N321 Care Plan 1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Client Initials	Age	Gender
06/02/2022	RB	53	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
White	Truck Driver	Single	Penicillin (N/V)
Code Status	**Height**	**Weight**	
Full	70 in	83.7 kg	

Medical History (5 Points)

Past Medical History: Calculus of Kidney, Disease of pancreas (Unspecified)

Past Surgical History: Appendectomy, tailbone removed (1992)

Family History:

Father: Stroke and Myocardial Infarction

Mother: Brain Aneurysm

Sister: Heart Disease and Lung problems

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use):

The patient is currently smoking, 40 pack year history. Patient denies any alcohol use. Patient currently uses marijuana once per month for five years.

Assistive Devices: None

Living Situation: Lives in a Condo with his daughter

Education Level: Some College

Admission Assessment

Chief Complaint (2 points): Abdominal pain

History of Present Illness – OLD CARTS (10 points): The 53-year-old Caucasian male presented to the hospital on 06/02/2022 with pain in his abdomen's upper and lower right quadrant. The patient stated that his pain started about a week ago and had gotten so bad that he

went to the emergency department. The patient said when he has first admitted to the hospital that his pain was consistent and that the pain was mainly in his abdomen but that it would also radiate to his back. When I asked the patient to describe his pain, he said it was aching. To treat his pain the patient uses a heating pad and medication. When I asked the patient the severity of his pain on a numeric pain scale of 0 to 10, 0 representing no pain and 10 being the most excruciating pain imaginable, he replied, "I am not in much pain today. I guess it is at a 2 or 3".

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute pyelonephritis

Secondary Diagnosis (if applicable): Urinary tract infection

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

E. coli is the causative agent of acute pyelonephritis due to its ability to adhere to and colonize the urinary tract and kidneys (Belyayeva & Jeong, 2019). E. coli has p. fimbriae which are adhesive molecules that can interact with receptors on the uroepithelial cells (Belyayeva & Jeong, 2019). E. coli in the kidneys causes an inflammatory response in the body, resulting in kidney scarring (Belyayeva & Jeong, 2019). It is hypothesized that the E. coli that is adhered to the kidney disrupts the protective barriers of the renal system, which can lead to localized infection, hypoxia, ischemia, and clotting to contain the infection (Belyayeva & Jeong, 2019). Inflammatory cytokines, bacterial toxins, and other reactive processes further lead to pyelonephritis (Belyayeva & Jeong, 2019). The signs and symptoms of acute pyelonephritis include chills, fever, pain in the back, side, or groin, nausea, vomiting, cloudy, dark, bloody, or foul-smelling urine, and frequent, painful urination (National Institute of Diabetes and Digestive and Kidney Diseases, 2020). My patient's symptoms included pain in his back, nausea, vomiting, cloudy urine, and frequent urination. The diagnostics for acute pyelonephritis are an

abdominal/pelvic CT with contrast and ultrasonography (Belyayeva & Jeong, 2019). My patient received an abdominal/pelvic CT with contrast to diagnose his acute pyelonephritis. Labs to diagnose pyelonephritis include a urine analysis (UA) and a urine culture (Cleveland Clinic, 2019). My patient received a UA and a urine culture to diagnose his pyelonephritis. The expected findings of acute pyelonephritis include a high fever, costovertebral angle (CVA) tenderness, and suprapubic tenderness (Belyayeva & Jeong, 2019). My patient presented with CVA tenderness and suprapubic tenderness. The treatment for acute pyelonephritis includes antibiotics, analgesics, and antipyretics (Belyayeva & Jeong, 2019). Nonsteroidal anti-inflammatory drugs (NSAIDs) help treat the pain and fever associated with acute pyelonephritis (Belyayeva & Jeong, 2019).

