

N431 Care Plan # 2

Lakeview College of Nursing

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N431 CARE PLAN

Demographics (3 points)

Date of Admission 7/12/2021	Patient Initials D.T.	Age 64 (11/18/56)	Gender F
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Widowed	Allergies Bupropion (shaky nervous)
Code Status Full Code	Height 163 cm	Weight 95kg	

Medical History (5 Points)

Past Medical History: CAD, Diastolic Heart Failure, HTN, HLD, IBS, Diverticulosis, Asthma, depression, anxiety, bipolar I disorder

Past Surgical History: Percutaneous Coronary Intervention with 1 stent 2015

Family History: Father: Passed away lung cancer early 40s **Mother:** Heart failure, CVA

Sister: End-stage renal disease.

Social History (tobacco/alcohol/drugs): Client denies ever smoking. She does not drink alcohol or use illicit drugs.

Assistive Devices: None

Living Situation: Client lives in house in Charleston, IL with adult daughter and son.

Education Level: Client graduated high school.

Admission Assessment

Chief Complaint (2 points): Lower left abdominal pain/reoccurring diverticulitis

History of present Illness (10 points):

64-year-old obese Caucasian female reports to SBL ED with lower left abdominal pain. The client has had frequent flare-ups of diverticulitis for the past three months. The client has experienced constant progressively worsening “sharp” pain since 7/8/21. The pain radiates from the LLQ to the RLQ. Pain is worse with ambulation or leaning forward. She rates the pain as

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greater than 10/10. She has been treating with Tylenol at home with no success. The client was treated with morphine in the ED, bringing the pain down to a 7/10.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Diverticulitis

Secondary Diagnosis (if applicable): N/A

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

Diverticula are saclike herniations that can most commonly be found in the sigmoid region of the colon though they can be found anywhere in the gastrointestinal tract (Hinkle & Cheever, 2017). A diverticulum happens in an area of the weakened structure in the wall of the colon. Diverticulosis is when there is a heavy presence of diverticula in the GI tract. This disease is common in older adult clients. Risk factors contributing to a client experiencing diverticulosis are a low-fiber diet, cigarette smoking, and regular use of NSAIDs or acetaminophen. When the diverticula become infected and inflamed, it is known as diverticulitis (Hinkle & Cheever, 2017). Diverticulitis leads to perforation of the colon, hemorrhage, and peritonitis. When symptoms of diverticulitis occur, it means the micro-perforations are occurring in the client's colon.

Chronic constipation may precede diverticulosis, and clients may experience mild bowel irregularity, bloating, or possibly no symptoms at all, with diverticulitis clients typically present with acute lower left quadrant pain, which was present in this client. This may be accompanied by constipation, nausea, and fever (Hinkle & Cheever, 2017). Recurrent diverticulitis implies a chronic complication such as a fistula. Scarring of the colon may lead to a narrowed passageway leading to narrow ribbon-like stools and more frequent constipation.

A colonoscopy is a primary method in which diverticulitis is typically diagnosed (Hinkle & Cheever, 2017). Other diagnostic studies that may be used to diagnose the diverticular disease

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are abdominal x-rays, CT scans, ultrasounds, and MRIs (Capriotti, 2020). Laboratory tests such as a CBC will show elevated WBC. This client also shows decreased Hgb, Hct, and RBC, implying she is having some GI tract bleeding. D.T. had a CT with contrast performed to assess the current severity of her diverticulitis.

Treatment of diverticulitis involves hospitalization, intravenous antibiotic therapy, and giving the bowel a rest (Hinkle & Cheever, 2017). This client is being treated with frequent pain medications given as needed for her pain. She is on a clear liquid diet to give her bowels a break. She is receiving intravenous Flagyl three times a day to fight off infection. Clients with recurrent exacerbations of diverticulitis may benefit from bowel surgery to correct the issue. Colon surgery results in a colostomy which may be reversed later depending on the severity of diverticular disease (Hinkle & Cheever, 2017). Clinical data that correlates to this client are her elevated neutrophils, decreased RBC, and lower left quadrant pain.

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. (2017). *Clinical handbook for Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Lippincott Williams & Wilkins.

