N431 Care Plan 2

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 10/23/2021	**Patient Initials** J. J	**Age** 75	**Gender** Male
Race/Ethnicity Caucasian	**Occupation** Retired from security	**Marital Status** Divorced	**Allergies** No known drug allergies
Code Status Full	**Height** 170.2 cm	**Weight** 88.5 kg	

Medical History (5 Points)

Past Medical History: Diabetes mellitus type 2, diverticulitis, iron-deficiency anemia, benign prostatic hyperplasia (BPH)

Past Surgical History: Colon surgery to correct diverticulitis (2001), cataract surgery- bilateral (2019), Esophagogastroduodenoscopy (09/10/2021), colonoscopy (09/10/2021), hemicolectomy from adenocarcinoma (10/23/2021)

Family History:

Mother- Alzheimer's (deceased)

Father- Myocardial infarction (deceased)

Paternal grandfather- Diabetes mellitus type 2 (deceased)

Maternal grandfather- Emphysema (deceased)

Son- Diabetes mellitus type 1 (living)

Other 5 children- Healthy (living)

Social History (tobacco/alcohol/drugs): Pt smoked three packs a day for 20 years (60 pack/year) but quit in 1991. Patient stated: "I drink 5-6 beers a day and sometimes have a few shots of whiskey too". Patient denied using drugs.

Assistive Devices: Patient uses reading glasses but does not require assistive devices for ambulation.

Living Situation: Patient lives in a home by himself and does not have any pets.

Education Level: Patient graduated from High School and did not attend college.

Admission Assessment

Chief Complaint (2 points): Scheduled hemicolectomy to remove an adenocarcinoma

History of present Illness (10 points): On 09/10/2021, this patient had an esophagogastroduodenoscopy and a colonoscopy to screen for colon cancer. During these procedures, the surgeon identified an adenocarcinoma in the right upper quadrant. This patient denied experiencing pain in his abdomen, aggravating factors, associated symptoms, or trying anything to reduce the pain or symptoms. On 10/23/2021, he arrived at Union Hospital for a scheduled hemicolectomy. This surgery was the first treatment that he received for the adenocarcinoma. He was admitted to the medical-surgical unit afterward.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Colorectal adenocarcinoma

Secondary Diagnosis (if applicable):

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

Cancer results from DNA mutations, which turn on oncogenes resulting in rapid cellular growth (Capriotti, 2020). Cancer can affect many organs, including the colon. Colon cancer is the third most common cause of death in the United States (American Cancer Society, 2021). Each year, 104,270 new cases are diagnosed (American Cancer Society, 2021). Ninety-five percent of colon cancers start out as adenocarcinomas which are benign polyps in the epithelial

lining of the intestine (Hinkle & Cheever, 2018). However, they can become cancerous and spread to the blood vessels, lymphatic nodes, and other body parts, which is why current guidelines recommend period screening between the ages of 50 and 74 (Hinkle & Cheever, 2018). Screening tests include a rectal examination, fecal occult testing, and colonoscopy (Hinkle & Cheever, 2018). The frequency of these tests varies depending on the individuals' risk factors (Hinkle & Cheever, 2018).

Most cases of colon cancer are diagnosed between 65 and 74, which is why increasing age is the most significant risk factor (Hinkle & Cheever, 2018). Additional risk factors include male gender, family history, smoking, excessive alcohol consumption, and history of inflammatory bowel disease or type two diabetes (Hinkle & Cheever, 2018). Individuals with colon cancer can experience no symptoms or elimination pattern changes, melena, abdominal pain, weight loss, and fatigue (Capriotti, 2020). Colon cancer is diagnosed by colonoscopy, barium enema, CT scan, and MRI (Capriotti, 2020). Treatment includes a colectomy, which removes the tumor and part of the colon, radiation, and chemotherapy (Capriotti, 2020). Following surgical removal, patients must have a colonoscopy every three months to continue monitoring for new growths (Capriotti, 2020).