Pathophysiology References (2) (APA):

Belyayeva, M., & Jeong, J. M. (2019). *Acute pyelonephritis*. Nih.gov; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK519537/

Cleveland Clinic. (2019). *Kidney Infection (Pyelonephritis); Symptoms, Treatment, Prevention*. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/15456-kidney-infection-pyelonephritis#:~:text=Two%20common%20laboratory%20tests%20are

National Institute of Diabetes and Digestive and Kidney Diseases. (2020, January 26). *Symptoms & Causes of Kidney Infection (Pyelonephritis) | NIDDK*. National Institute of Diabetes and Digestive and Kidney Diseases. https://www.niddk.nih.gov/health-information/urologic-diseases/kidney-infection-pyelonephritis/symptoms-causes

Laboratory Data (15 points)

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

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	4-4.9	5.14	4.37	N/A
Hgb	12-18	17	14.4	N/A
Hct	37-48	48.3	41.3	N/A
Platelets	90-450	270	187	N/A
WBC	4-10	17.53	21.07	The client's WBC count was elevated because he had an upper urinary tract infection. During the immune response, more WBCs are made to fight off the infection (Cleveland Clinic, 2019).
Neutrophils	40-80	85	N/A	The client has an elevated neutrophil count because he had a bacterial infection (Cleveland Clinic, 2022b).
Lymphocytes	20-40	30	N/A	N/A
Monocytes	2-10	6.3	N/A	N/A
Eosinophils	1-1.4	1.1	N/A	N/A
Bands	0-2	0.5	N/A	N/A

(Capriotti, 2020)

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	136	137	N/A
K+	3.5-5	3.7	3.5	N/A
Cl-	97-108	99	95	My client had a low chloride level due to losing fluid from vomiting and diarrhea (MedlinePlus, 2022a).
CO2	22-30	26	31	My client has a low CO2 level because his kidneys are not working correctly due to infection

				(MedlinePlus, 2022b).
Glucose	60-100	118	128	My patient has increased glucose; at this level, the patient might be pre-diabetic, and further investigation should be done. My client is also taking Creon which is a medication that increases blood glucose levels. (Cleveland Clinic, 2020).
BUN	5-20	22	15	N/A
Creatinine	0.5-1.5	0.84	0.65	N/A
Albumin	3.4-5.4	4	2.6	My patient has a low albumin level due to an infection in his kidneys (Cleveland Clinic, 2022a).
Calcium	8.6-10.3	10.3	9.7	N/A
Mag	1.3-2.1	1.7	1.7	N/A
Phosphate	N/A	N/A	N/A	N/A
Bilirubin	0.3-1.2	0.5	0.4	N/A
Alk Phos	44-127	91	60	N/A
AST	8-48	19	12	N/A
ALT	7-55	14	9	N/A
Amylase	N/A	N/A	N/A	N/A
Lipase	N/A	21	N/A	N/A
Lactic Acid	N/A	N/A	N/A	N/A

(Capriotti, 2020)

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	N/A	N/A	N/A	N/A
PT	N/A	N/A	N/A	N/A
PTT	N/A	N/A	N/A	N/A
D-Dimer	N/A	N/A	N/A	N/A
BNP	N/A	N/A	N/A	N/A
HDL	N/A	N/A	N/A	N/A
LDL	N/A	N/A	N/A	N/A
Cholesterol	N/A	N/A	N/A	N/A
Triglycerides	N/A	N/A	N/A	N/A
Hgb A1c	N/A	N/A	N/A	N/A
TSH	N/A	N/A	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	Clear no cloudiness	Hazy, dark yellow	N/A	The color of the urine was dark and hazy due to being dehydrated from the loss of fluids due to vomiting (Cleveland Clinic, 2021).
pH	4.5-8	5	N/A	N/A
Specific Gravity	1.05-1.025	1.025	N/A	N/A
Glucose	Less than 140	Negative	N/A	N/A
Protein	Negative	30	N/A	My client had increased protein in his urine due to an infection in his Kidneys (Mayo Clinic, 2019).
Ketones	Negative	15	N/A	My client may have ketones in the urine due to being pre-diabetic; this requires further investigation. My client is also taking Creon which increases blood sugar levels. (Mayo

				Clinic, 2019).
WBC	Less than 2	508 mcL	N/A	My client had increased WBCs due to an infection in the renal system (Mayo Clinic, 2019).
RBC	Less than 2	1000mcL	N/A	My client had increased RBC in his urine due to pyelonephritis (Mayo Clinic, 2017).
Leukoesterase	Negative	small	N/A	My client has leukoesterase in his urine due to pyelonephritis (UCSF Health, 2019).