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	4.28-5.56 3.80-5.41	3.91	3.50	Low RBC implies the client is anemic due to GI bleeding caused by diverticulitis (Capriotti, 2020).
Hgb	13.0-17.0 11.3-15.2	11.2	9.9	Decreased Hgb implies the client is anemic caused by GI bleeding due to diverticulitis (Capriotti, 2020).

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Hct	38.1-48.9 33.2-45.3	32.8	30.2	Diverticulitis results in lower GI bleed which can cause the client to become anemic (Capriotti, 2020).
Platelets	149-393	208	149	Normal range.
WBC	4.0-11.7	8.4	5.5	Normal range.
Neutrophils	45.3-79.0	81.3	71.9	Neutrophilia implies that the client is experiencing an infection in her body (Capriotti, 2020).
Lymphocytes	11.8-45.9	14.0	20.3	Normal range.
Monocytes	4.4-12.0	3.4	6.3	Monocytopenia may be the result of stress on the immune system, or may imply malignancy somewhere in the client's body (Capriotti, 2020).
Eosinophils	0-6.3	0.8	1.3	Normal range.
Bands	0-5.1	N/A	N/A	Normal range.

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	139	N/A	Normal range.
K+	3.5-5.1	4.5	N/A	Normal range.
Cl-	98-107	110	N/A	Hyperchloremia is most likely the result of dehydration, it may be associate with other diseases such as Cushing's syndrome or kidney disease (Capriotti, 2020).
CO2	21-31	21	N/A	Normal range.
Glucose	74-109	115	N/A	Hyperglycemia is common when the body is under acute distress or inflammation (Capriotti, 2020).
BUN	7-25	22	N/A	Normal range.
Creatinine	0.70-1.30	0.89	N/A	Normal range.

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Albumin	3.5-5.3	3.4	N/A	A decreased albumin level indicates the client may be experiencing stress on her liver or kidneys (Capriotti, 2020).
Calcium	8.6-10.3	8.7	N/A	Normal range.
Mag	1.6-2.5	N/A	N/A	N/A
Phosphate	2.5-4.5	N/A	N/A	N/A
Bilirubin	0.3-1.0	0.3	N/A	Normal range.
Alk Phos	34-104	48	N/A	Normal range.
AST	10-30	15	N/A	Normal range.
ALT	10-40	17	N/A	Normal range.
Amylase	30-110	N/A	N/A	N/A
Lipase	0-160	N/A	N/A	N/A
Lactic Acid	0.5-2.2	N/A	N/A	N/A
Troponin	0.000-0.030	N/A	N/A	N/A
CK-MB	0.60-6.3	N/A	N/A	N/A
Total CK	30-223	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	1(2-3)	N/A	N/A	N/A
PT	9.5-11.8 (1.5-2.5x)	N/A	N/A	N/A
PTT	30-40(1.5- 2.5x)	N/A	N/A	N/A

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D-Dimer	<=250	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A
HDL	>60	N/A	N/A	N/A
LDL	<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	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, amber, clear	light yellow	N/A	Normal range.
pH	5-8	5.0	N/A	Normal range.
Specific Gravity	1.005-1.035	1.012	N/A	Normal range.
Glucose	0-14.41	Normal	N/A	Normal range.
Protein	Negative	Negative	N/A	Normal range.
Ketones	Negative	Negative	N/A	Normal range.
WBC	Negative	Negative	N/A	Normal range.
RBC	0-5	Negative	N/A	Normal range.
Leukoesterase	0-5	Negative	N/A	Normal range.

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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	7.31-7.41	N/A	N/A	N/A
PaO2	40-50	N/A	N/A	N/A
PaCO2	10-50	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A
SaO2	60-75	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	N/A	N/A	N/A
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):

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Computerized Tomography (CT) abdomen and pelvis with contrast- This noninvasive test gives a visualization of the inflammation in the colon caused from diverticulitis. Contrast is utilized to

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give a better visualization of internal blood vessels. This is the primary diagnosis test for diverticulitis (Capriotti, 2020).

Colonoscopy- This invasive test gives an internal view of the inside of the colon. This diagnostic procedure can also be used to obtain tissue samples and remove polyps (Capriotti, 2020).

Diagnostic Test Correlation (5 points):

CT abdomen and pelvis with contrast- This test shows the client is experiencing worsening diverticulitis in the proximal sigmoid colon.

