

N321 Care Plan # 1

Lakeview College of Nursing

Name: Shana. M. Stanley

Demographics (3 points)

Date of Admission 09/08/2021	Patient Initials LE	Age 78	Gender F
Race/Ethnicity Japanese	Occupation Retired	Marital Status Unmarried	Allergies none
Code Status FULL	Height 5'0	Weight 127lb	

Medical History (5 Points)**Past Medical History:**

- Gerd
- Paroxysmal Atrial Fibrillation
- Tricuspid valve disorder
- Acute Pancreatitis
- Acute Cholecystitis
- Hypertension

Past Surgical History:

- Aortic valve replacement
- Mitral valve replacement
- ICD insertion(left)
- Pacemaker(left)
- Gallbladder removal
- Left hip replacement

Family History:

- Hypertension

Social History (tobacco/alcohol/drugs): NO

Assistive Devices: NO

Living Situation: Patient has significant other of 25yrs.

Education Level: Two years of college

Admission Assessment

Chief Complaint (2 points): Weakness and Diarrhea

History of present Illness (10 points): The patient presented to the ER with a complaint of weakness and diarrhea. She stated that she had been experiencing diarrhea and black stools for the past two days and that it is now accompanied by weakness.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Gastrointestinal Bleeding accompanied by Hypokalemia.

Secondary Diagnosis (if applicable): NA

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

The patient presented to the ER with a complaint of weakness and diarrhea. She stated that she had been experiencing diarrhea and black stools for the past two days and that it is now accompanied by weakness. Upon further assessment it was determine that the Patient was losing blood via the gastrointestinal tract which caused her stools to appear black. The patient was also showing signs of hypokalemia which was further supported by blood work showing a potassium of 2.6. According to Mayo gastrointestinal bleeding can occur in the upper or lower gastrointestinal tract and my present in red or coffee ground appearance

vomit or black tarry appearing stools (*Mayo Foundation, 2020*). The patient was also experiencing hypokalemia which is low potassium. According to the patients current diagnosis the lower potassium appears to be caused by the use of her current medication (Lasix) and her loose stools. According to WebMD hypokalemia can be caused by the use of diuretics and diarrhea among other things. The sings of Hypokalemia will often start to present its self as weakness and fatigue and may progress to arrhythmias, muscular cramps, and twitching (*Hypokalemia (low Potassium): Symptoms, Causes, DIAGNOSIS, TREATMENT 2021*).

Pathophysiology References (2) (APA):

Mayo Foundation for Medical Education and Research. (2020, October 15). *Gastrointestinal bleeding*. Mayo Clinic. Retrieved September 12, 2021, from <https://www.mayoclinic.org/diseases-conditions/gastrointestinal-bleeding/symptoms-causes/syc-20372729>.

WebMD. (n.d.). *Hypokalemia (low Potassium): Symptoms, Causes, DIAGNOSIS, TREATMENT*. WebMD. Retrieved September 12, 2021, from <https://www.webmd.com/digestive-disorders/hypokalemia>.

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	4.0-4.9 10 ⁶ /uL		2.17	These values are consistent with blood loss (Capriotti & Frizzell, 2016).
Hgb	12.0-16.0 g/dL		10.6	These values are consistent with blood loss

				(Capriotti & Frizzell, 2016).
Hct	37.0-48.0%		33.1	These values are consistent with blood loss (Capriotti & Frizzell, 2016).
Platelets	150-400 10 ³ /uL		181	
WBC	4.1-10.9 10 ³ /uL		8.05	
Neutrophils	1.50-7.70 10 ³ /uL		4.74	
Lymphocytes	1.00-4.90 10 ³ /uL		1.90	
Monocytes	0.00-0.80 10 ³ /uL		7.8	Monocytes are elevated due to trauma and inflammatory response (Capriotti & Frizzell, 2016).
Eosinophils	0.00-0.50 10 ³ /uL		8.6	Eosinophils are elevated due to trauma and inflammatory response (Capriotti & Frizzell, 2016).
Bands	NA		NA	

