N431 Care Plan # 1

Lakeview College of Nursing

Brandi Huson

Demographics (3 points)

Date of Admission 9-3-2021	**Patient Initials** FC	**Age** 83	**Gender** Male
Race/Ethnicity White	**Occupation** Retired	**Marital Status** Divorced	**Allergies** No known allergies
Code Status Full Code	**Height** 5’8	**Weight** 221 lbs	

Medical History (5 Points)

Past Medical History: Memory loss, Benign Prostatic Hyperplasia without urinary obstruction, Acute kidney injury, Hyperlipidemia, Sepsis, Wound infection.

Past Surgical History: Ileostomy, Cystoscopy urethral stent, Exploratory Laparotomy, Gastrotomy percutaneous tube insertion

Family History: Mother had a malignant tumor of lung.

Social History (tobacco/alcohol/drugs): Patient denies use of tobacco, alcohol, and drugs.

Assistive Devices: Eye glass, dentures, walker

Living Situation: The patient lived at home with his female companion prior to illness.

Education Level: College Graduate

Admission Assessment

Chief Complaint (2 points): Abdominal abscess

History of present Illness (10 points): Onset: The patient presented with an initial complaint of constipation in August. After undergoing an exploratory laparotomy, a bowel perforation was discovered, and an Ileostomy was put into place. The patient had further complications and failed a swallow test therefore a percutaneous endoscopic gastrostomy was performed, and a PEG tube was inserted. The patient was discharged on September 1, 2021, to Marshall Rehabilitation and

Nursing Center. While at the nursing home, the patient had oozing and excoriation around the ileostomy stoma and was readmitted to Union Hospital on September 3, 2021. Location: The abscess and excoriation were located on the patient's right lower quadrant of the abdomen. Duration: The patient complained of pain and a "burning feeling" at the site of the stoma for two days and was very disoriented prior to being readmitted. Characteristic Symptoms: The patient had an increased heart and respiration rate, fever, chills, and confusion. The skin around the stoma was red and visibly irritated. Associated and Aggravating factors: The patient reported that his "stomach hurt" around the Ileostomy site. The bag for the Ileostomy did not fit properly and was causing pain at and around the stoma site. Feces and stomach content were causing skin irritation and the patient was becoming more confused. Treatment and Timing: Upon discharge the patient had no skin irritation, but after being discharged the patient had complications with removal and application of the stoma bags. The patient was seen by a wound nurse and received treatment for the skin irritation. Severity: Upon being admitted the patient was very disoriented and had evidence of infection and skin irritation around the Ileostomy.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Sepsis

Secondary Diagnosis (if applicable):.

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

Sepsis can be a life- threatening illness when not detected and treated properly. Sepsis normally begins as Systemic Inflammatory Response Syndrome. This is when the body has been through some kind of trauma. Regarding this patient, the trauma occurred when he had exploratory surgery and Ileostomy placement. Vital organ systems such as respiratory, renal, hepatic, and

cardiac go into overdrive to compensate for the trauma. Cardiac rate and output increase as well as the respiratory rate. The patient will have a decrease in Gastrointestinal activity and urinary output. Systemic infection also called sepsis often follows SIRS. The immune system can be less active for a period of time following SIRS. The patient is then more susceptible to infection. Sepsis starts in the affected area of trauma and for this patient it was in the abdomen. The infection then spreads to other vital organs in the body and becomes systemic. The patient had increased BUN and Creatinine levels indicating kidney damage. Older adults, immunocompromised people, and infants are the most susceptible to sepsis.

The signs and symptoms of sepsis include elevated white blood cell count, increased heart and respiration rates, fever, chills, cool clammy skin, confusion, and extreme pain or discomfort. Upon admission the patient had an increased heart and respiration rates, confusion, and elevated white blood cell count. A complete blood cell count was performed revealing elevated white blood cell count and reduced red blood cell and hemoglobin count. The white blood cell count was elevated due to infection. The patient was prescribed Piperacillin Tazobactam/Zosyn which is a combination antibiotic to treat infection. Upon admission the patient was complaining of nausea and “stomach pain” at the site of Ileostomy. The patient was given Ondansetron to alleviate the nausea. The patient also had a prescription to Acetaminophen to take as needed for pain. Since the client had an Ileostomy and had a prior history of constipation, he was prescribed Magnesium Hydroxide and Docusate to prevent hard formed stools. A Computed Tomography (CT) of abdomen and pelvis with IV contrast was also performed to detect further diseases of the small bowel colon and other organs. The patient was also receiving Osmolyte adult non fiber formula via PEG tube to receive proper nutrition to fight infection since he was unable to

swallow. The patient had an IV infusing 5% dextrose to keep him hydrated. The patient was also receiving Enoxaparin to help prevent blood clotting due to immobility.