My patient was at high risk for colon cancer because of his gender, age, excessive alcohol consumption, and history of diverticulitis and type two diabetes. He did not experience any abdominal pain or other symptoms that indicated that he had colorectal adenocarcinoma. It was discovered during a routine colonoscopy on 09/10/2021. He has a minor medical history which made him a good candidate for surgery. The hemicolectomy was performed on 10/23/2021, and he was admitted to the medical-surgical unit afterward. Following the surgery, he developed paralytic ileus, which he is currently being treated for.

Pathophysiology References (2) (APA):

American Cancer Society. (2021, January 12). *Key statistics for colorectal cancer*. https://www.cancer.org/cancer/colon-rectal-cancer/about/key-statistics.html

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). 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 Done on 10/24/2021	Today's Value Done on 10/26/2021	Reason for Abnormal Value
RBC	4-6.6	3.03	3.43	My patient has iron-deficiency anemia. Iron is needed for RBC synthesis (Capriotti, 2020).
Hgb	14-18	7.1	8	My patient has iron-deficiency anemia. Iron is needed for RBC synthesis (Capriotti, 2020).
Hct	42-54	23.6	25.6	My patient has iron-deficiency anemia. Iron is needed for RBC synthesis (Capriotti, 2020).
Platelets	150-450	268	284	
WBC	4.5-10.8	9.7	8	
Neutrophils	60-80%	79.3	68.2	
Lymphocytes	20-40%	21	23	
Monocytes	3-13%	8.8	9.4	

Eosinophils	0-8.0%	0.3	1.8	
Bands	0-0.5	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-	134-144	133	133	Damage to the skin decreases its ability to maintain water and electrolyte balance (Capriotti, 2020). My patient has a large midline incision which is allowing water and electrolytes to exit the body. My patient is also taking pantoprazole which can cause hyponatremia (Jones & Bartlett Learning, 2020).
K+	3.5-5.2	4.18	3.94	
Cl-	96-106	100	96	
CO2	20-29	22.5	23.8	
Glucose	65-99	175	133	My patient has diabetes mellitus type 2 which causes elevated serum glucose levels when improperly managed (Hinkle & Cheever, 2018).
BUN	8-27	5	7	Low BUN levels can occur from poor protein intake/metabolism (Hinkle & Cheever, 2018). My patient was on a clear liquid diet following surgery which could explain the low protein intake. He also consumes alcohol daily which causes malnutrition which could explain his low protein and iron levels (Hinkle & Cheever, 2018).
Creatinine	0.76-1.27	0.69	0.65	Low creatinine levels can occur from poor protein intake/metabolism (Hinkle & Cheever, 2018). My patient was on a clear liquid diet following surgery which could explain the low protein intake. He

				also consumes alcohol daily which causes malnutrition which could explain his low protein and iron levels (Hinkle & Cheever, 2018).
Albumin	3.7-4.7	3.1	3	Low albumin levels can result from surgical trauma and cancer (Hinkle & Cheever, 2018). My patient just had major abdominal surgery to remove an adenocarcinoma. Low albumin levels indicate poor protein consumption (Capriotti, 2020). Malnutrition can result from chronic alcohol consumption (Hinkle & Cheever, 2018).
Calcium	8.6-10.2	8	8.3	Decreased calcium levels can occur when albumin levels are low because calcium binds to albumin in the blood (Capriotti, 2020).
Mag	1.3-3	N/A	N/A	
Phosphate	44-147	N/A	N/A	
Bilirubin	0-1.2	0.4	0.4	
Alk Phos	48-121	68	66	
AST	0-40	17	18	
ALT	0-44	21	14	
Amylase	30-110	N/A	N/A	
Lipase	0-160	N/A	N/A	
Lactic Acid	0.5-2.2	N/A	N/A	
Troponin	<0.4	N/A	N/A	
CK-MB	5-25	N/A	N/A	
Total CK	26-174	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	N/A	N/A	
PT	9.5-11.3	N/A	N/A	
PTT	20-39	N/A	N/A	
D-Dimer	<250	N/A	N/A	
BNP	<100	N/A	N/A	
HDL	>60	N/A	N/A	
LDL	<130	N/A	N/A	
Cholesterol	<200	N/A	N/A	
Triglycerides	<150	N/A	N/A	
Hgb A1c	4-5.6% Diabetic- <7%	N/A	N/A	
TSH	0.4-1.4	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 and clear	N/A	N/A	
pH	5.0-7.0	N/A	N/A	
Specific Gravity	1.003-1.005	N/A	N/A	
Glucose	Negative	N/A	N/A	
Protein	Negative	N/A	N/A	
Ketones	Negative	N/A	N/A	
WBC	0-25	N/A	N/A	

