N431 Care Plan # 2

Lakeview College of Nursing

Princess Anne Hernandez

Demographics (3 points)

Date of Admission 07/03/2021	**Patient Initials** M.M	**Age** 41 years old	**Gender** Female
Race/Ethnicity White/Caucasian	**Occupation** Unemployed	**Marital Status** Married	**Allergies** Ibuprofen- nausea and vomiting Latex- anaphylaxis Cyclobenzaprine- difficulty breathing and rash. Tetracycline- hives
Code Status FULL	**Height** 188 cm	**Weight** 71.5 kg	

Medical History (5 Points)

Past Medical History: Chronic myelogenous leukemia (CML), arthritis, generalized anxiety disorder (GAD), depression, hypertension (HTN), allergic rhinitis.

Past Surgical History: Cholecystectomy (2000), C-section (2002), tubal ligation (2002), laminectomy (2006), hysterectomy (2015)

Family History: Father: arthritis, hypertension, gastrointestinal ulcer; Mother: asthma, cervical cancer, dementia, emphysema, gastrointestinal ulcer, hypercholesterolemia, mental illness.

Social History (tobacco/alcohol/drugs): The patient smokes ½ pack per day since she was 15 years old. The patient denies the use of alcohol and recreational drug.

Assistive Devices: No assistive device use.

Living Situation: The patient lives alone and independently.

Education Level: Less than high school

Admission Assessment

Chief Complaint (2 points): abdominal pain and fever

History of present Illness (10 points):

The patient is a 41-year-old female admitted to the hospital on July 3, 2021, due to abdominal pain and fever. She states that she is experiencing pain that spread across her abdomen that started about a week ago that “comes and go” and improves with rest. On July 02, 2021, the pain becomes worse and constant, radiating to the chest and back that cause her to feel nauseated. She took Tylenol because she reports having a fever and to help with the pain. The pain becomes unbearable which she decides to go to the emergency to seek further treatment.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Colitis

Secondary Diagnosis (if applicable): N/A

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

Colitis is the inflammation of the submucosal or mucosa of the colon (Swearingen & Wright, 2019). Capriotti (2020) states that the cause is unknown; however, theories state that genetic, immunological, and environmental factors such as microorganisms causing inflammation can cause colitis. With colitis affecting the superficial mucosa of the colon, multiple ulcerations, diffuse inflammation, and shedding of the colonic epithelium happen. The mucosa becomes edematous, inflamed, and bleeding can happen. Abscesses, fistulas, obstructions, and fissures can also happen due to inflammation (Hinkle & Cheever, 2018). Ulceration can become covered with granulation tissue that can lead to the formation of pseudopolyps (Swearingen & Wright, 2019)

Bloody diarrhea is that hallmark finding for colitis (Swearingen & Wright, 2019). The patient may have six or more liquid stools each day, abdominal pain, fever, vomiting, dehydration, weight loss, fatigue, and anorexia (Hinkle & Cheever, 2018). The patient may have

anemia and pallor due to bleeding (Swearingen & Wright, 2019). For this patient, she is experiencing abdominal pain, fever, and fatigue. She was also anemic. However, she was not passing any stool and was constipated.

Hinkle & Cheever (2018) state that the laboratory tests for colitis are CBC, CMP, stool for occult blood, CRP, and ESR. The result can show decreased hemoglobin, hematocrit, potassium, magnesium, and calcium. There will be increase value for ESR, WBC, and CRP. The stool for occult blood may be possibly positive but not always (Hinkle & Cheever. The vital sign may show a mild fever of 37.2 – 37.7 degrees Celsius or fevers of greater than 38 degrees Celsius (Swearingen & Wright, 2019). The patient laboratory results show a hemoglobin level of 11.3 and a hematocrit level of 32.2, which are low. In addition, the calcium level of 8.0 was low from the patient lab result.

The most common diagnostic tests to help diagnose colitis are colonoscopy and biopsy (Capriotti, 2020). Colonoscopy will help determine the extent of the disease, and a biopsy can confirm the diagnosis (Swearingen & Wright, 2019). Other diagnostic tests used are MRI, CT scan, barium enema, abdomen ultrasound, and stool examination (Hinkle & Cheever, 2018). The patient had a CT scan showing a mid-transverse colon 4 cm length wall thickening, which confirms inflammation in the colon. In addition, the patient had barium enema that shows no abnormalities noted.