Colonoscopy- The client is pending a colonoscopy to allow tissue samples to be collected and as a part of a work-up to the clients impending bowel resection surgery.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	Coreg/ carvedilol	Xanax/ alprazolam	Abilify/ aripiprazole	Lipitor/ atorvastatin	Effexor/ venlafaxine
Dose	25 mg	1mg	10mg	80mg	75mg
Frequency	Daily	Q8H PRN anxiety.	At bedtime	Daily in the evening	Daily in the evening
Route	By mouth	By mouth	By mouth	By mouth	By mouth
Classification	Nonselective beta blocker and alpha-1 blocker, antihypertensive	Benzodiazepine, anxiolytic	Atypical antipsychotic, Antipsychotic	HMG-CoA reductase inhibitor, Antihyperlipidemic	Selective serotonin and norepinephrine reuptake inhibitor, antidepressant

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Mechanism of Action	Reduces cardiac output and tachycardia. Causes vasodilation and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload.	May increase effects of GABA and other inhibitory neurotransmitters by binding to specific benzodiazepine receptors in cortical and limbic areas of the CNS. GABA inhibits excitatory stimulation, which helps control emotional behavior.	May produce antipsychotic effects through partial agonist and antagonist actions. Acts as a partial agonist at dopamine receptors and serotonin receptors.	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver and increasing the amount of LDL uptake and breakdown.	Inhibits neuronal reuptake of norepinephrine and serotonin along with its active metabolite. These actions raise norepinephrine and serotonin levels elevating mood and reducing depression.
Reason Client Taking	To control hypertension	To relieve anxiety	To maintain stability with bipolar I disorder	To control lipid levels	To prevent relapse of major depression
Contraindications (2)	Asthma related to bronchospastic conditions, bradycardia, or a 2 nd or 3 rd degree heart block.	Acute-narrow angle glaucoma. Hypersensitivity to alprazolam or its components.	Hypersensitivity to aripiprazole and its components, increased thoughts of suicide while taking this medication.	Active hepatic disease, unexplained persistent rise in serum transaminase levels.	Use of a MAO inhibitor therapy in the last 14 days, hypersensitivity to venlafaxine or its component.
Side Effects/Adverse Reactions (2)	AV heart block, bradycardia.	Hypotension, hepatitis.	Seizures, suicidal ideation, GI bleeding.	Hepatic failure, pancreatitis.	GI hemorrhage, hepatitis, abnormal

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					bleeding.
Nursing Considerations (2)	Hold this medication if client is experiencing a systolic blood pressure below 100 or a heart rate below 60/min. Practice caution in clients with peripheral vascular disease as this medication may exacerbate arterial insufficiency .	Utilization of alprazolam concurrently with opioid therapy should only be used in clients where other methods of treatment are inadequate. Monitor these clients closely for signs of coma or respiratory depression. Plan to taper off dose when discontinuing as this medication can lead to dependency.	Use caution when giving this medication to elderly clients as it increases risk for serious cerebrovascular effects, such as a stroke and transient ischemic attack. Monitor clients closely for increase in suicidal ideation when adjustments to dosing are being made as this may lead to increase in those thoughts.	Atorvastatin must not be used in clients taking cyclosporine , gemfibrozil, or telaprevir due to high risk of developing rhabdomyolysis with acute renal failure. Notify provider if client develops acute condition suggestive of myopathy or has a predisposing risk of renal failure.	Should not be given to clients with bradycardia, congenital long QT syndrome, hypokalemia. Monitor for suicidal tendencies especially while changing dosage.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Assess blood pressure and heart rate. Withhold medication if systolic BP is below 100 or heart rate is below 60.	Assess respiratory status. Obtain baseline anxiety level and reassess after administering.	Review renal function and liver function tests. Review CBC as GI bleed is a potential adverse effect.	Monitor client's liver function and renal functions tests. Assess client for myopathy during drug therapy.	Assess blood pressure, notify provider if increase in diastolic blood pressure. Monitor electrolyte levels. Obtain baseline

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					EKG before beginning medication therapy to monitor for prolonged QT segment.
Client Teaching needs (2)	Teach the client the how to check her own blood pressure and pulse at home as well as the parameters at which the medication must be held. Advise client that abrupt discontinuation of this medication may result in rebound HTN and increased risk for MI.	Warn the client that abruptly stopping this medication may cause withdrawal symptoms to occur. Warn the client that they must never increase dose above prescription due to increased risk of dependency.	Advise client to get up slowly from a sitting or lying position to minimize orthostatic hypotension. Urge client to avoid alcohol during aripiprazole therapy.	Warn client that grapefruit juice can lead to danger serum atorvastatin levels in the blood. Emphasize that atorvastatin is not a suitable substitute for a diet low in cholesterol.	Avoid alcohol while taking this medication . Avoid use of any OTC medication without providers approval as there are many potential drug interactions.

