N321 Care Plan # 1 (Redo)

Lakeview College of Nursing

Name: Kati Davis

Demographics (3 points

Date of Admission *3/18/22*	**Client Initials** *K. L*	**Age** *26*	**Gender** *M*
Race/Ethnicity *White/ Non-Hispanic or Latino*	**Occupation** *Not employed*	**Marital Status** *Single*	**Allergies** *NKA*
Code Status *FULL*	**Height** *5'10"*	**Weight** *138lbs*	

Medical History (5 Points)

Past Medical History: *The client has a PMH of type II diabetes mellitus, HTN, anxiety, depression, hyperlipidemia, chronic pancreatitis, hepatitis, hiatal hernia, and esophageal ulcer.*

Past Surgical History: *The client has a PSH that includes an endoscopic ultrasound (2021,) and Upper GI endoscopy (2022).*

Family History: *Family history includes hypertension in his mother. There is ADHD in multiple relatives on his mother's side. His uncle on his mother's side died from complications related to alcohol use. There is no family history of suicide attempts. A history of depression and anxiety disorder is noted in his other in Care Everywhere.*

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use): *Childhood developmental issues* - *grew up with stepfather (who was present from infancy) and mother. Stepfather was not as present as much as he ideally should have been, due to work, but no issues in that relationship. Mother and stepfather split up around the time patient was 10 years old; mother realized she was lesbian and subsequently entered a relationship with a woman. The patient did not adjust well to this change.*

Substance abuse: The patient has heavily used alcohol since age 18, with amounts of up to 1.5 gallons of spirits daily. The patient denies the use of tobacco. The patient denies the use of cannabis. Mother states the patient has used many illicit substances in the past; there is documentation of methamphetamine abuse, heroin abuse, cocaine abuse, and ecstasy abuse in Care Everywhere. On 3/18/22, the patient reported he uses methamphetamines IV. Last use was the day before his admission (3/17/22).

Assistive Devices: *Gait belt was present if needed.*

Living Situation: *Lives with the mother of his child but also occasionally stays with his mother.*

Education Level: *High School graduate*

Admission Assessment

Chief Complaint (2 points): *Abdominal pain and feeling unwell.*

History of Present Illness – OLD CARTS (10 points): *Mr. Luedeke is a 26-year-old male with a previous medical history of diabetes, hypertension, hyperlipidemia, chronic alcohol pancreatitis, and methamphetamine abuse who presents to the ED with abdominal pain, nausea, vomiting, and generalized weakness and fatigue. The patient reports that his symptoms have progressively worsened over the last week or so. The patient was admitted a month ago for similar symptoms. He was found to have gastric outlet obstruction, presume to extrinsic mass. He left AMA prior to the completion of the workup. Was doing well initially post-hospital stay but has subsequently worsened. He endorses significant generalized/ epigastric abdominal pain, worse after eating meals. He has no appetite. He has nausea with vomiting. He reports black emesis for the last 3 days. No melena or hematochezia. He is still passing*

flatus and having normal movements, although they are loose. He reports poor compliance with his insulin. He does report compliance with his Creon. No fevers. He also endorses some chest pain, but without difficulty breathing. Over the last year, the patient has unintentionally lost 140 pounds.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): *Gastric outlet obstruction*

Secondary Diagnosis (if applicable): *Esophageal ulcer w. bleeding*

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

My patient suffers from gastric outlet obstruction (GOO). Gastric outlet obstruction is also known as pyloric obstruction. One may know they have gastric outlet obstruction if they experience symptoms such as nausea, epigastric pain, nonbilious vomiting, weight loss, and abdominal distention. My patient presented to the ED with complaints of many of these hallmark symptoms. The patient came to the ED with concern of abdominal pain, nausea, and vomiting. The patient has also had a 140lb unintentional weight loss within the last year. Peptic ulcer disease, gastric polyps, caustic ingestion, pyloric stenosis, gallstone blockage, congenital duodenal webs, and pancreatic pseudocysts, are the most common benign cause of gastric outlet obstruction. Patients who suffer from gastric outlet obstruction are often malnourished and dehydrated and have metabolic insufficiency. This is consistent with what the patient presents. The patient states he has no appetite at home which can cause malnourishment. The lack of nutrients can also cause fluid

