N321 Care Plan #1

Lakeview College of Nursing

Airelle Mitchell

Demographics (3 points)

Date of Admission 9/17/2021	Patient Initials K. C.	Age 63 8/13/1958	Gender Female
Race/Ethnicity Caucasian	Occupation Retired	Marital Status Single	Allergies Hydro morphine & Codeine Reaction to these is itching and watery eyes
Code Status DNR	Height 162.6 cm	Weight 46.00 kg	

Medical History (5 Points)

Past Medical History: Anemia, arthritis, chronic back pain, balance, bowel obstruction, brain metastases, buttock wound, cocaine abuse remission, colon cancer, coronary artery disease, decubitus ulcer, emphysema, hyperlipidemia, leg weakness bilateral, mitral regurgitation, neuropathy, alcoholism syndrome, osteoporosis, osteoarthritis, & urinary incontinence.

Past Surgical History: Open repair of ruptured bladder and suprapubic Cath placement at Carle (3/30/2021), cardiac catheter, bronchoscopy with biopsy, revisional fusion of lumbar spine.

Family History: N/A

Social History (tobacco/alcohol/drugs): Client is a former smoker and states she does not smoke or drink alcohol any more. Clients occasionally use's marijuana. Client is in cocaine remission.

Assistive Devices: Client uses a wheelchair and walker, but has not used walker in a while due to her leg weakness bilaterally.

Living Situation: Client lives alone with her dogs and cats. She will have hospice care coming to her home.

Education Level: Client's education level is 12th grade.

Admission Assessment

Chief Complaint (2 points): Abdominal pain

History of present Illness (10 points): Client is a 63-year-old Caucasian female who was admitted to the hospital on 9/17/2021 by EMS because of abdominal pain. The client stated the onset of pain started around noon in her home. The location of pain was mainly localized in the abdominal area. The quality of pain was stabbing and the client stated the pain was a 10/10 on a numeric scale 0-10. When assessing pain with vitals twice on 9/27/2021, the client stated a 0 on a numeric scale of 0-10. Client has Tylenol 500mg PO, that can be taken as needed for pain.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Bowel Obstruction

Secondary Diagnosis (if applicable): Abdominal pain

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

Pathophysiology

A bowel obstruction can be painful and can cause many issues in a person's body. Bowel obstruction can happen by swallowing air. Small intestines, when they are healthy, absorb and break down nutrients. When they become obstructed, nutrients are no longer absorbed or broken down, causing an obstruction (Hinkle & Cheever, 2018). Bowel dilation proximal to the transitions can cause an obstruction and lead to emesis (Hinkle & Cheever, 2018). When emesis

occurs, this can lead to electrolyte imbalances. If this doesn't get treated, edema and ascites can form. Further complications can happen by strangulation, which can lead to necrosis, congestion, and rupture of the intestinal wall. This could be potentially life-threatening if the client did not come to the hospital when she did.

Bowel obstruction has many signs and symptoms, and it depends on if it was a complete or partial obstruction. The general signs and symptoms of bowel obstruction are abdominal pain, nausea, vomiting, distended abdomen, and the client may pass blood or mucus. Still, they will not pass gas or fecal matter (Hinkle & Cheever, 2018). Other symptoms that could be signs of dehydration include drowsiness, parched tongue, thirst, malaise, and aching (Hinkle & Cheever, 2018).

Expected vitals with a bowel obstruction are tachycardia, increased respirations, dry mucous membranes, pain, and hypotension. The client had pain of 10/10 based on a numeric pain scale. Pain can affect many different vitals signs like heart rate, blood pressure, and respirations. Laboratory studies that should be done are a CBC and BMP for electrolytes. Assessing for these is essential because it informs the nurses what electrolytes are low and helps detect dehydration (Hinkle & Cheever, 2018). The client's vomiting can lead to decreased fluids and significantly reduced potassium levels, leading to cardiac issues—diagnostic tests to determine a bowel obstruction is a CT and abdominal x-ray (Capriotti, 2020). This patient had an abdominal and CT scan upon admission. An abdominal x-ray can determine if the colon is distended, and a CT scan with contrast dye can confirm a mechanical obstruction. The diagnostic testing would include an elevated WBC count and imbalanced electrolytes (Capriotti, 2020).