Hinkle & Cheever (2018) states that aminosalicylates are the medication choice for mild or moderate inflammation and the implementation of antibiotics therapy for any ongoing infection. Pain medication also helps to decrease severe abdominal pain. Other medications such as antidiarrheal and antiperistalsis help minimize peristalsis to rest the inflamed bowel (Swearingen & Wright, 2019). If medication treatment is ineffective, surgery may be performed

(Capriotti, 2020). The patient is receiving hydromorphone as needed every 2 hours for abdominal pain. In addition, she is also doing antibiotic therapy with Zosyn every 6 hours.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource medical-surgical, pediatric, maternity, and psychiatric-mental health* (5th ed.). Elsevier.

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 (10^6/mcl)	**4.28 – 5.41**	3.88	3.31	The patient has leukemia. Leukemia impairs the ability of the bone marrow to produce red blood cells, which causes a decrease in RBC levels (Pagana et al., 2020)
Hgb (g/dL)	**13 – 17**	13.5	11.3	Hemoglobin follows the RBCs, and considering the patient has leukemia and low RBCs, Hgb will also be decreased (Pagana et al., 2020).
Hct (%)	**38.1 – 48.9**	38.3	32.2	Hematocrit reflects the RBC and Hgb, and considering the patient has leukemia, low RBCs and Hgb, Hct will also be decreased (Pagana et al., 2020).
Platelets (k/mcL)	**149 – 393**	240	204	N/A

WBC (k/mcL)	**4.0 – 11.7**	7.2	5.0	N/A
Neutrophils (%)	**45.3 – 79.0**	68.1	47.7	N/A
Lymphocytes (%)	**11.8 – 45.9**	21.1	37.6	N/A
Monocytes (%)	**4.4 – 12.0**	10.1	10.5	N/A
Eosinophils (%)	**0 – 6.3**	0.4	3.7	N/A
Bands (%)	**0 – 5.1**	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- (mmol/L)	**136 - 145**	135	138	N/A
K+ (mmol/L)	**3.5 – 5.1**	3.8	3.7	N/A
Cl- (mmol/L)	**98 – 107**	102	106	N/A
CO2 (mmol/L)	**21 – 31**	27	27	N/A
Glucose (mg/dL)	**74 – 109**	90	98	N/A.
BUN (mg/dL)	**7 – 25**	5	3	A decreased level of BUN may be due to malnutrition (Pagana et al., 2020). The patient is experiencing abdominal pain and has leukemia and has not been eating well.
Creatinine (mg/dL)	**0.70 – 1.30**	0.66	0.55	A decreased creatinine level may be due to low protein intake (Pagana et al., 2020). The patient has not been eating well before admission and on a full liquid diet during the hospital stay.
Albumin (g/dL)	**3.5 – 5.3**	4.2	N/A	N/A
Calcium (mg/dL)	**8.6 – 10.3**	9.4	8.0	The patient was diagnosed with colitis. Colitis causes electrolyte imbalance and decreases calcium levels (Hinkle & Cheever, 2018).

Mag (mg/dL)	**1.6 – 2.5**	N/A	1.7	N/A
Phosphate (mg/dL)	**2.5 – 4.5**	N/A	N/A	N/A
Bilirubin (mg/dL)	**0.3 – 1.0**	0.8	N/A	N/A
Alk Phos (unit/L)	**34 – 104**	49	N/A	N/A
AST (U/L)	**10 – 30**	14	N/A	N/A
ALT (U/L)	**10 – 40**	14	N/A	N/A
Amylase (U/L)	**30 – 110**	N/A	N/A	N/A
Lipase (U/L)	**0 – 160**	26	N/A	N/A
Lactic Acid (mEq/ L)	**0.5 – 2.2**	0.6	N/A	N/A
Troponin (ng/mL)	**0.000 – 0.030**	0.010	N/A	N/A
CK-MB (ng/mL)	**0.000 – 0.030**	0.008	N/A	N/A
Total CK (intlU/L)	**30 – 223**	57	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. 86 – 1.14**	N/A	N/A	N/A
PT (seconds)	**11.9 – 15**	N/A	N/A	N/A
PTT (seconds)	**22.6 – 35. 3**	N/A	N/A	N/A
D-Dimer (ng/mL)	**</= 250**	N/A	N/A	N/A
BNP (pg/mL)	**< 100**	N/A	N/A	N/A
HDL (mg/dL)	**> 60**	N/A	N/A	N/A