and electrolyte imbalance and can in turn present dehydration. Hospitalization is required for all patients who present with symptoms of gastric outlet obstruction. The initial priority should be fluid restoration with normal saline and electrolyte balance restoration. During hospitalization, nasogastric decompression should begin. Again, this is consistent with the patient's treatment plan. The patient is on a clears diet with NPO after midnight, it is noted a priority of care is replacing the patient's potassium, and an NG tube was placed and begun. The nasogastric tube is placed to relieve discomfort and pain caused by gastric distention. If gastric outlet obstruction is irreparable with medical treatment, a long-term solution is needed to address the underlying cause.

Pathophysiology References (2) (APA):

FF;, K. A. H. P. W. C. S. (n.d.). *Gastric outlet obstruction: A red flag, potentially manageable*. Cleveland Clinic journal of medicine. Retrieved March 28, 2022, from https://pubmed.ncbi.nlm.nih.gov/31066665/

Jeong, S. J., & Lee, J. (2020, June 9). *Management of gastric outlet obstruction: Focusing on endoscopic approach*. World journal of gastrointestinal pharmacology and therapeutics. Retrieved March 28, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7288729/

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	*3.50 – 5.20*	*4.31*	*3.78*	
Hgb	*12.0-18.0*	*11.9 v*	*10.3 v*	The patient has an esophageal ulcer with bleeding. Due to the blood loss, the patient could experience iron deficiency anemia (Gasche et al., 2004). This would lower the hemoglobin levels.
Hct	*34.0 – 47.0%*	*36.0*	*30.8 v*	A low hematocrit can indicate an insufficient supply of healthy red blood cells (Gasche et al., 2004). This could be a result of the patient's esophageal ulcer with bleeding.
Platelets	*140-400*	*241*	*196*	*WNL*
WBC	*4.00 – 11.00*	*N/A*	*6.64*	*WNL*
Neutrophils	*47.0 – 73.0%*	*N/A*	*N/A*	*N/A*
Lymphocytes	*18.0 – 42.0%*	*18.0*	*33.1*	*WNL*
Monocytes	*4.0 – 12.0%*	*4.4*	*6.6*	*WNL*
Eosinophils	*0.0 – 5.0%*	*0.4*	*0.8*	*WNL*
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-	*136 – 145 mmol/L*	*N/A*	*136*	*WNL*

K+	*3.5 – 5.1 mmol/L*	*N/A*	*3.5*	*WNL*
Cl-	*98 – 107 mmol/L*	*N/A*	*95 v*	A low chloride level could be caused by fluid loss (Leeuwen and Bladh, 2021). Patient did report having loose stools, which could be the cause of this lowered level.
CO2	*22.0 – 29.0 mmol/L*	*N/A*	*29*	*WNL*
Glucose	*74 – 100 mg/dL*	*N/A*	*103 ^*	Glucose is very slightly elevated. When labs were drawn, there may have been too much sugar in the bloodstream at the time. The patient may not have taken insulin yet; he has diabetes (Leeuwen and Bladh, 2021).
BUN	*10 – 20 mg/ dL*	*N/A*	*11*	*WNL*
Creatinine	*0.55 – 1.02 mg/dL*	*N/A*	*0.55*	*WNL*
Albumin	*3.4 – 5.0 g/dL*	*2.5 v*	*N/A*	Patient has a history of alcoholism. Daily alcohol consumption may inhibit protein synthesis; albumin is the main protein found in our blood (Leeuwen and Bladh, 2021).
Calcium	*8.9 – 10.6 mg/dL*	*8.5 v*	*8.2 v*	Hypocalcemia can be a result of alcoholism (Leeuwen and Bladh, 2021). The patient has a history of alcohol abuse.
Mag	*1.6 – 2.6 mg/dL*	*N/A*	*1.9*	*WNL*

