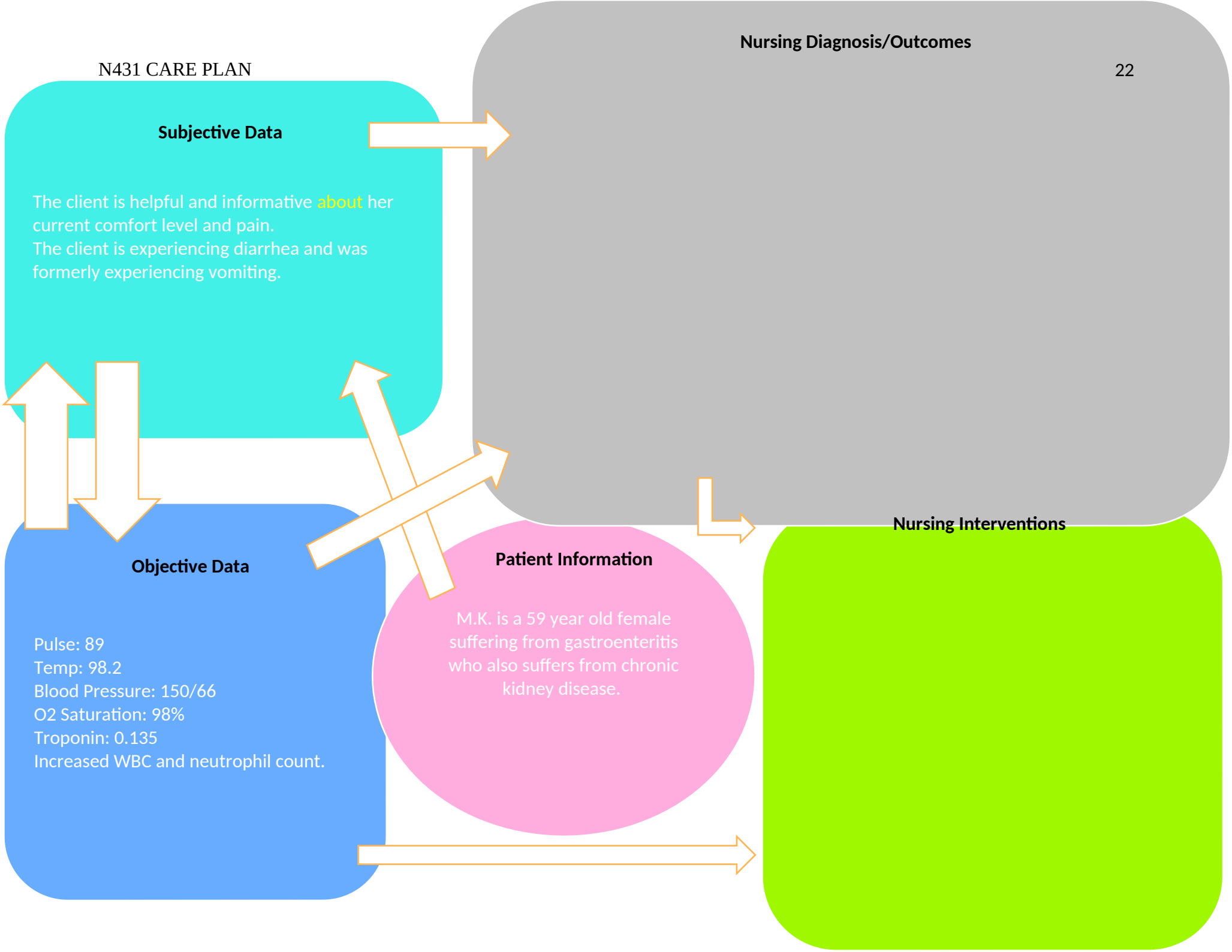
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

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. Nutritional deficiency related to gastroenteritis as evidenced by vomiting and diarrhea.	**The client is at risk for nutritional deficiency because her bowels are not functioning properly, and she is unable to hold any food without vomiting.**	**1. Providing the client with the appropriate electrolytes through IV administration.** **2. Using antibiotics to treat the gastroenteritis.**	**The client's electrolyte status improved over the course of her hospital stay.**
2. Fluid volume	**The client is at**	**1. Continuous infusion**	**The client no longer**

deficit related to gastroenteritis as evidenced by vomiting and diarrhea.	**risk for dehydration caused by her frequent vomiting and diarrhea.**	**of saline allows the client to maintain proper hydration by omitting the GI tract.** **2. Providing the client with ondansetron to reduce nausea and vomiting.**	**suffered from vomiting.** **The client's hydration status and urinary output improved over the course of the day.**
3. Altered urinary elimination related to chronic kidney disease as evidenced by troponin, BUN, and creatinine levels.	**The client's progressing kidney damage places her at risk for altered urinary elimination.**	**1. Administering antihypertensive medications to reduce the clients blood pressure to slow the progression of kidney damage.** **2. Ensuring the client follows a low protein diet.**	**The client's troponin levels continued to increase throughout the day, showing that her kidney disease was progressing.**
4. Ineffective individual coping strategies related to stress eating as evidenced by increased body weight.	**The client states that she uses food as a way of dealing with the stressors in her life.**	**1. Providing the client with information on other effective coping strategies such as meditation, visual imagery, and scheduling times to relax.** **2. Providing the client with healthy eating alternatives to the current diet she follows at home. Encouraging the client to eat healthier options may be an easier alternative to other methods.**	**The client understood the information that the student provided to her about alternative coping strategies.**

Other References (APA):

Concept Map (20 Points):


Nursing Diagnosis/Outcomes
Subjective Data
The client is helpful and informative about her current comfort level and pain.
The client is experiencing diarrhea and was formerly experiencing vomiting.
Objective Data
Pulse: 89
Temp: 98.2
Blood Pressure: 150/66
O2 Saturation: 98%
Troponin: 0.135
Increased WBC and neutrophil count.
Patient Information
M.K. is a 59 year old female suffering from gastroenteritis who also suffers from chronic kidney disease.
Nursing Interventions