LDL (mg/dL)	**< 130**	N/A	N/A	N/A
Cholesterol	**< 200**	N/A	N/A	N/A
Triglycerides	**<150**	N/A	N/A	N/A
Hgb A1c (%	**4 – 5.6**	N/A	N/A	N/A
TSH (mU/L)	**0.4 – 4**	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	**5 – 8**	8.0	N/A	N/A
Specific Gravity	**1.005 – 1.035**	1.008	N/A	N/A
Glucose	**negative**	Negative	N/A	N/A
Protein (mg/dL)	**Negative**	Negative	N/A	N/A
Ketones	**Negative**	Negative	N/A	N/A
WBC	**Negative**	Negative	N/A	N/A
RBC	**</= 2**	Negative	N/A	N/A
Leukoesterase	**Negative**	Negative	N/A	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	N/A
PaO2	**80 – 100**	N/A	N/A	N/A
PaCO2	**35 – 45**	N/A	N/A	N/A

HCO3	**22-26**	N/A	N/A	N/A
SaO2	**92 – 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**	Negative	N/A	Negative urine culture means no foreign microorganisms present in the patient's urine (Sarah Bush Lincoln, 2021).
Blood Culture	**Negative**	Negative	N/A	Negative blood culture means no foreign microorganisms present in the patient's blood (Sarah Bush Lincoln, 2021).
Sputum Culture	**Negative**	N/A	N/A	N/A
Stool Culture	**Negative**	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Hinkle, J. L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Elsevier.

Sarah Bush Lincoln Health Reference Guide. (2021). *Cerner*. https://www.sarahbush.org

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

- CTA chest with contrast (07/02/2021)
- CT abdomen and pelvis with contrast (07/02/2021, 07/03/2021)
- Barium enema (07/03/2021)

Diagnostic Test Correlation (5 points):

- CTA chest with contrast: The patient's abdominal pain radiates to chest. The purpose of CTA of the chest with contrast was to visualize the heart for pulmonary embolism, aortic dissection, and trauma (Pagana et al., 2020)

  Result: The result was normal and no pulmonary embolism or any trauma noted.
- CT abdomen and pelvis with contrast. The patient is experiencing abdominal pain. The purpose of CT of abdomen and pelvis with contrast was visualize abdominal and retroperitoneal organs for any tumor, cyst, abscess, inflammation, perforation, bleeding, and obstruction (Pagana et al., 2020)
- Result:
  - 07/02/2021: The result shows small intestines with features suggesting enteritis which suggest there is an infection going on in the small intestine. Fatty liver changes and mild hepatic enlargement.
  - 07/03/2021: The result shows there is a small supraumbilical ventral abdominal wall hernia containing fluid. Mid-transverse colon 4 cm length wall thickening, which confirms there is inflammation going on in the colon.

- Barium enema: The patient has mid-transverse colon 4 cm length wall thickening and suspected to have transverse colon mass. The purpose of barium enema is to visualize the colon for location of any polyps, tumor, and diverticula (Pagana et al., 2020)
    - The result show no suspicious stricture was identified.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's diagnostic and laboratory test reference* (15th ed.). Elsevier.

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

Home Medications (5 required)

Brand/Generic	Abilify/ aripiprazole	Sprycel/ dasatinib	Cymbalta/ duloxetine	Inderal/ propranolol	Tylenol/ acetaminophen
Dose	2 mg	100 mg	60 mg	10 mg	500 mg
Frequency	Once daily	Once daily	Once daily	PRN TID	PRN Q6h
Route	PO	PO	PO	PO	PO
Classification	Atypical antipsychotic	Antineoplastic agent/Tyrosine kinase inhibitor	Serotonin-norepinephrine reuptake inhibitor	Beta-adrenergic blocker	NSAID, antipyretic
Mechanism of Action	This medication acts as a partial antagonist at dopamine receptor and serotonin receptor which help with antipsychotic effect.	This medication targets imatinib-resistant BCR-ABL mutation by binding to active and inactive ABL-kinase which halts	This medication inhibits dopamine, neuronal serotonin, and norepinephrine reuptake to potentiate noradrener	This medication prevents arterial dilation and inhibit renin secretion which decrease blood pressure and heart rate.	This medication inhibits the production of prostaglandin interfering with pain impulse generation in the peripheral