(Capriotti, 2020)

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	Negative	N/A	N/A
Blood Culture	N/A	N/A	N/A	N/A
Sputum Culture	N/A	N/A	N/A	N/A
Stool Culture	N/A	N/A	N/A	N/A

(Capriotti, 2020)

Lab Correlations Reference (1) (APA):

Capriotti, T. M. (2020). *PATHOPHYSIOLOGY : introductory concepts and clinical perspectives.* (2nd ed., pp. 244, 277). F A Davis.

Cleveland Clinic. (2020). *Hyperglycemia: Causes, Symptoms, Treatments & Prevention*. Cleveland Clinic. https://my.clevelandclinic.org/health/diseases/9815-hyperglycemia-high-blood-sugar#:~:text=What%20is%20hyperglycemia%3F

Cleveland Clinic. (2021). *Cloudy Urine: Causes, Treatment, & What Does It Mean*. Cleveland Clinic. https://my.clevelandclinic.org/health/symptoms/21894-cloudy-urine#:~:text=What%20causes%20cloudy%20urine%3F

Cleveland Clinic. (2022a). *Albumin Blood Test: What It Is, Purpose, Procedure & Results*. Cleveland Clinic. https://my.clevelandclinic.org/health/diagnostics/22390-albumin-blood-test#:~:text=Albumin%20is%20protein%20in%20your

Cleveland Clinic. (2022b). *What are Neutrophils? What Can Cause High or Low Neutrophil Count*. Cleveland Clinic. https://my.clevelandclinic.org/health/body/22313-neutrophils#:~:text=Neutrophilia%3A%20Neutrophilia%2C%20also%20known%20as

Mayo Clinic. (2017). *Blood in urine (hematuria) - Symptoms and causes*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/blood-in-urine/symptoms-causes/syc-20353432

Mayo Clinic. (2019, October 23). *Urinalysis - Mayo Clinic*. Mayoclinic.org; Mayo Clinic. https://www.mayoclinic.org/tests-procedures/urinalysis/about/pac-20384907

MedlinePlus. (2022a). *Carbon Dioxide (CO2) in Blood: MedlinePlus Lab Test Information*. Medlineplus.gov. https://medlineplus.gov/lab-tests/carbon-dioxide-co2-in-blood/

MedlinePlus. (2022b). *Chloride Blood Test: MedlinePlus Medical Test*. Medlineplus.gov. https://medlineplus.gov/lab-tests/chloride-blood-test/#:~:text=Low%20levels%20of%20chloride%20may

UCSF Health. (2019). *Leukocyte Esterase*. Ucsfhealth.org. https://www.ucsfhealth.org/medical-tests/leukocyte-esterase-urine-test

Diagnostic Imaging

All Other Diagnostic Tests (5 points) and Diagnostic Test Correlation (5 points): My patient received two other diagnostic tests. One diagnostic tests my patient had done was a CT of the

abdomen and pelvis with contrast. Computed tomography (CT) of the abdomen and pelvis is a diagnostic imaging test used to help detect diseases of the small bowel, colon, and other internal organs (Radiology (ACR), 2022). A CT of the abdomen and pelvis also helps determine the cause of unexplained pain (Radiology (ACR), 2022). The CT revealed that the heart was enlarged. Minimal intrahepatic biliary ductal dilation. Peripherally calcified 18 mm structure adjacent to the pancreas could represent a splenic arterial pseudoaneurysm. Bilateral renal cysts measure up to 16 mm on the left. Mineralization was seen at the hamstring insertion into the ischio tuberosity, which can be seen with hydroxyapatite deposition disease. Surgical clips are seen in the region of the cecum from a prior appendectomy chronic T12 vertebral body fracture. My patient's second diagnostic test was an upper endoscopy (EGD). An upper endoscopy is a procedure used to inspect the inner lining of the upper digestive tract (American Cancer Society, 2019). The EGD revealed esophagitis, large amounts of fluid in the stomach, clots of blood in the abdomen, moderate gastritis multiple non-bleeding duodenal ulcers.