Phosphate	*N/A*	*N/A*	*N/A*	*N/A*
Bilirubin	*0.2 – 1.2*	*1.5 ^*	*1.7 ^*	Higher bilirubin level can be a result from poor liver function (Leeuwen and Bladh, 2021). Patient could have underlying liver issues from alcohol abuse.
Alk Phos	*40-150*	*91*	*121*	*WNL*
AST	*5 - 34*	*16*	*18*	*WNL*
ALT	*0 - 55*	*19*	*27*	*WNL*
Amylase	*N/A*	*N/A*	*N/A*	*N/A*
Lipase	*N/A*	*N/A*	*N/A*	*N/A*
Lactic Acid	*0.50 – 2.20 mmol/L*	*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	*0.9 – 1.1*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
PT	*11.7 – 13. Sec*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*

PTT	*22.4 – 35.9 Sec*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
D-Dimer	*45 – 500 ng/ mL*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
BNP	*N/A*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
HDL	*N/A*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
LDL	*N/A*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
Cholesterol	*N/A*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
Triglycerides	*N/A*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
Hgb A1c	*N/A*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
TSH	*0.350 – 4.940 U*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*

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	*Colorless – yellow*	*Light yellow/clear*	*N/A*	*WNL*
pH	*5 – 9*	*6.0*	*N/A*	*WNL*
Specific Gravity	*1.003 – 1.035*	*1.032*	*N/A*	*WNL*
Glucose	*(-)*	*> = 500 !*	*N/A*	Not enough insulin in the body at the time the urine sample was

				taken (Leeuwen and Bladh, 2021).
Protein	*(-)*	*(-)*	*N/A*	*WNL*
Ketones	*(-)*	*50 !*	*N/A*	The body cannot utilize sugar correctly for energy if you do not have enough insulin. This causes the production of hormones that break down fat for fuel, resulting in ketones in the urine, which are acids (Leeuwen and Bladh, 2021). The patient is diabetic.
WBC	*0-25*	*6*	*N/A*	*WNL*
RBC	*0-20*	*0*	*N/A*	*WNL*
Leukoesterase	*(-)*	*(-)*	*N/A*	*WNL*

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	*Nothing detected*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
Blood Culture	*Nothing detected*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
Sputum Culture	*Nothing detected*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*
Stool Culture	*Nothing detected*	*N/A*	*N/A*	*No values were recorded on admission day or day of assessment.*

Lab Correlations Reference (1) (APA):

(Ascp), M. B. M. L. A. V. M., & Msn, R. M. B. L. (2021). *Davis's Comprehensive Manual of Laboratory and Diagnostic Tests with Nursing Implications (Davis's Comprehensive Manual of Laboratory & Diagnostic Tests with Nursing Implications)* (9th ed.). F.A. Davis Company.

Gasche, C., Lomer, M. C. E., Cavill, I., & Weiss, G. (2004, August). *Iron, anaemia, and inflammatory bowel diseases*. Gut. Retrieved March 28, 2022, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1774131/

Diagnostic Imaging

All Other Diagnostic Tests (5 points): *EGD. This was ordered on the day of assessment (3/24/22); pending results.*

Diagnostic Test Correlation (5 points): *EGD is short for esophagogastroduodenoscopy. An endoscope is used to inspect the lining of the esophagus, stomach, and duodenum during an EGD. A provider may order an EGD test if the client is experiencing certain symptoms such as: vomiting blood, unexplained anemia, pain in the upper abdomen, regurgitating food, black or tarry stools, and unexplained weight loss. These fall in line with the patient's symptoms. The patient has black emesis, which can indicate a bleed, he has unintentionally lost 140 pounds in the last year, and his hemoglobin and hematocrit levels are low which could indicate potential anemia. This test is going to be done in hopes of finding an appropriate treatment for the patient's gastric outlet obstruction.*

Diagnostic Test Reference (1) (APA):

Day, J. A. (2017, April 26). *Esophagogastroduodenoscopy (EGD)*. Johns Hopkins Division of Gastroenterology and Hepatology. Retrieved March 28, 2022, from https://www.hopkinsmedicine.org/gastroenterology_hepatology/clinical_services/basic_endoscopy/esophagogastroduodenoscopy.html

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

Home Medications (5 required

Brand/Generic	amLODIPine/ (Norvasc)	carvedilol/ (coreg)	Insulin Lispro/ (Humalog Kwikpen0	Lantus solostar pen	Pancrelipase/ (creoniz)
Dose	10mg	25mg	18 units	40 units	8 capsules
Frequency	Daily	2 times daily	3 times daily	Daily @ bedtime	3 times daily
Route	Oral	Oral	Subcutaneous	Subcutaneous	oral
Classification	antihypertensive	Nonselective beta blocker and alpha- 1 blocker	Antidiabetics, Rapid acting insulins	Long-acting insulin	Enzymes