RBC	0-20	N/A	N/A	
Leukoesterase	Negative	N/A	N/A	

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

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
pH	7.35-7.45	N/A	N/A	
PaO2	80-100	N/A	N/A	
PaCO2	35-45	N/A	N/A	
HCO3	22-26	N/A	N/A	
SaO2	95-100%	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	
Blood Culture	Negative	N/A	N/A	
Sputum Culture	Negative	N/A	N/A	
Stool Culture	Negative	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.

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):

10/27/2021- Kidney-ureter-bladder (KUB) x-ray found abnormal loops in the small bowel indicating a small bowel obstruction or significant ileus.

Diagnostic Test Correlation (5 points):

A KUB x-ray provides images of the abdomen, pelvis, kidneys, ureters, and bladder (Capriotti, 2020). This is ordered to visualize masses in the abdomen and pelvis and stones in the urological system (Capriotti, 2020). This patient began experiencing belching, abdominal pain, and vomiting at three this morning. He was also not passing gas or feces. A KUB x-ray was performed to visualize the small intestine to rule out/confirm suspected paralytic ileus.

Diagnostic Test Reference (1) (APA):

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

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

Home Medications (5 required) : This patient only takes three drugs at home

Brand/Generic	Fortamet metformin HCl/	Hytrin/ terazosin HCl	Feosol/ ferrous sulfate		
Dose	1000 mg	5 mg	325 mg		
Frequency	BID	Daily HS	BID		
Route	PO	PO	PO		
Classification	Biguanide/antidiabetic	Alpha adrenergic blocker, benign prostatic hyperplasia agent	Hematinic/antianemic		
Mechanism of Action	Reduces glucose production by promoting glycogen storage in the liver. This drug may also increase glucose transport across adipose cell membranes making it easier for the body to use	Promotes vasodilation by blocking the alpha-adrenergic receptors in the bladder neck to increase urine flow	Normalizes RBCs by binding to hemoglobin		
Reason Client Taking	To reduce serum glucose levels because he has diabetes mellitus type 2	To improve urine flow because he has an enlarged prostate which makes it difficult to urinate	To replace iron in the body needed for RBC synthesis because this client has iron-deficiency anemia		
Contraindications (2)	Advanced renal disease, metabolic acidosis	Hypersensitivity to terazosin, other quinazolines, or their components, orthostatic hypotension	Hemochromatosis, hemolytic anemia		
Side Effects/Adverse Reactions (2)	Hypoglycemia, hepatic injury	Hypotension, dizziness	Hypotension, angioedema		
Nursing Considerations (2)	Withhold the drug 48 hours before and after testing involving contrast Monitor for lactic acidosis (s/s: abdominal pain, malaise, myalgias, respiratory distress)	Elderly patients can experience exaggerated adverse reactions and hypotension from this drug. The dosage of this drug should be reduced if the patient is also taking a diuretic or antihypertensive	Give iron tablets with a full glass of water or juice Give one hour before or two hours after meals to maximize absorption		
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain patients' blood glucose levels prior to administering and assess for symptoms of hypoglycemia.	Check blood pressure because it can cause hypotension Take pulse because this drug can cause	Check blood pressure before giving this drug because it can cause hypotension Assess for abdominal pain,		