Treatment of a bowel obstruction can be done surgically or non-surgically. Treatment includes fluid replacement, prophylactic antibiotics, intestinal decompression, and surgical consultation, depending on the type of obstruction. This client had electrolytes replaced through IV fluids and had potassium replaced because it was low(Capriotti, 2020). The client did not have to have surgery, so they followed the treatment of fluid replacement, prophylactic antibiotics like lactobacillus, and intestinal decompression.

Pathophysiology References (2) (APA):

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

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	**3.90-4.98 (mill/cumm)**	**3.48**	**4.39**	**Client's decrease could be due to past medical history of anemia. (Pagana, 2018)**
Hgb	**12.0-15.5 (gm/dL)**	**10.1**	**12.4**	**Client's low levels of Hgb could be due to past medical history of anemia. (Pagana, 2018)**
Hct	**35-45%**	**29.8**	**37.1**	**Client has an insufficient amount of red blood cells that could be due to anemia. (Pagana, 2018)**
Platelets	**140-400 (1000/mm3)**	**253**	**410**	**Clients high platelet count could be due to thrombocytosis because of**

				her existing diagnosis of cancer. (Pagana, 2018)
WBC	**4.0-9.0 (10 x 3/uL)**	**4.0**	**5.4**	**N/A**
Neutrophils	**40-70%**	**78.3**	**78.4**	**The client is fighting off a potential bacterial infection possibly from the wound on her left foot. (Pagana, 2018)**
Lymphocytes	**10-20%**	**8.8**	**10.2**	**Radiation and chemotherapy treatments can cause low levels of lymphocytes. (Pagana, 2018)**
Monocytes	**5%**	**7.3**	**7.7**	**N/A**
Eosinophils	**1-4%**	4.0	**3.1**	**N/A**
Bands	**0.0-10.0%**	**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-	**135-145 (mEq/L)**	**131**	**130**	**Client's abdominal obstruction holding in fluids by third spacing can cause hyponatremia. (Pagana, 2018)**
K+	**3.5-5.1 (mEq/L)**	**3.4**	**5.1**	**Client was vomiting due to bowel obstruction causes of low K+. (Pagana, 2018)**
Cl-	**98-107 (mEq/L)**	**97**	**91**	**Client's lung cancer could be the cause of slightly low levels of chloride. (Pagana, 2018)**
CO2	**21-31 (mEq/L)**	**29**	**31**	**N/A**
Glucose	**60-110 (mg/dL)**	**98**	**104**	**N/A**
BUN	**8-23 (mg/dL)**	**4**	**13**	**Low levels of BUN could be due to the clients malnutrition of imbalance electrolytes. (Pagana, 2018)**
Creatinine	**0.05-1.00 (mg/dL)**	**0.30**	**0.69**	**N/A**

Albumin	**3.5-5.2 (gm/dL)**	**N/A**	**3.2**	**Could be due to inflammation the client might still have from the bowel obstruction. (Pagana, 2018)**
Calcium	**8.4-10.0 (mg/dL)**	**7.5**	**9.2**	**Client's low levels of calcium could be due to electrolyte imbalance with the bowel obstruction. (Pagana, 2018)**
Mag	**1.3 - 2.1 (mg/dL)**	**1.3**	**2.2**	**N/A**
Phosphate	**2.5-5 (mg/dL)**	**N/A**	**N/A**	**N/A**
Bilirubin	**0.0-1.2 (mg/dL)**	**N/A**	**N/A**	**N/A**
Alk Phos	**35-105 (U/L)**	**N/A**	**N/A**	**N/A**
AST	**13-39 U/L**	**N/A**	**N/A**	**N/A**
ALT	**7-52 U/L**	**N/A**	**N/A**	**N/A**
Amylase	**60-100 U/L**	**N/A**	**N/A**	**N/A**
Lipase	**0-160 U/L**	**N/A**	**N/A**	**N/A**
Lactic Acid	**0.5-1.5 mEq/L venous**	**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**	**N/A**	**N/A**	**N/A**
PT	**10-12 seconds**	**N/A**	**N/A**	**N/A**