Mechanism of Action	Binds to dihydropyridine and nondihydropyridine cell membrane receptor sites on myocardial and vascular smooth-muscle cells and inhibits influx of extracellular calcium ions across slow calcium channels. This decreases intracellular calcium level, inhibiting smooth-muscle cell contractions and relaxing coronary and vascular smooth muscles, decreasing peripheral vascular resistance, and reducing systolic and diastolic blood pressure.	Reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload.	Binds to a glycoprotein receptor on the surface of the cell.	Promotes movement of sugar from blood into body tissues and also stops sugar production in liver.	Following activation in the alkaline pH of the duodenum, pancrelipase releases high levels of lipase, amylase, and protease, which facilitate the hydrolysis of fats into glycerol and fatty acids, starches into dextrins and sugars, and proteins into peptides
Reason Client Taking	This is used to help lower the client's hypertension.	This is used to treat hypertension.	Client is diabetic. Body resists insulin and needs to take insulin to keep blood glucose levels within desired	Client is diabetic. Body resists insulin and needs to take insulin to keep blood glucose levels within desired	This helps improved food digestion in certain conditions, where the pancreas is not working properly.

			range.	range.	
Contraindications (2)	1) Hypersensitivity to amlodipine 2) or its components	1) bronchial asthma 2) Stevens Johnson syndrome	1) Hypoglycemia 2) Hypokalemia	1) Low potassium in the blooe 2) Low blood sugar	1) Diabetes mellitus 2) Immunocompromised states
Side Effects/Adverse Reactions (2)	1) pounding heartbeats or fluttering in your chest 2) swelling in feet or ankles	1) Angina 2)Bradycardia	1) Redness, swelling, and itching at the injection site 2) Weight gain	1) Redness, swelling, and itching at the injection site 2) Weight gain	1) Neck pain 2) Dizziness
Nursing Considerations (2)	1) Educate the patient that drinking alcohol can further lower your BP and may increase certain side effects of this medication. 2) Instruct patient to tell provider if they have ever had liver disease.	1) avoid stopping drug abruptly in patients with hyperthyroidism because thyroid storm may occur, and in patients with angina because it may worsen of MI may occur. 2) If patient has heart failure, also give digoxin	1) Educate the patient to refrigerate the pen 2) Instruct patient to always use a new needle when using the insulin pen	1) Educate the patient to refrigerate the pen 2) Instruct patient to always take this form of insulin at night.	1) This may increase uric acid levels 2) Instruct patient to follow diet, take with meals and snacks

Hospital Medications (5 required)

Brand/Generic	Ondansetron HCL (PF)	Pantoprazole (Protonix)	Polyethylene glycol oral powder packet (MiraLAX)	Prochlorperazine (Compazine)	Sennosides (Senokot)
Dose	4mg	40mg	17g	10mg	8.6mg
Frequency	Daily PRN	TID	TID	Every 6 hours PRN	TID
Route	IV Push	Oral	Oral	Oral	Oral
Classification	Selective serotonin (5-HT3) receptor antagonist	Proton pump inhibitor	Osmotic laxatives	Piperaze phenothiazine	Laxatives
Mechanism of Action	Blocks serotonin receptors centrally in the chemoreceptor trigger zone and	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-	This works by holding water in the stool to soften the stool and	Alleviates psychotic symptoms by blocking dopamine receptors	Intestinal cells are irritated and stimulated, resulting in gut spasms, water influx, and bowel