Hospital Medications (5 required)

Brand/Generic	Norco/ hydrocodone -	Lovenox/ enoxaparin	Cozaar/ losartan	Flagyl/ metronidazole	Oxytrol/ oxybutynin
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	acetaminophen 7.5-325				
Dose	7.5-325mg	40 mg	100mg	500mg	5mg
Frequency	Q4H PRN pain	Daily	Daily	Q8H	Three times daily
Route	By mouth	Subcutaneously	By mouth	IV piggyback	By mouth
Classification	Opioid analgesic, combination pain medication	Low-molecular weight heparin, anticoagulant	Angiotensin II receptor blocker, antihypertensive	Nitroimidazole, antiprotozoal	Anticholinergic, antispasmodic (urinary)
Mechanism of Action	Binds to and activates opioid receptors at sites in the periaqueductal and periventricular gray matter and the spinal cord to produce pain relief.	Potentiates the action of antithrombin III, a coagulation inhibitor. Without thrombin, fibrinogen can not convert to fibrin and clots can not form.	Blocks binding of angiotensin II to receptor sites in many tissues, including adrenal glands and vascular smooth muscle. Inhibiting angiotensin II causes a reduction in blood pressure.	Undergoes intracellular chemical reduction during anaerobic metabolism. After this drug is introduced, it damages the bacterial DNA causing cell death.	Exerts antimuscarinic and potent direct antispasmodic actions on the smooth muscle of the bladder. This results in increased bladder capacity and decreased urge to void.
Reason Client Taking	To relieve moderate to severe pain.	Prophylaxis to prevent DVT during hospitalization.	To manage hypertension.	To treat diverticulitis.	To treat overactive bladder.
Contraindications (2)	Acute or severe bronchial asthma or hypercarbia. Respiratory depression,	Active major bleeding, History of heparin-induced thrombocytopenia (HIT)	Concurrent aliskiren therapy, hypersensitivity to losartan or its	Disulfiram use in the last 2 weeks, hypersensitivity to metronidazole or its	Acute hemorrhage, Gastrointestinal obstruction.

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	use of MAOI in the past 14 days.	in the past 100 days.	components.	components.	
Side Effects/Adverse Reactions (2)	Hypotension, respiratory depression, hepatic injury.	Hematemesis, melena, HIT.	Hypotension, hyperkalemia.	Hepatotoxicity, thrombocytopenia.	Arrhythmias, hypotension.
Nursing Considerations (2)	This medication has a high risk of abuse, addiction, and misuse. This medication should not be given to a client with a reduced level of consciousness or experiencing respiratory depression.	Use severe caution in clients experiencing any type of GI bleed (such as diverticulitis). Monitor serum potassium labs especially in clients with renal failure.	Monitor renal function and blood pressure to assess this medication's effectiveness. Monitor for muscle weakness as rhabdomyolysis is a rare adverse effect of this medication.	Obtain all cultures needed prior to beginning IV antibiotic therapy. Monitor client neurological status throughout this drug therapy. Report any new neuro changes to provider immediately.	Use cautiously in clients with diarrhea as it may signal incomplete GI obstruction. Monitor for anticholinergic effects on the CNS such as confusion or agitation.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain baseline pain level. Monitor for reduced level of consciousness or respiratory depression. Monitor for constipation. Assess liver function tests.	Monitor for signs of bleeding. Monitor CBC for anemia. Monitor electrolytes for hyperkalemia.	Monitor clients blood pressure. Assess electrolytes for hyperkalemia or hyponatremia. Monitor renal function.	Monitor liver function labs.	Assess urinary symptoms before and after admin. Verify that client is active passing gas/defecating.
Client Teaching needs (2)	Encourage clients to consume	Advise against NSAID or	Clients taking this medication	Urge client to report any signs of	Take this medication on an