		proliferation of leukemia cell.	gic and serotonergic activity in the CNS which may elevate mood		nervous system
Reason Client Taking	Depression	Chronic myelogenous leukemia	Depression	Anxiety (decrease heart rate)	Pain and fever
Contraindications (2)	Hypersensitivity to aripiprazole; Leukopenia	Hypersensitivity to dasatinib; hypertension	Hypersensitivity to duloxetine; renal impairment	Hypersensitivity to propranolol; Heart rate less than 60 bpm	Hypersensitivity to acetaminophen; severe hepatic impairment
Side Effects/Adverse Reactions (2)	Laryngospasm Drowsiness	Anemia Colitis	Fatigue Hepatotoxicity	Bradycardia Hypotension	Pancytopenia Hepatotoxicity
Nursing Considerations (2)	Monitor patient for difficulty swallowing due to risk of laryngospasm. Complete a fall assessment and ensure safety measure because this medication can exacerbate CNS effects such as drowsiness.	Administer this medication 2 hours before or after taking any antacid medication. Chemotherapy drug can pose be health hazard so carefully handle this medicine and try to keep the drug from touching the skin.	Monitor hepatic function due to increase of hepatotoxicity. Monitor patient for serotonin syndrome such as agitation, chills, diarrhea, and uncontrolled tremors.	Monitor blood pressure, apical and radial pulse; do not give if pulse is less than 60 and systolic blood pressure is < 100 mm Hg or 30 mm Hg below baseline. Do not stop abruptly because it may cause severe hypertension and myocardial ischemia.	Monitor renal function and liver function test for long term use. Ensure that daily dose of acetaminophen from all sources does not exceed 4000 mg of maximum daily limit.
Key Nursing Assessment(s)/	Assess blood pressure.	Assess blood pressure.	Assess and obtain	Assess vital sign such as	Assess for other OTC

Lab(s) Prior to Administration	Monitor CBC level such as neutrophil and WBC level.	Monitor CBC such as RBC, platelet, neutrophil	baseline blood pressure. Review liver function test.	blood pressure and heart rate. Review glucose, BUN and creatinine	medication containing acetaminophen patient taking due to risk of acetaminophen toxicity. Review patient liver function test
Client Teaching needs (2)	Instruct the patient to swallow medication whole and do not chew or divide tablet. Advise patient to get up slowly from lying down and sitting position to prevent orthostatic hypotension	Tell patient to avoid taking grapefruit juice. Take this medication once daily without regards to food.	Inform patient that full effect may take weeks to happen. Advise patient not to stop this medication abruptly because adverse reaction may happen.	Advise patient to take medication at the same time everyday Check blood pressure and heart rate before taking and hold if HR is <60 and systolic BP is <100 or 30 mmHg below baseline.	Follow dosage guidelines of medication and do not exceed daily limit. Teach patient about the of hepatoxicity such as bleeding, easy bruising, and malaise.

Hospital Medications (5 required)

Brand/Generic	Dilaudid/ hydromorphone hydrochloride	Zofran/ ondansetron	Zosyn/ Piperacillin-Tazobactam	Benadryl/ diphenhydramine	Protonix/ pantoprazole sodium
Dose	1mg/1mL	4mg/2mL	3.375 mg/ 50 mL	25 mg	40mg
Frequency	PRN Q2h	PRN Q6h	Q6h	PRN Q6h	Once daily
Route	IV push	IV push	IV piggyback	PO	PO
Classification	Opioid analgesic	Antiemetic	Antibiotic combination	Antihistamine	Proton pump inhibitors