Diagnostic Test Reference (1) (APA):

American Cancer Society. (2019). *Upper Endoscopy | Upper Endoscopy Procedure | EGD*. Www.cancer.org. https://www.cancer.org/treatment/understanding-your-diagnosis/tests/endoscopy/upper-endoscopy.html#:~:text=An%20upper%20endoscopy%20is%20a

Radiology (ACR), R. S. of N. A. (RSNA) and A. C. of. (2022). *Computed Tomography (CT) - Abdomen and Pelvis*. Radiologyinfo.org. https://www.radiologyinfo.org/en/info/abdominct

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

Home Medications (5 required)

Brand/Generic	Creon/pancrelipase	Pantoloc/pantoprazole sodium	**N/A**	**N/A**	**N/A**
Dose	24000-76000 units	40 mg	**N/A**	**N/A**	**N/A**
Frequency	1 capsule TID	Once daily	**N/A**	**N/A**	**N/A**
Route	PO	PO	**N/A**	**N/A**	**N/A**
Classification	Enzymes (Karnik & Jan, 2019)	Pharmacologic class: Proton pump inhibitor Therapeutic class: Antiulcer	**N/A**	**N/A**	**N/A**
Mechanism of Action	Pancrelipase are porcine enzymes and contain mixtures of pancreatic lipase, amylase, and protease. Lipase is a digestive enzyme involved in the hydrolysis and degradation of fats. Amylase is a digestive enzyme involved in the hydrolysis and digestion of starches. Proteases are enzymes involved in the breakdown of proteins and amino acids. (Karnik & Jan, 2019)	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphate enzyme system in gastric parietal cells. Pantoprazole irreversibly inhibits the final step in gastric acid production by blocking the exchange of intracellular hydrogen and potassium, preventing hydrogen from entering the stomach and additional hydrochloride from forming. (Jones & Bartlett Learning, 2021)	**N/A**	**N/A**	**N/A**
Reason Client Taking	Chronic pancreatitis	Stomach ulcers	**N/A**	**N/A**	**N/A**
Contraindications (2)	Hypersensitivity to the drug and hypersensitivity to pork protein. (Karnik & Jan, 2019)	Concurrent therapy with rilpivirine-containing products or hypersensitivity to pantoprazole (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**

Side Effects/Adverse Reactions (2)	Oral irritation and abdominal pain. (Karnik & Jan, 2019)	Diarrhea and pancreatitis (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**
Nursing Considerations (2)	1. Glucose monitoring is advised for patient who are hypoglycemic and hyperglycemic 2. Monitor abdominal symptoms, intake, weight, growth, stool character, and fecal fat. (Karnik & Jan, 2019)	1. Know that both cutaneous and systemic lupus erythematosus have occurred within days to years after pantoprazole was initiated. The most common finding was arthralgia, cytopenia, and rash 2. Monitor patient's urine output because pantoprazole may cause acute tubulointerstitial nephritis. (Jones & Bartlett Learning, 2021).	**N/A**	**N/A**	**N/A**

Hospital Medications (5 required)

Brand/ Generic	Carafate/ sucralfate	Alternagel/ aluminum hydroxide	Lovenox/ enoxaparin sodium	Creon/ pancrelipase	Pantoloc/ pantoprazole sodium