PTT	**30-45 seconds**	**N/A**	**N/A**	**N/A**
D-Dimer	**Negative, less than 250 mg/mL**	**N/A**	**N/A**	**N/A**
BNP	**Less than 100 pg/mL**	**N/A**	**N/A**	**N/A**
HDL	**< 60 md/dL**	**N/A**	**N/A**	**N/A**
LDL	**< 100 mg/mL**	**N/A**	**N/A**	**N/A**
Cholesterol	**< 200 mg/dL**	**N/A**	**N/A**	**N/A**
Triglycerides	**<150 mg/dL**	**N/A**	**N/A**	**N/A**
Hgb A1c	**< 5.7%**	**N/A**	**N/A**	**N/A**
TSH	**0.5-5.0**	**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	**N/A**	**N/A**	**N/A**	**N/A**
pH	**5.0-8.0**	**N/A**	**N/A**	**N/A**
Specific Gravity	**1.005-1.034**	**N/A**	**N/A**	**N/A**
Glucose	**Negative**	**N/A**	**N/A**	**N/A**
Protein	**Negative**	**N/A**	**N/A**	**N/A**
Ketones	**Negative**	**N/A**	**N/A**	**N/A**
WBC	**0-0.5**	**N/A**	**N/A**	**N/A**
RBC	**0-3**	**N/A**	**N/A**	**N/A**
Leukoesterase	**Negative**	**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):

Lakeview college of Nursing Diagnostic Lab Value Sheet

Sarah Bush Lincoln Center Hospital System. Medical Value

Pagana, K.D, Pagana, T. N. (2018). Mosby's diagnostic and laboratory test reference (6th ed.).

St. Louis, MO.: Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

1. Chest X-Ray – Routine, some congestion, and a mass was shown per lung cancer.
2. CT of abdomen - N/A
3. X-Ray Abdomen KUB 1 View - N/A

Diagnostic Test Correlation (5 points):

1. X-rays can detect many different things such as bone density, erosion, fluid, and it can show anterior, posterior, or lateral views of the body (Hinkle & Cheever, 2018). A chest X-ray was performed on the client due to routine checks of the ER. The chest X-ray results should be a mass in the lung, which could be due to the client's lung cancer. An abdominal X-ray was performed on the client to see if any fluid accumulated due to the client's abdominal pain and to diagnose the client's bowel obstruction. Results of the abdominal X-ray showed fluid accumulation in third spacing and distilled collapsed bowel.
2. A computed tomography scan with contrast shows a visualization of tumors and injury to soft tissue, ligaments, severe trauma to the chest, abdomen, pelvis, head, or spinal cord (Hinkle & Cheever, 2018). The client received a CT with contrast to show where the abdomen's obstruction and pain were occurring.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required)

Brand/Generic	**Albuterol**	**Hydrocodone acetaminophen (Norco)**	**Ondansteron**	**Ibuprofen**	**Pramipexole**
Dose	**2.5 mg - 3 mL**	**Tablet 325 mg**	**Tablet 8 mg**	**Tablet 200 mg**	**Tablet 0.5 mg**
Frequency	**Q6H**	**Q4H (PRN)**	**PRN**	**Q8H**	**TID**
Route	**Inhalant**	**PO**	**PO**	**PO**	**PO**
Classification	**Adrenergic Bronchodilator (Jones, 2021)**	**Opioid analgesic (RxList, 2021)**	**Antiemetic (Jones, 2021)**	**Analgesic (Jones, 2021)**	**Antiparkinsonian (Jones, 2021)**
Mechanism of Action	**Relaxes bronchial smooth muscle cells and inhibits histamine release. (Jones, 2021)**	**Binds to and activates opioid receptors at sites in the periaqueductal and periventricular gray matter (Jones, 2021)**	**To prevent nausea and vomiting associated with chemotherapy. (Jones, 2021)**	**Reducing inflammatory systems and pain. (Jones, 2021)**	**Can stimulate dopamine receptors in the brain to ease Parkinson's disease. (Jones, 2021)**

Reason Client Taking	**To prevent exercise induced bronchospasm. (Jones, 2021)**	**To manage severe pain (Jones, 2021)**	**To prevent nausea and vomiting. (Jones, 2021)**	**To reduce mild to moderate pain. (Jones, 2021)**	**To treat Parkinson's disease. (Jones, 2021)**
Contraindications (2)	**Hypersensitivity to acetaminophen & hepatic impairment. (Jones, 2021)**	**Hypersensitivity to other opioids may exhibit cross-sensitivity to hydrocodone. Should not be administered to these patients (RxList, 2021).**	**Concomitant use of apomorphine and hypersensitivity to Ondansteron. (Jones, 2021)**	**Hypersensitivity to NSAIDS & bleeding. (Jones, 2021)**	**Hypersensitivity to this drug or its components. (Jones, 2021)**
Side Effects/Adverse Reactions (2)	**Bronchospasm & hypertension. (Jones, 2021)**	**Nausea & drowsiness. (RxList, 2021)**	**Thirst & chest pain. (Jones, 2021)**	**Hypertension & diverticulitis. (Jones, 2021)**	**Confusion & orthostatic hypotension. (Jones, 2021)**
Nursing Considerations (2)	**Monitor serum potassium levels and tolerance can occur with prolonged use. (Jones, 2021)**	**Norco can become addictive and abused. (RxList, 2021)**	**Hypokalemia and hypomagnesemia need to be corrected before the use of this drug. Monitor client's signs and symptoms of hypersensitivity. (Jones, 2021)**	**Use it with extreme caution for clients with bleeding and it should be avoided with a recent MI. (Jones, 2021)**	**Monitor the patient for postural deformity and take safety precautions until CNS effects are known. (Jones, 2021)**