	peripherally at vagal nerve terminals in the intestine.	adenosine triphosphatase enzyme system, or proton pump, n gastric parietal cells.	increases the number of bowel movements.		movement.
Reason Client Taking	Nausea & vomiting	Treat GERD	Mild-moderate nausea	To control nausea and vomiting	Constipation
Contraindications (2)	1) Concomitant use of apomorphine 2) Hypersensitivity to ondansetron or its components	1) concurrent therapy with rilpivirine – containing products 2) hypersensitivity to pantoprazole	1) Patients with known or suspected bowel obstruction 2) patients known to be allergic to polyethylene glycol	1) Age less than 2 years 2) hypersensitivity to prochlorperzine	1) GI or rectal bleeding 2) Fecal impaction
Side Effects/Adverse Reactions (2)	1) Arrhythmias 2)hypotension	1) C-Diff 2) hepatotoxiciy	1) bloating 2) stomach pain	1) hypotension 2) Blurred vision	1)Rectal bleeding 2) Low potassium levels
Nursing Considerations (2)	1) Nurse should assess for extrapyramidal symptoms, nausea, vomiting 2) Nurse should monitor liver function test.	1) Take before meals 2)Do not crush	1) Hold for loose stools 2) Dissolve in water	1) Rotate I.M. injection sites to prevent irritation and sterile abscesses. 2) Avoid contact between skin and solution	1) Discontinue if patient experiences cramping 2) Administer alone for better absorption

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *Nurse's Drug Handbook 2021*. Jones & Bartlett Learning. (Original work published 2021)

Assessment

Physical Exam (18 points) – HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	The patient is alert, cooperative, and in no acute distress. Patient appears thin for his height.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds: 1** **Braden Score: 20** **Drains present: Y☐ N ☒** **Type:**	Skin is white, intact, warm, and dry without jaundice. Normal turgor. No rashes, bruises, or lesions present. There is a wound present on the (L) posterior scalp. It appears to be a pressure injury, scab is present, soft peri wound and blanchable.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Normocephalic, anicteric sclera, moist mucous membranes, no oral lesions. NG is in place. The head and neck are symmetrical. Trachea is midline without deviation. Oral cavity pink moist and clear. Auricles are bilateral no visible deformities. The septum is midline no visible

	bleeding. Teeth are natural and in tact.
CARDIOVASCULAR: **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:**	Rate and rhythm S1, S2 are normal without murmur, click, rub, or gallops. No neck vein distension. No edema present.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Breathing is equal and non-labored.
GASTROINTESTINAL: **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 ☐**	Home diet: patient has no appetite at home. Current diet in hospital setting: clears and NPO @ midnight. Height: 5’10” Weight: 138lbs Last BM: 3/23/22 Wound: (L) posterior scalp pressure injury, scab present, soft peri wound and blanchable.

Size: 16 (left side) **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine is light yellow and clear.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☐ N☒** **Fall Score: 7** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☒**	. Patient neuros are intact with full range of motion in extremities. He is mobile. His fall score is 7. However, towards the end of the clinical day he needed an assist to get out of bed. This could be due to his weakness which is a result of the clears and NPO diet.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:**	Patient is oriented x's 4. He is alert and able to use senses as they are intact. His level of consciousness is alert. He shows equal strength and clear speech.

Speech: **Sensory:** **LOC:**	
PSYCHOSOCIAL/CULTURAL: **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Appropriate affect, good eye contact, and a normal speech pattern. For coping, patient has Xbox in his room. His development level would be categorized as normal adult. No specific religion practiced.

Vital Signs, 2 sets (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0920	89	112/81	18	97.6 F	97 on RA
1115	82	127/93	18	97.6 F	100

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0930	3	Stomach	Mild	Dull	N/A
1115	8	Stomach & throat	Severe	“Feels like my NG tube ends in my throat. Very uncomfortable”	Told nurse, Dianna, his pain rating.

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:**	Double lumen picc (L) Placed on 3/22/22 Length: 45cm Patient tolerance: tolerated well IV dressing assessment: clear, dry, and intact Size: 4

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
2677.26 mL	2050 mL

Nursing Care

Summary of Care (2 points)

Overview of care: *Vitals are stable. NG tube was placed and turned on today. The patient tolerated placement well.*

Procedures/testing done: *EGD scheduled for today (3/24/22)*

Complaints/Issues: Complaints *of discomfort and pain from the NG tube*

Vital signs (stable/unstable): *Stable*

Tolerating diet, activity, etc.: *The patient is on NPO currently for his scheduled*

EGD.