Dose	1 g	20 mL	40 mg	12000-3800-6000 units	40 mg
Frequency	Q6h daily AC and HS	Q4h PRN	Daily at 1300	2 capsules TID with meals	1 tablet BID
Route	PO	PO	SubQ	PO	PO
Classification	Pharmacologic class: GI protectant Therapeutic class: Antiulcer (Jones & Bartlett Learning, 2021).	Pharmacologic class: Aluminum salt Therapeutic class: Antacid, phosphate binder (Jones & Bartlett Learning, 2021).	Pharmacologic class: Low-molecular-weight heparin Therapeutic class: Anticoagulant (Jones & Bartlett Learning, 2021).	Enzyme (Karnik & Jan, 2019)	Pharmacologic class: Proton pump inhibitor Therapeutic class: Antiulcer (Jones & Bartlett Learning, 2021).
Mechanism of Action	Reacts with hydrochloric acid to form a complex that buffers acid. The complex adheres electrostatically to proteins on the ulcer's surface and creates a protective barrier at the ulcer site. (Jones & Bartlett Learning, 2021).	Neutralizes or reduces gastric acidity, increasing stomach, and duodenal alkalinity. Protects stomach and duodenum lining by inhibiting pepsin's proteolytic activity. (Jones & Bartlett Learning, 2021).	Potentiate the action of antithrombin III. By binding with antithrombin III, enoxaparin rapidly binds with and inactivates clotting factors. Without thrombin, fibrinogen cannot convert to fibrin, and thrombus cannot form. (Jones & Bartlett Learning, 2021).	Pancrelipase is a porcine enzyme and contains mixtures of pancreatic lipase, amylase, and protease. Lipase is a digestive enzyme involved in the hydrolysis and degradation of fats. Amylase is a digestive enzyme involved in the hydrolysis and digestion of starches.	Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphate enzyme system in gastric parietal cells. Pantoprazole irreversibly inhibits the final step in gastric acid production by blocking the exchange of intracellular hydrogen and potassium, preventing hydrogen from entering the stomach and additional

				Proteases are enzymes involved in the breakdown of proteins and amino acids. (Karnik & Jan, 2019)	hydrochloride from forming. (Jones & Bartlett Learning, 2021)
Reason Client Taking	Stomach ulcer	Stomach ulcer	Prevent DVT	Chronic pancreatitis	Stomach ulcer
Contraindications (2)	No contraindications for this medication. (Jones & Bartlett Learning, 2021).	Hypersensitivity to aluminum or its components (Jones & Bartlett Learning, 2021).	Active major bleeding and hypersensitivity to benzyl alcohol (Jones & Bartlett Learning, 2021).	Hypersensitivity to the drug and hypersensitivity to pork protein. (Karnik & Jan, 2019)	Concurrent therapy with rilpivirine-containing products or hypersensitivity to pantoprazole (Jones & Bartlett Learning, 2021).
Side Effects/ Adverse Reactions (2)	Diarrhea and vomiting (Jones & Bartlett Learning, 2021).	Constipation and electrolyte imbalances (Jones & Bartlett Learning, 2021).	Hematemesis and hyperkalemia (Jones & Bartlett Learning, 2021).	Oral irritation and abdominal pain. (Karnik & Jan, 2019)	Diarrhea and pancreatitis (Jones & Bartlett Learning, 2021).
Nursing Considerations (2)	Use cautiously in patients with chronic renal failure because of increased risk of aluminum toxicity. Monitor diabetic patient's	Know that two 0.6 g aluminum hydroxide tablets can neutralize 16 mEq of acid. Monitor patient's serum levels of sodium, phosphate, and other	Use with caution in patients with an increased risk of hemorrhage, as from active ulcerative or angiodysplasia GI disease. Use cautiously in those with	1. Glucose monitoring is advised for patient who are hypoglycemic and hyperglycemic 2. Monitor abdominal symptoms, intake,	Ensure the continuity of gastric acid suppression during transition from oral to IV because even a brief interruption can lead to serious complications.

	blood glucose level closely because hyperglycemia can occur and require an adjustment of antidiabetic drug therapy. (Jones & Bartlett Learning, 2021).	electrolytes, as appropriate. (Jones & Bartlett Learning, 2021).	bleeding diathesis, diabetic retinopathy, hepatic or renal impairment, or recent GI disease. (Jones & Bartlett Learning, 2021).	weight, growth, stool character, and fecal fat. (Karnik & Jan, 2019)	Expect to monitor INR or PT during therapy if patient takes an oral anticoagulant. (Jones & Bartlett Learning, 2021).

All data from (Jones & Bartlett Learning, 2021).

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2021). *2022 Nurse's Drug Handbook.* Jones & Bartlett Learning.