	Assess for signs of dehydration which increases the risk of developing lactic acidosis	tachycardia	diarrhea, N/V which indicate iron toxicity		
Client Teaching needs (2)	Check blood glucose levels regularly, avoid alcohol because it increases the risk of developing hypoglycemia	Take this drug at the same time each night Change positions slowly to prevent syncope	Take medication with a full glass of orange juice to increase absorption Stools should become dark green or black, if they do not, notify the provider		

Hospital Medications (5 required):

Brand/Generic	Lovenox/enoxaparin sodium	Protonix/ pantoprazole	Zofran/ ondansetron HCl	Humalog/Insulin lispro	Norco/ hydrocodone bitartrate/ acetaminophen
Dose	40 mg	40 mg	4 mg	Sliding scale based on blood glucose level	5-325 mg
Frequency	Daily	Daily	Q4H PRN	PRN	Q4H PRN
Route	Subcutaneous	Intravenous	Intravenous	Subcutaneous	Oral
Classification	Low-molecular weight heparin/anticoagulant	Proton pump inhibitor/antiulcer	Selective serotonin receptor antagonist/antiemetic	Rapid-acting insulin/ antidiabetic/hormone	Opioid/ opioid and non-opioid analgesic
Mechanism of Action	Binds to and inactivates Factor Xa and thrombin to prevent clot formation	Inhibits the hydrogen-potassium-adenosine triphosphatase system in gastric cells to reduce gastric acid production	Prevents serotonin release in the small intestine to reduce nausea and vomiting	Brings glucose into the cells so the body can use it	Binds to and activates opioid receptors at sites in the periaqueductal and periventricular gray matter, the ventromedial medulla, and the spinal cord to reduce pain.

Reason Client Taking	To prevent deep-vein thrombosis because he just had surgery and has reduced mobility	To treat gastroesophageal reflux disease (GERD). This patient does not have a history of GERD but experienced heartburn while hospitalized due to decreased gastrointestinal motility.	To prevent and reduce nausea and vomiting. This patient was giving this drug following surgery and to relieve nausea and vomiting that occurred from an intestinal blockage	To reduce blood glucose levels from diabetes mellitus type 2	To treat postsurgical pain
Contraindications (2)	Active major bleeding, heparin-induced thrombocytopenia within the last 100 days, allergy to pork	Concurrent therapy with rilpivirine-containing products, hypersensitivity to pantoprazole or its components	Congenital long QT syndrome, concurrent use of apomorphine	Hypoglycemia, hypersensitivity to lispro or its components	Acute or severe bronchial asthma or hypercarbia, suspected paralytic ileus
Side Effects/Adverse Reactions (2)	Purpura, persistent bleeding from surgical wounds	Hyperglycemia, hyponatremia	Bronchospasms, arrhythmias	Local allergic reaction, lipodystrophy	CNS depression, Respiratory depression.
Nursing Considerations (2)	Watch closely for bleeding and notify provider if platelet count falls below 100,000 Keep protamine sulfate nearby in case of accidental overdose	Reconstitute this drug with 10 mL of normal saline and give over 2 minutes Monitor for decreased urine output or blood in the urine because this drug can cause acute interstitial nephritis	Drug is not diluted when giving intravenously for postoperative nausea and vomiting Monitor closely for signs of anaphylaxis and bronchospasm	Only mix with NPH insulin Draw up rapid-acting insulin into the syringe first	Know that hydrocodone should not be given to patients with impaired consciousness, nor should the drug be administered on an as-needed basis. Use cautiously in elderly patients, as they are at increased risk for respiratory depression.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Review platelet and potassium levels before giving. Enoxaparin can cause hyperkalemia	Review sodium and magnesium labs because these values can decrease while taking this drug Test blood glucose because this drug can cause hyperglycemia	Review potassium and magnesium levels. Low levels of these electrolytes need to be corrected before giving this drug because it can cause arrhythmias Monitor EKG for prolonged QT interval before	Check blood glucose before administering to prevent hypoglycemia Assess abdomen for lipodystrophy and avoid areas bruised or painful	Assess pain level before administering Assess respirations because this drug cannot be given if they are less than 12 Assess bowel