Pathophysiology References (2) (APA):

Caprotti, T. (2020) *Davis advantage for pathophysiology: introductory concepts and clinical perspectives.* Philadelphia: F.A. Davis. Company

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

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	F 4-5.5milliion M 4.5-6 million	4.0 million	5.03 million	Red blood cell production was decreased due to the systemic response to infection. (Hinkle and Cheever)
Hgb	F 12-15g/dL M 14-16 g/dL	14.6 g/dL	12.0 g/dL	Hemoglobin was low because of the reduced production of blood cells because of the sepsis. (Hinkle and Cheever)

Hct	F 42-52% M 35-47%	45%	36.9%	
Platelets	150,000-400,000 cells/mm3	185,000 cells/mm3	210,000 cells/mm3	
WBC	4,500-11,000 cells/mm3	12,400 cells/mm3	11,200 cells/mm3	White blood cells increase during infection to help the body fight illness. (Hinkle and Cheever)
Neutrophils	45%-75%	50.3%	50%	
Lymphocytes	20%-40%	30.5%	32%	
Monocytes	4%-6%	8.6%	5.1%	Monocytes help fight infection and get rid of dead or damaged cells. (Hinkle and Cheever)
Eosinophils	<7%	8.6%	10.5%	
Bands	0.0-3.0%	Not charted	Not charted	

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145 mEq/L	146 mEq/L	144 mEq/L	The sodium level is slightly elevated which could be from the patient being slightly dehydrated since he was unable to swallow and also from kidney insufficiency. (Hinkle and Cheever)
K+	3.5-5.0 mEq/L	4.04 mEq/L	3.5 mEq/L	
Cl-	97-107 mEq/L	107 mEq/L	101 mEq/L	
CO2	21-31 mmol/L	26.2 mmol/L	29.8 mmoml/L	
Glucose	70-100	156 mg/dL	127mg/dL	Glucose is elevated because of the body's natural response to fight off infection. (Hinkle and Cheever)
BUN	5-25 mg/dL	54 mg/dL	39 mg/dL	Sepsis can cause damage to vital organs such as the kidneys which can result in renal insufficiency. (Hinkle and Cheever)

Creatinine	.6-1.3 mg/dL	1.73 mg/dL	1.70 mg/dL	Sepsis can cause damage to vital organs such as the kidneys which can result in renal insufficiency. (Hinkle and Cheever)
Albumin	3.5-5.2 gm/ dL	3.0 gm/dL	2.7 gm/dL	The patient was suffering from kidney insufficiency. He was on a feeding tube so he may be malnourished as well (Hinkle and Cheever).
Calcium	8.7-10.2 mg/dL	8.7 mg/dL	8.1 mg/dL	The patient was suffering from sepsis which can cause low blood calcium levels (Hinkle and Cheever, 2018)
Mag	1.3/3.0 mg/ dL	2.3	2.1	
Phosphate	44-147 IU/L	135 IU/L	107 IU/L	
Bilirubin	.1-1.4 mg/dL	.5 mg/dL	.7 mg/dL	
Alk Phos	40-120 U/L			
AST	10-30 U/L	28 U/L	34 U/L	The AST is elevated because carvedilol can cause liver enzymes to be increased. (Hinkle and Cheever, 2018)
ALT	10-40 U/L	39 U/L	40 U/L	
Amylase	30-110 U/L	Not charted	Not charted	
Lipase	0-160 U/L	Not charted	Not charted	
Lactic Acid	0.5-2.2 mmol/L	Not charted	Not charted	
Troponin	0.4ng/ml	Not charted	Not charted	
CK-MB	5-25 units/L	Not charted	Not charted	
Total CK	26-174 units/L	Not charted	Not charted	