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 mmol/L		143	
K+	3.5-5.1 mmol/L		2.6	Dehydration, diarrhea, medication (Capriotti & Frizzell, 2016).
Cl-	98-107 mmol/L		99	
CO2	21.0-32.0 mmol/L		27	
Glucose	60-99 mg/dL		107	
BUN	5-20 mg/dL		21	
Creatinine	0.5-1.5 mg/dL		1.2	
Albumin	3.4-5.4 g/dL		NA	

Calcium	8.5-10.1 mg/dL		9.0	
Mag	1.6-2.6 mg/dL		NA	
Phosphate	3.4-4.5		2.4	These values are consistent with blood loss (Capriotti & Frizzell, 2016).
Bilirubin	-	NORMAL		
Alk Phos	44-147 U/L	NA		
AST		NA		
ALT		NA		
Amylase		NA		
Lipase		NA		
Lactic Acid		NA		

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			NA	
PT			NA	
PTT			NA	
D-Dimer			NA	
BNP			NA	
HDL			NA	
LDL			NA	
Cholesterol			NA	

Triglycerides			NA	
Hgb A1c			NA	
TSH			NA	

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Light yellow		YELLOW	
pH	5.0-7.0		6.5	
Specific Gravity	1.003-1.030		NA	
Glucose	Negative		Negative	
Protein	Negative		Negative	
Ketones	Negative		Negative	
WBC	0-25/uL		0	
RBC	0-20/uL		0	
Leukoesterase	Negative		Negative	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	NA		Negative	
Blood Culture	NA		Negative	
Sputum Culture	NA		Negative	

Stool Culture	NA		Negative	
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Lab Correlations Reference (1) (APA): Capriotti, T., & Frizzell, J. P. (2016). Pathophysiology: introductory concepts and clinical perspectives. Philadelphia: F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Patient is scheduled for an endoscopy.

Diagnostic Test Correlation (5 points): An endoscopy is the most common test used to determine the source of a GI bleed (U.S. National Library of Medicine, 2021).

Diagnostic Test Reference (1) (APA):

U.S. National Library of Medicine. (2021, August 2). *GI bleed | gastrointestinal bleeding*. MedlinePlus. Retrieved September 12, 2021, from <https://medlineplus.gov/gastrointestinalbleeding.html>.

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

Home Medications (5 required)

Brand/Generic	Hydrocodone	Lasix	Warfarin	Vitamin D	Multi vitamin
Dose	325mg tab	40mg tab	Pt wasn't sure	Pt wasn't sure	Pt wasn't sure
Frequency	prn	Once a day	Once a day	Once a day	Once a day
Route	oral	oral	oral	oral	oral
Classification	opioid	Loop diuretic	Anticoagulant	Vitamins	Vitamins
Mechanism of Action	Bind to and activates opioid receptors to produce pain relief.	Inhibits sodium and water reabsorption in the loop of Henle.	Interferes with the livers ability to synthesize vitamin K	Vitamin D has indirect action on the bone by regulating calcium and	Over all replacment

				phosphate metabolism .	
Reason Client Taking	Ankle pain	hypertension	Clotting	Replacement	replacement
Contraindications (2)	Bronchial asthma Hypersensitivity to hydrocodone.	Anuria Hypersensitivity to furosemide.	Bleeding or bleeding tendencies diverticulitis	High amounts of phosphates in the blood Excessive amounts of vitamin D in the body	Iron overload Gastritis
Side Effects/Adverse Reactions (2)	Anxiety CNS depression	Dizziness Vertigo arrhythmias	Intercranial hemorrhage Hypotension	Growth issues Chest pain	Stomach irritation Constipation
Nursing Considerations (2)	Hydrocodone increases the risk of addiction. Should not be given to a client with impaired consciousness.	Obtain pt weight before giving drug Should be give in the morning as to not interrupt pt sleep.	Insure negative pregnancy test Monitor INR	Excessive amounts of vitamin D can harm unborn baby Don't give to child without medical advice	Don't take with milk Pregnancy