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	plenty of fluids and high fiber foods to prevent constipation. Do not combine this medication with alcohol and avoid other products containing Tylenol to prevent hepatic injury.	aspirin medications as it increases chances of GI bleeds. Teach client to report signs of potential bleeding such as unusual bruising or petechiae.	once daily should take it nightly with a meal to enhance the absorption of the medication. Avoid consuming alcohol or more than one quart of grapefruit juice while using this medication.	allergic reaction while receiving medication administration. Advise client to report any CNS changes that occur while receiving this drug therapy.	empty stomach unless adverse GI symptoms develop. Warn clients of potential decrease of CNS while taking this medication .
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Medications Reference (1) (APA):

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

Assessment**Physical Exam (18 points)**

GENERAL (1 point):	Alertness: Client is alert. Orientation: Oriented to person, place, time, and situation. Distress: Client is grimacing/showing signs of discomfort. Overall appearance: Client is obese, she looks malnourished and exhausted.
INTEGUMENTARY (2 pts):	Skin color: Skin is pale, appropriate color for race. Character: Skin is very dry and scaly especially in lower extremities. Temperature: Warm. Turgor: Skin is loose, turgor is loose than 3 seconds. Rashes: None. Bruises: None. Wounds: 2-inch scabbed abrasion on left forearm no signs of bleeding. Braden Score: 18 (medium risk) Drains present: None N/A

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Nasogastric: None Size: N/A Feeding tubes/PEG tube: None Type: N/A	
GENITOURINARY (2 Points): Color: Yellow Character: Clear Quantity of urine: 200mL Pain with urination: None Dialysis: N/A Inspection of genitals: N/A Catheter: None Type: N/A	
MUSCULOSKELETAL (2 points): Neurovascular status: Nail beds pink with cap refill < 3 seconds. ROM: Active in all 4 extremities bilaterally. Supportive devices: Walker Strength: 5 in all 4 extremities bilaterally. ADL Assistance: Yes Fall Risk: Yes Fall Score: 30 Activity/Mobility Status: Up with 1 and a walker Independent (up ad lib) No Needs assistance with equipment Yes Needs support to stand and walk Yes	
NEUROLOGICAL (2 points): MAEW: Yes PERLA: Yes Strength Equal: Yes Orientation: Oriented to person, place, time, situation. Mental Status: Cognitive and alert. Speech: Clear and sensible. Sensory: Sensation intact in all extremities. Can differentiate sharp and dull stimuli. LOC: Client is awake and alert.	
PSYCHOSOCIAL/CULTURAL (2 pts): Coping method(s): Client relies on her children to get by daily, she claims she is unable to cope well with her recurring diverticulitis. Developmental level: Client is a high school graduate. She is unable to work currently. Client can read, write, and make informed decisions. Religion & what it means to pt.: Client is a Catholic, attends church weekly alone. Personal/Family Data (Think about home environment, family structure, and available family support): Client widowed 4 years ago to cancer. Client lives in home with her two adult children who support the client.	

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Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
830	62	96/56	16	36.6 tympanic	97
1125	75	112/74	16	37.0 tympanic	98

Vital Sign Trends:

Vital signs are stable. The client's morning dose of carvedilol 25mg was withheld due to low systolic blood pressure. Hypotension is likely result of hydromorphone medication client received in the ED the previous night.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0920	Numeric	Lower left quadrant	9/10	Sharp	Administered Norco as prescribed.
1000	Numeric	Lower left quadrant	7/10	Sharp	None

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: Location of IV: Date on IV: Patency of IV: Signs of erythema, drainage, etc.: IV dressing assessment:	22 G Left hand 7/12/21 NS flowing at 75ml/hr. None Clear transparent dressing

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Intake and Output (2 points)

Intake (in mL)		Output (in mL)	
Gelatin	120 mL	Void	200 mL
Water	240 mL		
NS IV 75ml/hr*5hr=	375mL		

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

Overview of care: Client is receiving antibiotic therapy to treat her recurrent diverticulitis exacerbations.

Procedures/testing done: Client is pending a colonoscopy. Client is tentatively scheduled for a bowel resection surgery on July 28, 2021.

Complaints/Issues: Client complains of lower left quadrant pain.