			giving this drug		sounds because this drug can cause constipation
Client Teaching needs (2)	Inform provider about unexplained bruising or bleeding from the gums Taking NSAIDs or aspirin increases the risk of bleeding while using this drug	Notify provider about diarrhea because this drug can cause Clostridium difficile Notify provider if urine output decreases while on this medication	Report signs of allergic reaction Seek immediate medical attention if you experience unusual, severe, or persistent symptoms	Do not rub injection site rotate injection site	Do not consume alcohol while taking this medication because it increases the risk of overdose and respiratory depression Consume adequate fluids and high-fiber foods to prevent constipation

Medications Reference (1) (APA):

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

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:**	A&O x 4

Distress: **Overall appearance:**	No acute distress noted. This patient is well-groomed
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☒ N ☐** **Type:**	 Pink Dry Warm Skin turgor assessed with immediate recoil No rashes or bruises noted Large midline incision from the sternum to a few inches below the umbilicus 16, deducted for nutrition because he is currently NPO because of paralytic ileus. I also deducted one for activity because he did not leave the bed during my shift. However, the nurse told me that he walks without difficulty. The patient told me that yesterday he walked several laps around the floor but was not feeling up to it today. Nasogastric (NG) tube placed in the left naris on 10/27/2021.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Head and neck symmetrical. The trachea is midline without deviation. No lymphadenopathy inspected or palpated. Thyroid is nonpalpable. Bilateral auricles are pink without drainage or lesions noted. Bilateral PERRLA. Intact EOMs bilaterally. Sclera is white. Conjunctiva is pink. The nose is free of discharge and lesions. Dentition is poor with several teeth missing on the lower left and lower right. Throat is pink, moist, and without lesions. Tonsils 1+.
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	 Clear S1 and S2 heart sounds. No audible murmur, gallops, or rubs noted. Pulses 2+ throughout bilaterally. Capillary refill normal, less than 3 seconds. No edema inspected or palpated in extremities.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breath sounds even, regular and nonlabored bilaterally. No crackles, wheezes, or rhonchi 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 ☒** **Nasogastric: Y ☒ N ☐** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Low sugar, but patient stated that he eats out frequently. He was previously on a clear liquid diet but that was changed to NPO because of suspected paralytic ileus 170.2 cm 88.5 kg Hypoactive in all 4 quadrants 10/25/2021 Abdomen tender to light palpation in all 4 quadrants. No masses or organomegaly noted. Abdomen was firm with abdominal distention noted. Large midline incision with staples and abdominal binder. Serosanguinous drainage coming from the wound. No erythema noted. Large vertical scar under umbilicus from previous colon surgery Size: 12, length: 62 cm, location: left naris, confirmed by aspiration and auscultation and secured by tape. Brown/green output via low-intermittent suction
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Patient did not void during my shift because he has been NPO since 0900 and has not received fluids since early this morning. Patient reported a scant amount of pale-yellow urine this morning. Genitalia clean without rashes or lesions.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	 Normal, no neurological deficits noted. Full ROM in upper and lower extremities bilaterally. Equal and firm grips in upper extremities bilaterally. Equal and firm pedal pushes/pulls in lower extremities bilaterally. Patient does not use assistive devices and is a standby assist 20 Although he is not currently receiving fluids, he is NPO which can cause him to experience dizziness while ambulating. Therefore, fall precautions are still in place.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐**	Equal and firm grips in upper extremities bilaterally. Equal and firm pedal pushes/pulls in

PERLA: Y ☒ N☐ **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	lower extremities bilaterally. Oriented to person, place, time, and situation. Cognitive with clear speech. Normal sensory response in upper and lower extremities bilaterally. Alert
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):**	Patient enjoys watching television and having a few beers to unwind. No developmental delays observed. Patient attends First Assembly of God but does not attend weekly. He lives alone and does everything by himself, including yard work. He picks up his grandchildren from school M-F which allows him to see them often. He sees one of his sons almost every day when he comes to pick up his children. He sees his other five children a few times a month.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1430	81 Right radial	116/74 Right arm	18	97.3 F Oral	94% Room air
1705	80 Right radial	128/78 Right arm	16	99.3 F Oral	93% Room air