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	>1.1	Not charted	Not charted	
PT	M9.6-11.8 F9.5-11.3	Not charted	Not charted	
PTT	30-40 seconds	Not charted	Not charted	
D-Dimer	<250 ng/mL	Not charted	Not charted	
BNP	<100pg/mL	Not charted	Not charted	
HDL	<60 mg/dl	Not charted	Not charted	
LDL	<130 mg/dL	Not charted	Not charted	
Cholesterol	<200 mg/dL	Not charted	Not charted	
Triglycerides	150 mg/dL	Not charted	Not charted	
Hgb A1c	Diabetic <7% Nondiabetic 4-5.6%	Not charted	Not charted	
TSH	.4-1.4 mu/L	Not charted	Not charted	

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	Clear/yellow	Not charted	Not charted	
pH	4.5-8	Not charted	Not charted	
Specific Gravity	1.005-1.035	Not charted	Not charted	
Glucose	Negative	Not charted	Not charted	
Protein	Negative	Not charted	Not charted	

Ketones	Negative	Not charted	Not charted	
WBC	None or rare	Not charted	Not charted	
RBC	None or rare	Not charted	Not charted	
Leukoesterase	None or rare	Not charted	Not charted	

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	Not charted	Not charted	
PaO2	80-10 mmHg	Not charted	Not charted	
PaCO2	35-45 mmHg	Not charted	Not charted	
HCO3	22-26 mEq/ L	Not charted	Not charted	
SaO2	92%-100%	Not charted	Not charted	

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	Not charted	Not charted	
Blood Culture	Negative	Not charted	Not charted	
Sputum Culture	Negative	Not charted	Not charted	
Stool Culture	Negative	Not charted	Not charted	

Lab Correlations Reference (1) (APA):

Caprotti, T. (2020) *Davis advantage for pathophysiology: introductory concepts and clinical perspectives.* Philadelphia: F.A. Davis. Company

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

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Computed Tomography (CT) of abdomen and pelvis with IV contrast. CT of the abdomen and pelvis is used to detect diseases of the small bowel, colon, and other organs.

Compute Tomography of the head with out IV contrast. Ct of the head is performed to check the brain and assess for central nervous system infection.

Computed Tomography Angiography (CTA) is performed to assess patients for Pulmonary Embolism.

Diagnostic Test Correlation (5 points): The patient had a previous bowel perforation and Ileostomy placement. The test was performed to assess for further diseases of the colon and other organs.

The patient was suffering from septic infection and memory loss. This test was performed to help evaluate if the patient had suffered from head injury or stroke. The patient had a previous fall from his previous hospital admission. The patient was also suffering from the inability to swallow and was disoriented.

The patient had undergone major surgery prior to admission and suffered from immobility so this test was performed to assess for Pulmonary Embolism.

Diagnostic Test Reference (1) (APA):

Ouellette, D.R. (2020, September 18). *What is the role of CTA in the detection of pulmonary embolism (PE)?* Medscape. https*://www.medscape.com/answers/300901-8517/what-is-the-role-of-cta-in-the-detection-of-pulmonary-embolism-pe*

Radiologyinfo.org (2018, June 18). Computed tomography-Abdomen and Pelvis. https://www.radiologyinfo.org/en/info/abdominct

Radiologyinfo.org (2018, June 22). *Computed tomography-Head.* *https://www.radiologyinfo.org/en/info/headct*

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

Home Medications (5 required)

Brand/ Generic	Ipratropium/ Albuterol	Acetylsalicylic acid/ Aspirin	Carvedilol/ Coreg	Furosemide/ Lasix	Ondansetron/ Zofran
Dose	2.5-0.5mg/3mL	81mg tablet	3.125mg	40mg	4mg
Frequency	PRN q 6 hours	Daily	2 times/day	Daily	PRN q 4 hours
Route	Inhaled Solution	Oral/ PEG tube	PEG tube	PEG tube	PEG Tube
Classification	Anticholinergic/ Bronchodilator	Salicylate/ NSAID	Nonselective beta and alpha 1 blocker/ Antihypertensive	Loop diuretic/ antihypertensive	Selective serotonin receptor antagonist/ antiemetic
Mechanism of Action	Blocks acetylcholine's effects in the bronchi and bronchioles further relaxing smooth muscles and causing bronchodilation. This will increase airflow to the lungs.	Reduces the signs and symptoms of inflammation by blocking cyclooxygenase 1.	Reduces cardiac output and causes vasodilation which reduces blood pressure and cardiac workload.	Inhibits sodium and water reabsorption and increase urine formation.	Reduces nausea and vomiting by preventing the release of serotonin in the small intestine.
Reason Client Taking	To help improve breathing.	To reduce the risk of heart attack or stroke and help alleviate pain and inflammation.	To reduce the patient's blood pressure.	To reduce edema caused by renal disease.	The patient felt nauseous.
Contraindications (2)	Liver or kidney disease	Liver or kidney	Severe liver	Oliguria Hypersensi	Long QT syndrome