			drug (penicillin and beta-lactamase inhibitor)		
Mechanism of Action	This medication binds with opioid receptors in the spinal cord and higher level in the CNS. It also stimulates kappa and mu receptors that alters perception of pain response	This medication blocks serotonin receptor centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminal in the intestine	Piperacillin kills bacteria by inhibit bacterial cell wall synthesis and binds to one or more of penicillin-binding protein that inhibit cell wall biosynthesis. Tazobactam inhibit bacterial beta-lactamase	This medication binds to central and peripheral H1 receptor, competing with histamine for these sites and preventing it from reaching its site action	This medication interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphatase in gastric parietal cells
Reason Client Taking	Severe pain rating 7-10	Nausea	Abdominal infection	Itching	Gastric reflux
Contraindications (2)	Narrowing of GI tract Paralytic ileus	Hypersensitivity to ondansetron Severe liver disease	Hypersensitivity to penicillin and beta-lactamase Hypersensitivity to cephalosporins	Hypersensitivity to diphenhydramine Chronic idiopathic constipation	Hypersensitivity to pantoprazole Kidney inflammation
Side Effects/Adverse Reactions (2)	CNS depression Respiratory depression	Intestinal obstruction Constipation	C. difficile infection Drug-induced thrombocytopenia	Epigastric distress Agranulocytosis	Hepatotoxicity Constipation
Nursing Considerations (2)	Give hydromorphone before pain becomes intense. Monitor for respiratory	Monitor for decrease bowel activity because it can mask symptom of progressive	Test patient for C. difficile if patient develop diarrhea. Monitor for improvement with infection	Administer drug on an empty stomach, 1 hour before or 2 hours after meals, to increase	Administer delayed release oral suspension 30 minutes before meal. Monitor patient for

	depression.	ileus. Monitor closely for serotonin syndrome.	.	the absorption. Provide safety measures because medication can cause dizziness and drowsiness.	bone fracture
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess vital sign such as respiration and blood pressure. Review liver function test.	Assess vital sign such as heart rate and blood pressure. Review potassium and magnesium level.	Obtain baseline vital sign, CBC, renal function test. Obtain culture and sensitivity test before starting medication	Assess blood pressure and heart rate. Review CBC such as neutrophil count.	Assess patient urine output. Review PT and INR.
Client Teaching needs (2)	Instruct patient to take drug as prescribe and take it before pain worsen. Instruct patient to report any constipation, difficulty breathing, severe nausea and vomiting	Advise patient to seek medical attention if patient experiencing worsening and persistent nausea and vomiting. Advise patient to report sign of hypersensitivity such as rash	Instruct patient to complete full course of antibiotic therapy. Educate patient that skipping doses can increase your risk of infection that is resistant to medication.	Advise patient to take medication with food to minimize GI distress. Avoid drinking alcohol while taking this medication	Instruct the patient to swallow medication whole and do not crush or chew. Advise patient to expect relief of symptoms within 2 weeks of use.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Sarah Bush Lincoln Health Reference Guide. (2021). *Cerner*. https://www.sarahbush.org

Assessment

Physical Exam (18 points)

GENERAL (1 point):	
Alertness:	Alert and responsive
Orientation:	Oriented to person, place, time, situation.
Distress:	No acute distress
Overall appearance:	Appropriately dress, well-groomed
INTEGUMENTARY (2 points):	
Skin color:	Usual for ethnicity
Character:	Skin dry and intact
Temperature:	Warm to touch
Turgor:	Elastic turgor
Rashes:	No rashes
Bruises:	No bruises
Wounds: .	No wounds
Braden Score:	Braden score 21
Drains present: Y☐ N ☒ **Type: n/a**	No drain present
HEENT (1 point):	
Head:	Normocephalic, symmetrical facial feature
Neck:	Palpable thyroid cartilage, no tracheal deviation, no palpable lymph nodes, 3+ carotid pulse bilaterally
Ears:	Gray tympanic membranes bilaterally, auricle pinna are intact. Hard hearing
Eyes:	Pupils are equal, round, reactive to light, and accommodate, white sclera & conjunctiva, intact extraocular movements. Wear glasses.
Nose:	Bilateral patency, no discharge, no frontal or maxillary sinus pain
Teeth:	Pink, moist, firm gingiva Pink, moist buccal mucosa Rise and fall of soft palate, symmetrical uvula.
CARDIOVASCULAR (2 points):	
Heart sounds: **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):**	S1, S2 clear with no murmur. No friction rubs or gallop.