Hospital Medications (5 required)

Brand/Generic	**Tylenol**	**Enoxaparin**	**Linezolid**	**Morphine**	**Lactobacillus**

	Acetaminophen				
Dose	**500 mg 1 tablet**	**40 mg**	**600mg – 300mL**	**2mg – 2 mL**	**1 cap**
Frequency	**PRN**	**Daily**	**Q12H**	**PRN**	**Daily**
Route	**PO**	**Subcutaneous injection Abdomen**	**IV push**	**IV push**	**PO**
Classification	**Antipyretic; nonopioid analgesic (Jones, 2021)**	**Anticoagulant (Jones, 2021)**	**Antibiotic (Jones, 2021)**	**Opioid analgesic. (Jones, 2021)**	**Probiotic (RxList, 2021)**
Mechanism of Action	**Inhibits cyclooxygenase by blocking prostaglandin production and interfering with pain impulse. (Jones, 2021)**	**To prevent the client from bleeding out by clotting the blood. (Jones, 2021)**	**To inhibit bacterial infection by interfering with RNA protein. (Jones, 2021)**	**Activates and binds with opioid receptors to relieve pain. (Jones, 2021)**	**Is a good bacteria that will help digest, breakdown, and absorb nutrients. (RxList, 2021)**
Reason Client Taking	**To relieve mild to moderate pain. (Jones, 2021)**	**To prevent deep vein thrombosis. (Jones, 2021)**	**To treat skin infection. (Jones, 2021)**	**To manage moderate to severe pain. (Jones, 2021)**	**To treat diarrhea. (RxList, 2021)**
Contraindications (2)	**Severe hepatic impairment & severe active liver disease. (Jones, 2021)**	**Heparin induced thrombocytopenia (HIT) & Major bleeding. (Jones, 2021)**	**Hypersensitivity to Linezolid. Only on contradiction. (Jones, 2021)**	**Watch for respirations due to respiratory depression. Hypersensitivity to morphine. (Jones, 2021)**	**If the client has a yeast infection or hypersensitivity to lactose.**
Side Effects/Adverse Reactions (2)	**Fatigue & Hypokalemia. (Jones, 2021)**	**Confusion & pulmonary edema. (Jones, 2021)**	**Headache & Abdominal pain. (Jones, 2021)**	**Thrombocytopenia & apnea. (Jones, 2021)**	**Gas or bloating. (RxList, 2021)**
Nursing Considerations (2)	**Use acetaminophen cautiously with respiratory impairment.**	**Use cation in patients who are at a higher risk for a hemorrhage.**	**Infuse over 30 -120 minutes with D5W, normal saline,**	**Morphine can lead to abuse and addiction & tachycardia.**	**If a client's immune system is weakened, then this can**

	Don't confuse milligrams with millimeters to prevent a medication error. (Jones, 2021)	**Expect a delay in the elderly. (Jones, 2021)**	**or lactated ringers. Monitor CBC while on this antibiotic. (Jones, 2021)**	**(Jones, 2021)**	**cause bacteria to grow too much. Monitor clients for allergic reactions. (RxList, 2021)**

Medications Reference (1) (APA):

Jones, D. W. (2021). *Nurse's drug handbook.* (A. Barlett, Ed.) (20th ed.). Jones & Bartlett Learning.

RxList. (2021). RxList. WebMD. Retrieved 1 October 2021 from https://www.rxlist.com/script/main/hp.asp

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Client was alert and oriented to person, place, time, and situation (x4). She did not appear to be in any distress. She was calm and seemed tired. Client's overall appearance was disheveled.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** **Braden Score:**	Client's skin was pink, dry, warm, and intact. Skin turgor was less than three seconds. Skin was absent of rashes, but did have a bruise on the left wrist. Client had a wound on the left foot that was wrapped in gauze. Client has a braden score of 18. The client is at a mild risk for skin breakdown. No drains present.