	Enlarged prostate	disease Frequent upset stomach	disease Asthma	tivity to furosemide	Hypersensitivity to Ondansetron
Side Effects/Adverse Reactions (2)	Pain or difficulty urinating Constipation	Decreased blood iron level Stomach pain	Hyperglycemia Elevated liver enzymes	Ototoxicity Constipation	Dry mouth Intestinal obstruction
Nursing Considerations (2)	Use cautiously in patient with benign prostatic hyperplasia. Use cautiously in patients with renal dysfunction.	Take with food to avoid upset stomach. Do not crush time released aspirin.	Monitor the patient's blood glucose levels. Should not be withheld before major surgery**.**	This medication may cause constipation so monitor bowel movements. Administer drug slowly IV over 1-2 minutes to prevent hearing loss.	May mask gastric distention following abdominal surgery. Electrolyte imbalances should be corrected prior to administration.
Key Nursing Assessment(s) /Lab(s) Prior to Administration	The patient had low BUN and Creatinine levels indicating renal dysfunction. The patient had been diagnosed with benign prostatic hyperplasia.	The patient was in pain and took aspirin daily as part of a heart healthy regimen.	The patient had an elevated blood glucose level so this should be monitored during treatment.	The patient had low BUN and Creatinine levels indicating renal disfunction so this can aid in reducing edema because of renal disfunction.	The patient had a previous bowel perforation and underwent an exploratory laparotomy and ileostomy placement so monitor bowel sounds closely.
Client	Teach client to report	Do not take	Do not stop	Take	Report

Teaching needs (2)	difficulty voiding. Teach the patient how to properly use the inhaler.	with ibuprofen because it will reduce the effects of aspirin. Notify provider if bloody or tarry stools occur.	taking the medication abruptly. This medication may cause orthostatic hypotension so use caution when standing up.	several hours before bedtime to avoid having to get up and use the bathroom. Take the medication at the same time everyday to maximize therapeutic effects.	signs of hypersensitivity such as rash immediately. Seek treatment immediately if symptoms worsen.

Hospital Medications (5 required)

Brand/Generic	Docusate/ Senna	Piperacillin tazobactam/ Zosyn	Acetaminophen/ Tylenol	Enoxaparin/ Lovenox	Magnesium Hydroxide/ Milk of Magnesia
Dose	50mg	12.5 mL/hr	650mg	40mg	30mL
Frequency	BID	Over 4 hours	PRN q 4	Daily	PRN TID
Route	IV	IV	IV	Subcutaneous	Oral suspension
Classification	Surfactant/ Laxative, stool softener	Beta lactamase inhibitor/antibiotic	Nonsalicylate/ Antipyretic	Low-molecular - weight heparin/ Anticoagulant	Mineral/ Electrolyte replacem