Peripheral Pulses: **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema: N/A**	Regular heart rhythm Pulses: 3+ radial bilaterally, carotid bilateral, tibial bilaterally <3 seconds No neck vein distention Edema: 0
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	 No accessory muscle use Respiratory Rate: Regular Respiratory pattern: Regular Respiratory sounds: clear in all lobes anteriorly and posteriorly. Lung aeration: Equal in all lobes anteriorly and posteriorly
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet:** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** N/A **Feeding tubes/PEG tube Y ☐ N ☒** **Type:** N/A	 Normal diet Full liquid 168.5 cm 73.0 kg Active bowel sound in all four quadrants 07/02/2021 Slight tenderness and pain with palpation on upper right and left quadrant. No guarding. Abdomen slight firm and distended. No noted distention No noted incision No noted scars No noted drains No noted wounds
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** N/A **Catheter: Y ☐ N ☒** **Type:** N/A **Size:** N/A	 Yellow Clear 600 mL

MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** 35 **Activity/Mobility Status:** **Independent (up ad lib)** **Needs assistance with equipment: No** **Needs support to stand and walk No**	 Pink nailbeds, cap refill <3 seconds, warm extremities Active in all 4 extremities bilaterally No supportive device 5 active motions against full resistance in all four extremities bilaterally Independent (up ad lib). The patient can get up on her own and go to the bathroom and do ADL on her own
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	 Oriented to person, time, place, and situation. Negative for altered mental status. Normal cognition Clear speech Light and deep stimuli response Alert, awake and answer question appropriately
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 available family support):**	 The patient likes to watch television and talk to everyone to cope in the hospital. Her boyfriend visits her. Appropriate for age. No noted deficit. Capable of deciding for self. The patient is a Christian and believes in God. The patient lives alone and independently in Mattoon, IL. She was married but now separated. She has three children. Her ex-husband is her available family support.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0749	61 bpm	148/75 mmHg	18 bpm	36. 3 C	98 % room air
1300	63 bpm	135/69 mmHg	18 bmp	36.2 C	97% room air

Vital Sign Trends:

The systolic blood pressure is high, which may be due to the patient abdominal pain. Other vital signs such as pulse, respiration, temperature, and oxygen saturation are within normal range and stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0819	Numeric Scale	Upper abdomen	7/10	"Constant aching and cramping"	Administer hydromorphone (Dilaudid)
1041	Numeric scale	Upper abdomen	7/10	"Constant aching and cramping"	Administer hydromorphone (Dilaudid)

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 G **Location of IV:** left antecubital fossa **Date on IV:** 07/052021 **Patency of IV:** Patent and infusing easily. **Signs of erythema, drainage, etc.:** No sign of erythema, drainage, swelling or tenderness. **IV dressing assessment:** clean, dry and intact	0.9% Sodium Chloride (normal saline): 75 ml/hr.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Breakfast: 50%	600 mL of urine

Lunch: 50% Fluids: 50 mL: piperacillin and tazobactam (IV medication) 240 ml: water 500 ml: 0.9% sodium chloride	No void

Nursing Care

Summary of Care (2 points)

Overview of care: Administer medication, check vital sign, completed physical assessment.

Procedures/testing done: The patient did not have any tests completed on 07/06/2021.

Complaints/Issues: Patient complains constant abdominal pain.

Vital signs (stable/unstable): Vital signs such as pulse, respiration, temperature, and oxygen saturation are within normal range and stable. The systolic blood pressure was high and above the normal range, which may be due to the constant abdominal pain that the patient is experiencing.

Tolerating diet, activity, etc.: The patient is on a full liquid diet and ate 50% of breakfast and lunch. The patient is independent, can get up on her own, and do activities independently.

Physician notifications: Notify physician of additional abnormal laboratory findings such as calcium, BUN and creatinine. The patient will continue to take prescribed medication and taper down the use of pain medication from Q2h to Q4h. Consultation for surgery was made.

Future plans for patient: The patient will be discharged at home and receive follow-up care from her primary care provider. Abdominal surgery may be a future plan.

Discharge Planning (2 points)

Discharge location: The patient will go home to Mattoon, IL.

Home health needs (if applicable): N/A

Equipment needs (if applicable): N/A

Follow up plan: Follow up with physician.

Education needs: Education about possible new medication and lifestyle modification due to colitis.