Drains present: Y☐ N X **Type:**	
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Client's head and neck appeared to be midline with no deviation. Her ears were intact and symmetrical. No drainage noted. Client was able to hear well, with no hearing impairment. Client wears glasses, but not consistently. Eyes appeared to be symmetrical with no drainage. Client's nose was midline. Client's upper teeth were missing because her dentures were lost in the hospital. She was also missing a few teeth on the bottom. Tongue appeared to be pink and midline.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N X** **Edema Y ☐ N X** **Location of Edema:**	S1 and S2 heard. Client had a regular heartbeat. Peripheral pulses were palpable bilaterally in the brachial, radial, and carotid arteries. The lower extremities were not hard to palpate. Capillary refill was less than 3 seconds. No edema was presented.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N X** **Breath Sounds: Location, character**	No abnormal lung sounds heard upon auscultation. No accessory muscles used. No chest deformities noted.
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 X** **Nasogastric: Y ☐ N X** **Size:** **Feeding tubes/PEG tube Y ☐ N X**	Client eats a normal diet at home and in the hospital with no restrictions. Client weighs 46.00 kg (101.4 lbs) Client stands 162.6 cm (5'3") Last bowel movement two days ago. Clients' bowel sounds were active 5 -30 seconds in all four quadrants for a minute. Client had abdominal distention. Client had no drains present. Client did have scars where she had surgeries and she had a wound on her left foot. No ostomy, nasogastric, or feeding tubes.

Type:	
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N X** **Dialysis: Y ☐ N X** **Inspection of genitals:** **Catheter: Y X N ☐** **Type:** **Size:**	Urine was yellow with a tinge of light orange/pink color. Client denied any pain or burning. Client did have a urinary catheter. No dialysis.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y X N ☐** **Fall Risk: Y X N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐ X** **Needs support to stand and walk☐X**	Neurovascular status is intact and is in control. ROM is passive and she needs assistance with lower extremities. Client uses a wheelchair. Client stated she did use a walker but since she has been having a hard time with her legs she just uses the wheelchair. Her strength is equal in her upper extremities and weak in her lower extremities bilaterally. She does have ADL assistance. Client is a high fall risk with a score of 88. Client requires assistance with ambulation. The client did not get out of bed during my shift.
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Client has difficulty moving lower extremities bilaterally. Clients can move upper extremities well bilaterally. Client exhibited PERLA. Strength is equal in upper extremities and lower extremities are very weak. Client is A&O x 4. Mental status is appropriate for her age. She can understand and answer questions. Speech is normal and is audible. No mumbling or slurring noted. Sensory is intact and no signs of LOC.
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):**	Client lives at home by herself. Hospice will be coming to her home. Coping methods are used by doing puzzles, watching TV, and reading. The client's religion is christian. Family will come around, she said “Whatever is left of them”. She does have friends. Developmental level is appropriate for her age.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0815	78 bpm	119/85 mmHg	16 rpm	36.3 C	95%
1030	76 bpm	112/84 mmHg	16 rpm	36.4 C	95%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0815	Numeric 0-10	N/A	0	N/A	Administer pain meds (Tylenol).
1030	Numeric 0-10	N/A	0	N/A	Administer pain meds (Tylenol).

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:**	Client has an 18-gauge IV central port in the right upper chest. IV was placed on 9/17/2021. IV site is dry, and intact. IV is patent. No Drainage, erythema, swelling, inflammation, or warmth. IV dressing was clear and intact. Saline locked till the Dr. could get new orders for potassium.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Oral Intake – 480 mL	**Void 480 mL**

Client did eat all of her breakfast. Eggs and toast with butter.	

Nursing Care

Summary of Care (2 points)

Overview of care: Care for the client consisted of assessing pain, providing comfort at bedside, and administering medication with the nurse. Orders were requested to stop potassium because her levels were high. They had her finger pricked in the middle of the night because her port was not working properly to withdraw blood for labs. Phlebotomy came back to reassess the potassium levels and retry access to the port. The port was still not working, so they poked one of her veins to do a venipuncture for the lab. The client was supposed to be discharged around 1500.

Procedures/testing done: Phlebotomy came around 1030 to take blood for a new CBC and BMP results.