Vital Sign Trends: Vital signs were stable during my shift. His temperature had spiked from his baseline so I informed his nurse so she could continue to monitor for infection.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1430	Numerical	Throat	3/10	Patient stated: "It just hurts from this tube".	I brought him ice chips. 1530- The patient stated that his throat felt better and was a 2/10.
1705	Numerical	Abdomen (incision)	4/10	Patient stated: "My incisions burn".	I Informed the nurse about his pain, but she did not give him any pain medication before I left.

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:**	18 g- saline lock Left hand 10/22/2021 Patent, I flushed the IV during my assessment. No signs of erythema or drainage noted. Dressing is clean, dry, and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
0- Patient is NPO	1600 brown/green drainage from NG tube since 1155. 600 mLs of output during my shift. Patient did not void during my shift

Nursing Care

Summary of Care (2 points):

Overview of care: I took two sets of vitals on this patient, assessed his pain, and made sure that he was comfortable in bed. I brought him ice chips for his sore throat and informed the nurse about his incisional pain. The nurse administered subcutaneous enoxaparin, but his other drugs were withheld because he is NPO. I educated this patient about ambulating and changing positions to increase peristalsis and to splint his abdomen with movement.

Procedures/testing done: This patient left the room at 1400 for a KUB x-ray for suspected paralytic ileus.

Complaints/Issues: This patient reported mild pain and discomfort in his throat and abdomen. He received ice chips for his throat but did not receive pain medication before I left for the day.

Vital signs (stable/unstable): Patient's vital signs were stable during my shift.

Tolerating diet, activity, etc.: Patient did not leave the bed during my shift other than to go down to radiology. He did not void during my shift because he did not intake any fluids by mouth or IV.

Physician notifications: The nurse did not contact the physician regarding this patient.

Future plans for patient: Ambulate as tolerated to help improve bowel function and prevent thrombi formation. Remain NPO until peristalsis returns or surgical intervention is required.

Discharge Planning (2 points)

Discharge location: Home. Currently, there is not a discharge date set for this patient.

Home health needs (if applicable):

Equipment needs (if applicable):

Follow up plan: Follow up with his primary physician and surgeon that performed the hemicolectomy.

Education needs: Balanced nutrition, diabetes management, risk for infection, reduce alcohol consumption, wound management

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. Impaired skin integrity related to hemicolectomy as evidenced by large, painful midline incision	Skin protects the body from microbes, helps regulate body temperature, and maintains electrolyte balance (Capriotti, 2020). If the skin is impaired, the patient is at risk for infection, hypothermia, and electrolyte imbalance.	1.Monitor incisions daily for color changes, warmth, redness, and swelling which indicate infection. 2.Educate patient on changing positions slowly and splinting abdomen with movements especially coughing to prevent incisions from re-opening.	Goal met- Surgical incision was assessed during my physical assessment. It was dry, and clean, and was not red, warm, or swollen Goal met- During my assessment, I educated the patient about changing positions slowly and the importance of splinting the abdomen with movement and actions that increase abdominal pressure
2. Dysfunctional gastrointestinal motility related to hemicolectomy as evidenced by findings of paralytic ileus, abdominal distention, hypoactive	If this postoperative complication is not addressed this patient's bowel could necrose or rupture which could cause peritonitis	1. Encourage physical activity and positional changes to promote peristalsis 2.Inspect nasogastric tube to ensure it is functioning correctly which will help clear the intestinal blockage	Goal met- During my assessment I encouraged the patient to change positions in bed and ambulate as tolerated to help promote bowel elimination. He stated that he did not feel like ambulating today because he was uncomfortable but would frequently change