					ent
Mechanism of Action	Allows more fluid in stools making feces softer and easier to pass.	Kills bacteria by inhibiting the synthesis of bacterial cell walls**.**	Blocks prostaglandin production and interferes with pain impulses	Rapidly binds with and inactivates clotting factors.	When used as a laxative it stimulates fluid secretion and intestinal motiliy.
Reason Client Taking	The patient struggled with constipation.	The patient had acquired an infection and had become septic.	The client was experiencing pain from skin excoriation from improper ileostomy bag placement.	The patient had undergone surgery, so he was taking this medication to prevent pulmonary embolism.	The patient struggled with constipation. He was also on a feeding tube so mineral replacement was necessary.
Contraindications (2)	Intestinal Obstruction Undiagnosed abdominal pain	Penicillin Allergy Blood clotting disorder	Hepatic impairment Active liver disease	Active major bleeding Pork Products	Intestinal perforation Ileostomy
Side Effects/Adverse Reactions (2)	Muscle weakness Abdominal cramps and distention	Severe stomach pain Low white blood cell count	Dyspnea Oliguria	Hyperlipdemia Confusion	Dyspnea Flatulence
Nursing Considerations (2)	Electrolyte imbalances Vitamin and mineral deficiencies	Assess the patient for fever. Assess the patient for prolonged nausea and vomiting.	Use cautiously in patient with severe renal impairment. Liver enzymes should be monitored closely to assess	Use cautiously in patients with renal impairment. Do not administer via IM injection**.**	The drug is not metabolized. Monitor electrolytes frequentl

			for liver damage.		y in pateints with renal impairment.
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	The patient had an ileostomy and prior bowel perforation so monitor output and assess bowel sounds.	The patient had an ill-fitting ileostomy that developed infection resulting in sepsis. The patient's white blood cell count was elevated. He also had increased heart and respiratory rate.	The patient was in pain from the skin excoriation, but his AST was elevated so liver enzymes should be closely monitored. The patient also had elevated BUN and Creatinine, so the nurse needs to monitor for toxicity as well.	Normal INR, APTT, and platelet levels should be checked prior to administration. The patient should also be assessed for bleeding.	The patient had renal impairment evidenced by the BUN and Creatinine levels so monitor electrolytes closely.
Client Teaching needs (2)	Long term use could result in dependency. Increase fiber intake.	Take the medication exactly as directed. Report signs and symptoms of hypersensitivity immediately.	Do not exceed the recommended dose. Educate on the signs of hepatotoxicity such as bruising, malaise, and bleeding.	Taking aspirin or other NSAID's may increase the risk for bleeding. Educate on how to give subcutaneous injections at home.	Educate the patient on increasing dietary fiber and exercise. Notify the provider if abdominal pain, nausea or vomiting occur

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). 2020 *Nurse's Drug Handbook*. Burlington, MA

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alert and oriented to person. The patient was confused and disoriented and could not express where he was at or what day it was. No acute distress. The patient was well groomed.
INTEGUMENTARY (2 points): **Skin color:** Pink, warm, dry, and intact **Character:** Intact **Temperature:** Warm **Turgor:** With in normal limits **Rashes:** Skin excoriation around ileostomy on the right lower quadrant of abdomen **Bruises:** Bruises present on right and left upper arms **Wounds:** The patient had a midline abdominal surgical incision from a previous laparotomy. The wound was bandaged, and no drainage or tenderness was noted. The skin on the abdomen was excoriated around the ileostomy. **Braden Score:** 15 **Drains present: Y☐ N ☒** **Type:**	
HEENT (1 point): **Head/Neck:**	Head and Neck are symmetrical. Trachea is midline without deviation.

Ears: **Eyes:** **Nose:** **Teeth:**	Bilateral auricles pink and moist with no lesions noted. A hearing deficit was noted. Bilateral PEERLA. Bilateral EOM's intact. Bilateral conjunctiva white, bilateral sclera pink. Septum is midline. The patient had eyeglasses and dentures.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:**2+ throughout **Capillary refill:** Less than 3 seconds **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Clear S1 and S2 sounds with no murmurs, gallops, or rubs noted. Normal rate and rhythm.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Normal rate and rhythm. Respirations regular, nonlabored, and symmetrical bilaterally. Lung sounds clear with no crackles, wheezes, or ronchi noted throughout bilaterally.
GASTROINTESTINAL (2 points): **Diet at home:** The client was unable to state his diet prior to hospitalization. **Current Diet:** Osmolyte adult non fiber formula via PEG tube **Height:** 5'8 **Weight:** 221lbs **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** No drains present **Wounds:** Midline surgical incision on the abdomen. The skin around the ileostomy was pink and excoriated**.** **Ostomy: Y ☒ N ☐** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☒ N ☐**	Bowel sounds normoactive upon auscultation of all 4 quadrants. No tenderness upon palpation of all 4 quadrants. Bowel movements were constantly assessed via Ileostomy bag. No abdominal distention noted. Midline abdominal incision. Ileostomy