Complaints/Issues: The client was complaining about her top teeth dentures missing. No pain complaints or other issues during my shift.

Vital signs (stable/unstable): Vital signs were stable for both vitals assessments during my shift 0700 - 1130.

Tolerating diet, activity, etc.: The client was not active during my shift. She was in bed and sleeping most of the time. The client had a catheter so she did not get up to go to the bathroom. The client's diet is normal and not restricted.

Physician notifications: Physician was notified about her potassium being low due to it coming from a finger prick because they wanted to reassess with a new blood sample.

Future plans for patient: Client will be discharged later today 9/27/2021 around 1500.

Discharge Planning (2 points)

Discharge location: The client will be discharged to her home.

Home health needs (if applicable): Client will have hospice come to her home.

Equipment needs (if applicable): Clients will need a wheelchair and walker.

Follow up plan: Follow up plans will be to make an appointment with her primary care provider.

Education needs: The client should be educated on hospice services because she will be having hospice come to her home.

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
● Include full nursing diagnosis with "related to" and	● Explain why the nursing diagnosis was chosen		● How did the patient/family respond to the nurse's actions?

"as evidenced by" components			• Client response, status of goals and outcomes, modifications to plan.
1. Risk for skin breakdown related to bed bound as evidenced by mild braden score.	Client is bed bound due to impaired movement related to her weakness bilaterally in her lower extremities. She states she can't really feel them sometimes.	**1.** Placing pillows or pads under her bony prominences. **2.** Changing the client's position every two hours.	**Goal met:** When moving the client to give her enoxaparin, we were able to put pillows under her bony prominences to decrease the chances of having skin breakdown. **Goal met:** The client was able to be moved every two hours.
2. Risk for constipation related to bed bound as evidenced by the use of pain medications and not having a bowel movement for two days.	The client has opioids (morphine) prescribed to her for pain management and this can cause severe constipation.	**1.** Encouraging the client to eat foods high in fiber and drinking plenty of fluids. **2.** Assessing bowel sounds.	**Goal met:** When talking with the client about not having a bowel movement, it is important she is educated on drinking plenty of fluids and eating a diet high in fiber. **Goal met:** I was able to assess her bowel sounds and heard 5 - 30 in all 4 quadrants for a full minute.
3. Impaired physical mobility related to limited ROM of the legs as evidenced by client's weakness in her legs.	The client had impared physical activity because she has little feeling of her legs and can't walk due to her legs weakness.	**1.** Assess the client's safety in the room to perform physical mobility. **2.** Evaluate the need for assistive devices.	**Goal met:** During my shift I was able to assess her room by making sure it was safe with no clutter or anything obstructing the walkway. **Goal met:** The client needs a wheelchair to get around and a gait belt.

Other References (APA):

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

Concept Map (20 Points):

Objective Data:

1. The client's pulse was a 78 at 0800 and 76 at 1030.
2. Lab values like sodium and potassium were low.
3. Oxygen Saturation of 95%.
4. Client had an IV port on the left upper chest.
5. The clients lung sounds were normal with no use of accessory muscles.

Nursing Diagnosis/outcomes:

1. **Impaired physical mobility related to limited ROM of the legs as evidenced by client's weakness in her legs.**
   - Outcome: Client will be evaluated for assistive devices and the client will need a wheelchair and gait belt for assistance.
2. **Risk for constipation related to bed bound as evidenced by the use of pain medications and not having a bowel movement for two days.**
   - Outcome: Client will increase fluid and fiber intake to relieve constipation.
3. **Risk for skin breakdown related to bed bound as evidenced by mild braden score.**
   - Outcome: Client will be turned every 2 hours to help with skin breakdown.

Subjective Data:

1. The client said she copes with puzzles, TV, and reading books.
2. The client stated a 0/10 based on the numeric pain scale.
3. The client said she is a christian.
4. The client said she lives at home alone and has friends that can come visit her.

Patient Information:
The clinet is a 63 year old caucasian female that was brought into the ER by EMS due to abdominal pain. The client had a bowel obstruction. She had imbalanced electrlytes shown through her lab values.

Nursing Interventions:

1. Placing pillows or pads under her bony prominences.
2. Changing the client's position every two hours.
3. Encouraging the client to eat foods high in fiber and drinking plenty of fluids.
4. Assessing bowel sounds.
5. Assess the client's safety in the room to perform physical mobility.
6. Evaluate the need for assistive devices.