Hospital Medications (5 required)

Brand/Generic	Amiodarone	Ferrous sulfate	Furosemide	Acetaminophen (Tylenol)	Alum-mag hydroxide
Dose	200mg	324mg	40mg tab	500mg	30ml
Frequency	daily	X2 daily	Once a day	PRN	prn
Route	oral	oral	oral	Oral	oral
Classification	Antiarrhythmic	Iron replacement	Loop diuretic	Antipyretic	Antacid
Mechanism of Action	Acts on the cardiac cell membrane prolonging repolarization and the refractory period	Act to normalize RBC production by binding with hemoglobin	Inhibits sodium and water reabsorption in the loop of Henle.	Inhibits the enzyme cyclooxygenase, blocking prostaglandin production and interfering with pain impulse generation in the peripheral nervous system.	Neutralizes or reduces gastric acidity
Reason Client Taking	Hist of A-fib	Iron deficiency	hypertension	Pain management	GI upset
Contraindications (2)	Bradycardia SA node dysfunction	Hemochromatosis Hemolytic anemias	Anuria Hypersensitivity to furosemide.	Hypersensitivity to acetaminophen, hepatic impairment	Hypersensitivity to aluminum only one shown in book
Side Effects/Adverse Reactions (2)	Anxiety Confusion Bradycardia	Hypotension Abdominal cramps	Dizziness Vertigo arrhythmias	Hypotension, Stridor	Encephalopathy Constipation
Nursing Considerations (2)	Check for pacemaker and review settings Use inline filter during IV administration	Give with full glass of juice or water Monitor pt B/P after IV dose is given	Obtain pt weight before giving drug Should be given in the morning as to not interrupt pt sleep.	Monitor renal function Do not exceed daily limits	Don't give within 2hrs of other oral drugs Monitor serum levels

Medications Reference (1) (APA): Jones & Bartless Learning. (2020). 2020 Nurse’s drug handbook (19th ed.). Burlington, MA.

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Pt appears alert and oriented x3 person, place, and day of week, groomed, and in no pain.</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	<p>Pt skin is warm, pink, and dry, with bruising on upper chest and arms. Turgor slow return, Pt has a Braden score of 19.</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<ul style="list-style-type: none"> • Head and neck symmetrical, trachea midline no deviation, thyroid not palpable, no noted nodules. Bilateral carotid pulses palpable. • Eyes bilateral sclera white, bilateral cornea foggy, conjunctive pink, slight drainage in left eye. • Nose septum midline turbinate’s moist and pink. • Mouth pharynx moist and pink, dentation good, mucosa pink and moist with lesion on upper right side.

<p>CARDIOVASCULAR (2 points): Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>. Clear S1 and S2 heard without gallops or rubs. Peripheral pulses palpable. Capillary refill less than 3sec. Edema noted in both lower legs. Pt is paced.</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Respirations are regular and even without laboring. Lungs sound clear throughout bilaterally.</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: 5'0 Weight:127 Auscultation Bowel sounds: Last BM: 0800 Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Diet at home is normal, current diet is clear liquids, Abdomen is soft, tender in LLQ and LRQ, bowel sounds normal.</p>
<p>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Urine is yellow and clear in character, output 100ml. No pain with urination noted. BM loose and black in color.</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status:</p>	<p>.Pt can perform ROM and ADL's with assistance. Fall score is a 10 moderate fall</p>