Type: PEG Tube	
GENITOURINARY (2 Points): **Color:** Yellow **Character:** Clear **Quantity of urine:** 150 mL **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** Clean with no lesions noted **Catheter: Y ☐ N ☒** **Type:** **Size:**	The patient was incontinent but at times he could verbalize when he needed to use the restroom.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** Walker **Strength:** Full strength **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 110 **Activity/Mobility Status:** 3 person assist with gait belt and walker **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ Yes **Needs support to stand and walk** ☐ Yes	Full strength and range of motion in all extremities bilaterally. The patient was able to get up and sit in a chair during therapy. He tolerated the treatment well but was tired afterwards. The patient is unable to get out of bed by himself at this time.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** Alert **Mental Status:** Confused **Speech:** Clear and intact, communicates appropriately for his age. **Sensory:** Intact **LOC:** Alert	.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:**	The patient was suffering from memory loss. The patient has a female companion that came to visit him every day. He also has a son that came to visit as well. His female companion was his

Personal/Family Data (Think about home environment, family structure, and available family support):	primary caregiver prior to hospitalization. She verbalized “We are Christians and have a very good support system. We also have several very close friends.”

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0845	98	91/54	16	98.1	95% room air
1210	90	139/76	16	97.5	97% Room air

Vital Sign Trends: The patients vitals were stable the entire time.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0810	0-10	Patient stated “no pain”	0	none	none
1210	0-10	Patient stated “no pain”	0	none	none

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22gauge **Location of IV:** Right Hand **Date on IV:** 9-7-2021 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No signs of erythema or drainage. **IV dressing assessment:** Clean, dry, and intact	5% Dextrose infusing at 70mL/hr

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
180mL osmolyte 420 mL Dextrose Total= 600mL	150mL urine 200mL feces Total output= 350mL

Nursing Care

Summary of Care (2 points)

Overview of care: The patient was receiving antibiotic treatment for septic infection and was receiving tube feeding. No diagnostic testing was scheduled at this time. The patient was NPO because of the inability to swallow. The patient's vital signs were stable upon treatment.

Procedures/testing done:

Complaints/Issues: The patient had problems with the Ileostomy bag fitting properly. This led to skin excoriation and infection. The patient had become septic from infection. The patient was confused and suffered from memory loss. The patient's vital signs were stable at the time of treatment. The patient also had a PEG tube inserted because he failed a swallow test, but he was tolerating tube feeding. The tube feeding was slowly being increased from 30mL/hr to 50mL/hr during the time of treatment. The goal of tube feeding rate was to increase to 90mL/hr.

Vital signs (stable/unstable): Stable

Tolerating diet, activity, etc.: The patient was unable to ambulate independently but did ambulate with 3 person assist, gait belt, and walker. The patient tolerated ambulating to chair well. The patient was incontinent but was able to communicate the need to urinate from time to time. The patient was tolerating tube feeding.

Physician notifications: Not applicable

Future plans for patient: The patient will be discharged to Marshall Rehabilitation and Nursing Center at a later date.

Discharge Planning (2 points)

Discharge location: Marshall Rehabilitation and Nursing Center

Home health needs (if applicable): Not applicable

Equipment needs (if applicable): Not applicable

Follow up plan: The patient will be discharged to Marshall Rehabilitation and Nursing Center at a later date.

Education needs: The nursing center will address patient education needs.

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. Risk for infection related to improper Ileostomy bag placement as evidenced by abdominal abscess and skin excoriation.	The patient had a previous surgery and fecal content was not being properly contained which increased the risk of infection. The patient had pain and excoriation at the stoma site. The patient also	**1.**Frequently assess vital signs related to signs of infection such as heart and respiratory rate, mental status, and temperature. **2.**Maintain aseptic technique when changing Ileostomy bag.	The patient tolerated frequent vital monitoring. The patient experienced relief when the ileostomy bag was finally fitted properly and was not damaging his skin.