bowel sounds, and inability to pass gas or stool for the last two days			positions in bed. Goal met- I assessed the nasogastric tube when assessing the patient's vital signs. It was intermittently suctioning and consistently removing green/brown fluid from the patient's stomach.
3. Acute pain related to nasogastric tube and midline incision as evidenced by patient's numerical pain ratings of 3/10 and 4/10	Acute pain impairs comfort, rest, and healing.	**1.**.Assess patient's pain using OLDCART and numerical pain scale **2**.Administer analgesics as prescribed and provide non-pharmacological pain relief methods. Document the patient's response to the inventions using the pain scale.	Goal met- Patient's pain level and characteristics were assessed while assessing his vitals. Goal partially met- I informed the nurse about this patient's pain but analgesics were not administered before I left. I gave the patient ice chips to help with his throat discomfort and assessed his pain again at 1530. His pain rating decreased from a 3/10 to a 2/10 after my intervention.
4. Risk for infection related to inadequate defenses as evidenced by midline incision	Infection is a serious complication that patients can develop following invasive surgeries	1. Assess vital signs every 4 hours for increases in temperature, heart rate, and respiratory rate which can indicate the patient has developed an infection 2. Monitor white blood cell count and provide wound care as ordered	Goal met- I assessed the patient's vital signs twice during my shift. His temperature had increased so I informed the nurse so that she could continue monitoring his vital signs for changes. Goal partially met- This patient's WBCs were within the normal range when I checked them during my shift. I did not clean the incision during my shift.

Other References (APA):

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

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

Concept Map (20 Points):

Subjective Data

"It just hurts from this tube".
"My incisions burn".
Patient reported that he has not passed gas or had a bowel movement since 10/25/2021.
Patient reported throat pain of 3/10 and abdominal pain of 4/10.

Nursing Diagnosis/Outcomes

Impaired skin integrity related to hemicolectomy as evidenced by large, painful midline incision
Outcome: Before discharge, the wound will decrease in size and demonstrate increased granulation.
Dysfunctional gastrointestinal motility related to hemicolectomy as evidenced by findings of paralytic ileus, abdominal distention, hypoactive bowel sounds, and inability to pass gas or stool for the last two days
Outcome: Before discharge, the patient will demonstrate normal bowel elimination evidenced by active bowel sounds, absence of abdominal distention, and elimination of soft stools.
Acute pain related to nasogastric tube and midline incision as evidenced by patient's numerical pain ratings of 3/10 and 4/10
Outcome: The patient's pain intensity will decrease as evidenced by her numerical pain rating within 1 hour.
Risk for infection related to inadequate defenses as evidenced by midline incision
Outcome: The patient's surgical incision will remain free of swelling, redness, and warmth while hospitalized.

Objective Data

Large midline incision with staples and abdominal binder
Hypoactive bowel sounds
Abdominal distention
Abdomen tender to palpation in all four quadrants
KUB x-ray findings: abnormal loops in small intestine indicating obstruction or significant ileus
NG tube in left naris set to low intermittent suction

Patient Information

On 10/22/2021, a 75-year-old male with a history of diabetes, diverticulitis, iron-deficiency anemia, BPH, and adenocarcinoma presented to Union Hospital to undergo a hemicolectomy

Nursing Interventions

1.Monitor incisions daily for color changes, warmth, redness, and swelling which indicate infection.
2.Educate patient on changing positions slowly and splinting abdomen with movements especially coughing to prevent incisions from re-opening.
1. Encourage physical activity and positional changes to promote peristalsis
2.Inspect nasogastric tube to ensure it is functioning correctly which will help clear the intestinal blockage
1.Assess patient's pain using OLDCART and numerical pain scale
2. Administer analgesics as prescribed and provide non-pharmacological pain relief methods. Document the patient's response to the inventions using the pain scale.
1. Assess vital signs every 4 hours for increases in temperature, heart rate, and respiratory rate which can indicate the patient has developed an infection
2. Monitor white blood cell count and provide wound care as ordered