Physician notifications: *None recorded*

Future plans for the client: *Continue IV fluids, replace potassium, NG tube to suction (completed,) EGD ordered.*

Discharge Planning (2 points)

Discharge location: *No discharge plans on file. Predicting patient will leave AMA.*

Home health needs (if applicable): *None recorded*

Equipment needs (if applicable): *None recorded*

Follow up plan: *Follow up with PCP after discharge.*

Education needs: *Patient should discharge with a prescription for Narcan long with instruction for him and family on identifying an OD and when/how to administer the medication.*

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	**Rationale**	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation**
• Include full nursing diagnosis with	• Explain why the nursing diagnosis			• How did the client/family

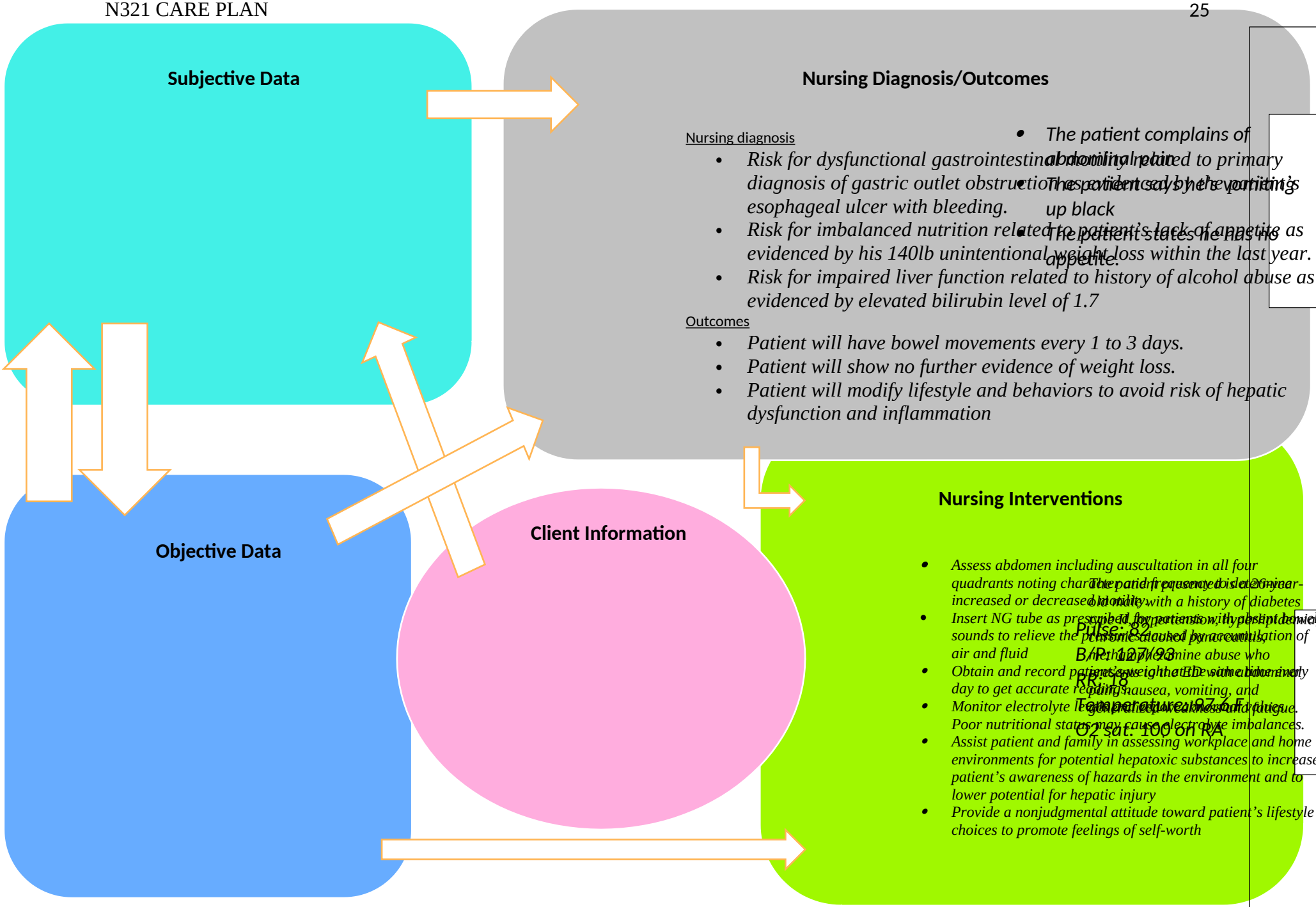
"related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	was chosen			respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Risk for dysfunctional gastrointestinal motility related to primary diagnosis of gastric outlet obstruction as evidenced by the patient's esophageal ulcer with bleeding.	*The patient risks food not moving adequately through the throat, esophagus, stomach and intestines. Digestion will be altered and complicated.*	• *Assess abdomen including auscultation in all four quadrants noting character and frequency to determine increased or decreased motility.* • *Insert NG tube as prescribed for patients with absent bowel sounds to relieve the pressures caused by accumulation of air and fluid*	• *Patient will have bowel movements every 1 to 3 days.*	• *Patient verbalizes strategies to promote heathy bowel function* • *Patient maintains a normal electrolyte balance*
2. Risk for imbalanced nutrition related to patient's lack of appetite as evidenced by his 140lb unintentional weight loss within the last year.	*This nursing diagnosis was chosen because of the patient's rapid, unintentionally weight loss.*	• *Obtain and record patient's weight at the same time every day to get accurate readings.* • *Monitor electrolyte levels and report abnormal values. Poor nutritional status may cause electrolyte imbalances.*	• *Patient will show no further evidence of weight loss.*	• *Patient and family communicate understanding of special dietary needs, either verbally or through behavior* • *Patient states plan to monitor and maintain specific target weight after*