	had increased heart and respiratory rate and increased white blood cell count.		
2. Risk for shock related to abdominal infection as evidenced by increased heart and respiratory rate, increased white blood cell count, and confusion.	The patient had a prior abdominal surgery and Ileostomy placement. The patient presented with signs of infection. The stoma was not properly fitted exposing the patient to fecal content.	**1.** Assess bowel sounds. **2.**Monitor blood pressure, cardiac, and respiratory rate.	The patient was disoriented but was alert enough to understand when the nurse came in to check bowel sounds and assess vitals. After explaining the importance of monitoring the vitals during time of infection the patient and his companion were understanding.
3. Risk for impaired gas exchange related to infection as evidenced by increased respiratory rate and decreased oxygen delivery due to damaged cells**.**	The patient had developed systemic infection that had spread from his abdomen to other vital organs. The patient's labs revealed kidney damage.	**1.**Reposition client frequently. **2.**Assess mental status frequently**.**	A decrease in mental status can be indicative of lack of oxygen to the brain. The client was disoriented but he was cooperative during mental status assessment and was able to identify himself and occasionally time. The patient was able to move from the bed to chair with the help of respiratory therapy and tolerated the activity well.
4. Risk for imbalanced nutrition: less than body's requirements related to inability to swallow as evidenced by PEG tube insertion and tube feeding.	The patient had developed the inability to swallow and had a PEG tube inserted to ensure he was getting proper nutrition for wound healing and fighting infection.	**1**.Administer initial tube feedings at 30mL/hr and increase as tolerated. 2. Monitor electrolyte balance.	The patient started tube feedings at an initial rate of 30mL/hr and had gradually increased to 50mL/hr. He was tolerating the adjustment well. Electrolytes were being monitored by obtaining a complete metabolic panel.

Other References (APA):

Swearingen, P.L. (2019). *All-in-One nursing care planning resource medical surgical, pediatric, maternity, and psychiatric-mental health.* Elsevier.

Concept Map (20 Points):

Subjective Data

The patient had pain around the Ileostomy stoma site and increased confusion. Skin excoriation was present around the stoma site.

The nursing home noted fecal content leaking from the Ileostomy bag.

Objective Data

Patient reports no pain
Pulse 90
Respirations 16
Blood Pressure 139/76
Temperature 97.5
O2 Saturation 97% room air
Height 5'8
Weight 221lbs
BUN 39mg/dL
Creatinine 1.70mg/dL
WBC 11,200 cells/mm3

Patient Information

FC
Male
83 years old
Memory loss, BPH without urinary obstruction, acute kidney injury, hyperlipidemia, sepsis, wound infection

Nursing Diagnosis/Outcomes

Risk for infection related to improper Ileostomy bag placement as evidenced by abdominal abscess and skin excoriation.
Risk for shock related to [illegible] infection as evidenced by increased heart and respiratory rate, increased white blood cell count, and confusion.
Risk for impaired gas exchange related to infection as evidenced by increased respiratory rate and decreased oxygen delivery due to damaged cells.
Risk for imbalanced nutrition: less than body's requirements related to inability to swallow as evidenced by PEG tube insertion and tube feeding.

Outcomes:
1. The patient tolerated frequent vital monitoring.
The patient experienced relief when the ileostomy bag was finally fitted properly and was not damaging his skin.
2. The patient was disoriented but was alert enough to understand when the nurse came in to check bowel sounds and assess vitals. After explaining the importance of monitoring the vitals during time of infection the patient and his companion were understanding.
3. A decrease in mental status can be indicative of lack of oxygen to the brain. The client was disori[illegible]ted but he was cooperative during mental status assessment and was able to identify h[illegible]nself and occasionally time.
The patient was able to move from the bed to chair with the help of respiratory therapy and tolerated the activity well
4. The patient started tube feedings at an initial rate of 30mL/hr and had gradually increased to 50mL/hr. He was tolerating the adjustment well. Electrolytes were being monitored by obtaining a complete metabolic panel.

Nursing Interventions

1.Frequently assess vital signs related to signs of infection such as heart and respiratory rate, mental status, and temperature.
2. Maintain aseptic technique when changing Ileostomy bag.
3. Assess bowel sounds.
4.Monitor blood pressure, cardiac, and respiratory rate.
5. Reposition client frequently.
6. Assess mental status frequently.
7. Administer initial tube feedings at 30mL/hr and increase as tolerated.
8. Monitor electrolyte balance.