<p>ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 10 Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/> Pt can perform ROM and ADL's with assistance. Fall score is a 10 moderate fall risk. Patient needs assistance with IV pole when using the restroom.</p>	<p>risk. Patient needs assistance with IV pole when using the restroom.</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: AOX3 Mental Status: UNDERSTANDABLE Speech: NORMAL Sensory: NORMAL LOC: ALERT</p>	<p>Pt has positive MAEW and PERLA, strength was equal with some generalized weakness. Orientation normal with mental status ANO X3, speech understandable, sensory normal, and LOC alert.</p>
<p>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):</p>	<p>Pt lives at home with partner and often sits outside to relax.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	62	156/70	18	98.7	94% room air
1030	70	132/80	18	98.5	96% room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	1-10	na	0	na	na
1030	1-10	na	0	na	na

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:	20 gage RAC 0.9% @ 50

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240ML	100ML URIN LOOSE STOOLS

Nursing Care

Summary of Care (2 points)

Overview of care:

I was able to preform a full body assessment on the pt including inspecting the IV site and flushing. Pt did =nt require much help moving around just asstance with moving the IV pole as needed.

Procedures/testing done: GI consult is schduled

Complaints/Issues: Loose stools

Vital signs (stable/unstable): stable

Tolerating diet, activity, etc.: liquid diet pt understands reason, activity good.

Physician notifications: number of looses stools and color on rounding

Future plans for patient: GI consult

Discharge Planning (2 points)

Discharge location: To home

Home health needs (if applicable): NA

Equipment needs (if applicable): NA

Follow up plan: NA

Education needs: NA at this point

Nursing Diagnosis (15 points)

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

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Intervention (2 per dx)</p>	<p>Evaluation</p> <ul style="list-style-type: none"> • How did the patient/family respond to the nurse’s actions? • Client response, status of goals and outcomes, modifications to plan.
<p>1. Fatigue related to fluid loss. As evidenced by abdominal labs and sings of dehydration</p>	<p>Pt is currently experiencing fatigue due to the fluctuation of her fluid imbalance.</p>	<p>1. Promote ambulation 2. Promoter fluid intake.</p>	<p>PT agreed that ambulation should be happening. PT is also consuming as much as water as she can.</p>

<p>2. Risk for activity intolerance related to dehydration and bowel issues . As evidenced sedentary disposition</p>	<p>The Pt is currently experiencing highs and lows of energy due to her fluid fluctuation and loose stools</p>	<p>1. Promote ambulation 2. Promote passive range of motion in bed during moments of weakness.</p>	<p>PT agrees to ambulation and asked for education on exercises she can do in bed when she feels weak.</p>
<p>3. Risk for Anxiety related to blood in stool. As evidenced by concerns expressed by Pt about further loss of blood and blood replacement</p>	<p>Pt has expressed worry and concern about her new diagnosis and upcoming GI consult. She appears agitated after using the restroom and seeing blood.</p>	<p>1. Provide education to Pt in regard to GI issues after consultation 2. Promote meaningful conversations about any worries she may have before discharge.</p>	<p>PT would be happy to receive education, and felt better about the situation once conversations about her concerns were had.</p>

Other References (APA):

Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health. St. Louis, MO: Elsevier.

Concept Map (20 Points):

Subjective Data

Pts labs indicate hypokalemia and gastrointestinal bleeding.

Nursing Diagnosis/Outcomes

1. Fatigue related to fluid loss. As evidenced by abdominal labs and sings of dehydration.
2. Risk for activity intolerance related to dehydration and bowl issues . As evidenced sedentary disposition
3. Risk for Anxiety related to blood in stool. As evidenced by concerns expressed by Pt about further loss of blood and blood replacement.

Objective Data

Pt expresses that she is weak and has concerns about bleeding.

Patient Information

Pt is a 78 year old female that presented to the ER on 9-8-21 with complaints of weakness and loose stools. She is a full code.

Nursing Interventions

1. Promote ambulation
 2. Promoter fluid intake.
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1. Promote ambulation
 2. Promote passive range of motion in bed during moments of weakness.
1. Provide education to Pt in regard to GI issues after consultation
 2. Promote meaningful conversations about any worries she may have before discharge.