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 colitis and enteritis as evidence by a 7/10 pain assessment	Acute pain is a high priority. The patient is experiencing constant abdominal pain.	1. Administration of hydromorphone every 2 hours 2. Assess the patient response to medication.	By the end of the day, the goal is that the patient has a tolerable pain level and comfort. We gave her Hydromorphone at least every two hours if her pain level is 7/10. After 45 minutes of giving her, she states that her pain level is 4/10. A pain rate of 4 or less than that was her tolerable pain level. She feels much better. A tolerable level was reached; however, the goal is still ongoing.
2. Ineffective health	The patient's	1. Wash hands or	By the time of discharge,

management related to the patient complex health status due to colitis and leukemia as evidence by ongoing abdominal infection	already health is already compromised due to leukemia. Right now, she is admitted to the hospital due to colitis and taking antibiotic therapy	perform hand hygiene before having contact with the patient. 2. Administration of antibiotic Zosyn or Piperacillin-Tazobactam every 6 hours.	the goal is that the patient infection improved. Every time we walk into the patient room, we ensure that we perform hand hygiene. The patient is aware of ongoing antibiotic therapy that needs to be done every 6 hours. She is compliant with the medication. The goal is still ongoing.
1. Fatigue related to constant abdominal pain as evidence by patient's verbalization of low energy.	The patient is feeling fatigued due to her abdominal pain and wants to take a rest.	1. Provide a low stimulus, organized, quiet environment for the patient. **2.** Provide rest period in between activities.	By the end of the day, the goal is that the patient maintains an appropriate energy level. The patient is provided with a low stimulus and quiet environment to rest more and prevent sensory overload, increasing fatigue more. We provided her with rest between giving medication, doing ADLs, and after she ate her meals. The goal is still ongoing.
4. Constipation related to medication use as evidenced by patient having last bowel movement 4 days ago	The patient is taking medications that cause constipation. In addition to that, her last bowel movement was four days ago.	1. Encourage the patient to drink at least 2 liters of water throughout the day. 2. Encourage the patient to do some activity, exercise, or walking.	By the time discharge, the goal is that the patient will have a regular bowel elimination pattern re-established and maintained. We encourage the patient to walk around and do some exercise. She gets up and goes to the bathroom on her own. We ensure that she is drinking water and offer her some when her cup was empty. The goal is still ongoing.

Other References (APA): N/A

Concept Map (20 Points):

Subjective Data

The patient reports having constant upper abdominal pain.
Pain radiates to the chest and back.
Reports feeling nauseated.
The abdominal pain is "constant aching and cramping."
The patient states pain level is 7/10

Nursing Diagnoses/Outcome

Acute pain related to colitis and enteritis as evidence by a 7/10 pain assessment.
Goal: By the end of the day, the goal is that the patient has a tolerable pain level and comfort.
Ineffective health management related to the patient complex health status due to colitis and leukemia as evidence by ongoing abdominal infection.
Goal: By the time of discharge, the goal is that the patient infection improved
Fatigue related to constant abdominal pain as evidence by patient's verbalization of low energy.
Goal: By the end of the day, the goal is that the patient maintains an appropriate energy level.
Constipation related to medication use as evidenced by patient having last bowel movement 4 days ago.
Goal: By the time discharge, the goal is that the patient will have a regular bowel elimination pattern re-established and maintained.

Objective Data

Objective Data:

Vitals: Blood pressure: 148/75 mmHg and 135/69 mmHg
Assessment: Abdomen slight tenderness and pain with palpation on RUQ and LUQ. Abdomen slight firm and distended.
Diagnostic: CT scan of abdomen and pelvis show: On 07/02/2021 show small intestine with features suggesting enteritis, Fatty liver change and mild hepatic enlargement. On 07/03/2021 show small supraumbilical hernia with fluid. Mid-transverse colon 4 cm length wall thickening.
Labs: RBC 3.88 and 3.31; Hgb 11.3; Hct 32.3; BUN 5 and 8; Creatinine 0.66 and 0.55; Calcium 8.0

Patient Information

A 41-year-old White Caucasian female with chronic myelogenous leukemia, arthritis, generalized anxiety disorder, depression, hypertension, and allergic rhinitis was admitted to the hospital due to abdominal pain and diagnosed with colitis.

Nursing Interventions

Administration of hydromorphone every 2 hours
Assess the patient response to medication.
Wash hands or perform hand hygiene before having contact with the patient.
Administration of antibiotic Zosyn or Piperacillin-azobactam every 6 hours.
Provide a low stimulus, organized, quiet environment for the patient.
Provide rest period in between activities.
Encourage the patient to drink at least 2 liters of water throughout the day.
Encourage the patient to do some activity, exercise, or walking.

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