				discharge.
3. *Risk for impaired liver function related to history of alcohol abuse as evidenced by elevated bilirubin level of 1.7*	*Patient reports alcohol abuse. Has consumed up to 1.5 gallons of spirits daily. This pattern of drinking will affect the liver and its function.*	• *Assist patient and family in assessing workplace and home environments for potential hepatoxic substances to increase patient's awareness of hazards in the environment and to lower potential for hepatic injury.* • *Provide a nonjudgmental attitude toward patient's lifestyle choices to promote feelings of self-worth*	• *Patient will modify lifestyle and behaviors to avoid risk of hepatic dysfunction and inflammation*	• *Patient follows prescribed treatment plan.* • *Patient expresses feelings about condition and its effect on family.*

Other References (APA):

Linda Lee Phelps. (2020). *Sparks & Taylor's Nursing Diagnosis Reference Manual.* Wolters Kluwer Medical.

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Nursing diagnosis
Risk for dysfunctional gastrointestinal motility related to primary diagnosis of gastric outlet obstruction as evidenced by chronic esophageal ulcer with bleeding.
Risk for imbalanced nutrition related to patient's lack of appetite as evidenced by his 140lb unintentional weight loss within the last year.
Risk for impaired liver function related to history of alcohol abuse as evidenced by elevated bilirubin level of 1.7
Outcomes
Patient will have bowel movements every 1 to 3 days.
Patient will show no further evidence of weight loss.
Patient will modify lifestyle and behaviors to avoid risk of hepatic dysfunction and inflammation
The patient complains of abdominal pain
The patient says he's vomiting up black
The patient states he has no appetite.
Objective Data
Client Information
Nursing Interventions
Assess abdomen including auscultation in all four quadrants noting character and frequency of bowel sounds, increased or decreased motility
Insert NG tube as prescribed for patients with persistent vomiting to relieve the pressure caused by accumulation of air and fluid
Obtain and record patient's weight daily with the same scale and at the same time of day to get accurate readings
Monitor electrolyte levels and report abnormalities. Poor nutritional status may cause electrolyte imbalances.
Assist patient and family in assessing workplace and home environments for potential hepatotoxic substances to increase patient's awareness of hazards in the environment and to lower potential for hepatic injury
Provide a nonjudgmental attitude toward patient's lifestyle choices to promote feelings of self-worth
The patient presents to the ED via personal vehicle with a history of diabetes mellitus, hypertension, hyperlipidemia, and alcohol and amphetamine abuse who reports nausea, vomiting, and generalized weakness and fatigue.
Pulse: 84
B/P: 127/93
RR: 18
Temperature: 97.6 F
O2 sat: 100 on RA