Vital signs (stable/unstable): Blood pressure and heart rate were both low this morning.

Tolerating diet, activity, etc.: No complaints regarding clear liquid diet, client is used to this diet.

Physician notifications: Primary care provider recommends bowel resection surgery due to recurrent diverticulitis.

Future plans for patient: Client is tentatively scheduled for a colon resection surgery on July 28, 2021.

Discharge Planning (2 points)

Discharge location: Client will discharge to home with her son.

Home health needs (if applicable): None

Equipment needs (if applicable): None

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Follow up plan: Client will follow up with her regular provider to prepare for bowel surgery.

Education needs: Client needs education regarding future colostomy care.

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 diverticulitis as evidenced by “9/10 sharp pain” in the lower left quadrant.	This client is suffering from debilitating pain due to her illness.	1. Offer nonpharmacological pain relief methods such as distraction. 2. Assess the effectiveness of pharmacological therapy 30 mins after administering of pain medication.	This method of pain management are inadequate at bringing down client’s pain. Client’s pain is reduced to a 7/10 after giving prescribed opioid medication.
2. Risk for impaired gas exchange related to hospitalization as evidenced to extended periods of bedrest.	Prolonged periods of bedrest put the client at risk for atelectasis, which leads to impaired gas exchange.	1. Position client with head of the bed up to facilitate gas exchange. 2. Teach client incentive spirometry (IS). Encourage client to perform IS every hour while awake.	Client tolerates elevated head of bed well. Client acknowledges importance of performing IS. Demonstrates proper technique.
3. Anxiety related to recurring diverticular disease as evidenced by clients past medical history of anxiety and frequent	This client suffers from depression and anxiety. Frequent hospitalization and upcoming surgery will increase stress and anxiety.	1. Perform deep breathing exercise to promote relaxation. 2. Provide client with a low stimulus environment.	Client performs breathing exercises, but unsuccessfully controls client’s anxiety. Low stimulus hospital room allows the client to rest.

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hospitalizations.			
4. Imbalanced nutrition: less than body requirements related to diverticular disease as evidenced by clear liquid diet.	The client is put on a clear liquid diet to give her bowels some rest and recover from inflammation. This puts her at risk for insufficient nutritional intake.	1. Offer client frequent fluids and gelatin as tolerated. 2. Weigh client daily to assess for rapid weight loss.	Client tolerates clear liquid diet well. Client shows no signs of rapid changes in weight.

Other References (APA): N/A

Concept Map (20 Points):

Subjective Data

Client presents with sever “sharp” LLQ pain. Pain is rated higher than 10/10 initially in the ED. Pain persists as high as 9/10.

Nursing Diagnosis/Outcomes

- 1. Acute pain related to diverticulitis as evidenced by “9/10 sharp pain” in the lower left quadrant.
- Bring pain down to a tolerable level.
- 2. Risk for impaired gas exchange related to hospitalization as evidenced to extended periods of bedrest.
- Maintain an SaO2 of at least 97%.
- 3. Anxiety related to recurring diverticular disease as evidenced by clients past medical history of anxiety and frequent hospitalizations.
- Client report anxiety level reduced to a manageable level.
- 4. Imbalanced nutrition: less than body requirements related to diverticular disease as evidenced by clear liquid diet.
- Maintain client’s usual body wight.

Objective Data

Abnormal Vitals
 Blood pressure 96/56
 Abnormal Labs
 RBC 3.50
 Hgb 9.9
 Hct 30.2
 Assessment Findings
 Tenderness LLQ
 Rigid abdomen
 Diagnostic testing
 CT abdomen Diverticulitis in sigmoid colon

Patient Information

64-year-old obese female with history of depression anxiety and heart disease reports with diverticulitis for the fourth time since March.

Nursing Interventions

1. Offer nonpharmacological pain relief methods such as distraction.
2. Assess the effectiveness of pharmacological therapy 30 mins after administering of pain medication.
3. Position client with head of the bed up to facilitate gas exchange.
4. Teach client incentive spirometry (IS). Encourage client to perform IS every hour while awake.
5. Perform deep breathing exercise to promote relaxation.
6. Provide client with a low stimulus environment.
7. Offer client frequent fluids and gelatin as tolerated.
8. Weigh client daily to assess for rapid weight loss.