Karnik, N. P., & Jan, A. (2019). *Pancrelipase*. Nih.gov; StatPearls Publishing.

https://www.ncbi.nlm.nih.gov/books/NBK534847/

Assessment

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

GENERAL:	Appears alert and oriented x person, place, and

Alertness: **Orientation:** **Distress:** **Overall appearance:**	time, well-groomed, no acute distress.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient skin color is normal for ethnicity. Skin is warm and dry upon palpation. Patient has areas of ecchymosis from IV sticks at the hospital on his forearm. Patient had a right arm infiltrate that was swollen, cold. Normal quantity, distribution, and texture of the hair. Nails without clubbing or cyanosis. Skin turgor normal mobility. Capillary refill less than 3 seconds fingers and toes bilaterally. Braden score is 21.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical, trachea is midline without deviation, thyroid is not palpable, no noted nodules. Bilateral carotid pulses are palpable and 2+. Bilateral sclera white, bilateral cornea clear, bilateral conjunctiva pink, no visible drainage from eyes. Bilateral lids moist and pink without lesions or discharge noted. PERRLA bilaterally. EOMs intact bilaterally. Bilateral auricles no visible or palpable deformities, lumps, or lesions. Septum is midline no deviation noted. No visible bleeding or polyps. Uvula is midline; soft palate rises and falls symmetrically. Hard palate intact, Dentition is good, oral mucosa moist without lesions noted. Tongue was pink with no lesions.
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:**	Clear S1 and S2. Normal rate and rhythm. All left extremities and right leg were warm, pink, dry, and symmetrical. Patient right arm was swollen and under IV site was cold due to IV infiltration. Peripheral pulses Dorsalis pedis 2+ throughout bilaterally, Popliteal 2+ bilaterally, Radial pulse 2+ bilaterally. Capillary refill less than 3 seconds finger and toes bilaterally.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Nonlabored breathing. Respirations are symmetrical. Anterior and posterior were clear throughout all lobes. No wheezes or rhonchi

	noted**.**
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 ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	The patient's diet at home is a regular diet and the patient's current diet just progressed from liquid diet to regular diet. The patient weighs 183.7 kg and is 70 in. tall. Abdomen is rigid, distended, and tender in the RUQ and RLQ. No masses noted upon palpation of all four quadrants. Bowel sounds are hyperactive in all four quadrants. Minimal CVA tenderness noted bilaterally. Last bowel movement was two weeks ago. The patient has no incisions noted. The patient has no scars noted. The patient has no drains noted. The patient had a right arm infiltrate
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	**Hazy, dark-yellow urine. Absence of pain, urgency or retention. Patient did urinate frequently. No blood in the urine noted. Patient urinated a excessive amount once during shift. Urinated 1,500 cc's. Genitals no abnormalities were noted. The genitals were clean and intact with no lesions noted.**
MUSCULOSKELETAL: **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 ☐**	Patient is A&Ox4. All left extremities and right leg were warm, pink, dry, and symmetrical. Patient right arm was swollen and under IV site was cold due to IV infiltration. Peripheral pulses Dorsalis pedis 2+ throughout bilaterally, Popliteal 2+ bilaterally, Radial pulse 2+ bilaterally. All extremities have a full range of motion. Steady gait. The patient has no supportive devices. The patient demonstrates normal and equal strength for his age in all extremities. The patient has a Morse fall score of 20.
NEUROLOGICAL: **MAEW: Y ☒ N☐**	Hand grips and arm pushes and pulls demonstrate normal and equal strength. Patient alert and

PERLA: Y ☒ N☐ **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	oriented to person, place, and time with normal speech. PERRLA bilaterally. The patient moves all extremities well. Memory is normal, and thought process is intact. Sensation is intact bilaterally to pain and light touch.
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):**	The patient utilizes marijuana to help manage pain and stress in his life. The patient is in the generativity vs. stagnation developmental stage. Baptist patient believes in God but does not attend church regularly. The patient's support system is his daughter's; he said, "They are all I got."

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0830	72 bpm	136/77 mmHg	16 Breaths/min	36.9℃ (Oral)	96% on room air
1120	72 bpm	135/80 mmHg	15 Breaths/min	37.2℃ (Oral)	93% on room air

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0930	Numeric Pain Scale	Abdomen	2-3 out of 10	Ache radiates to the back	Heating pad and medication
1120	Numeric Pain Scale	Abdomen	2-3 out of 10	Ache radiates to the back	Heating pad and medication

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	20 gauge Left posterior hand 06/06/2022 IV is patent with no signs of infiltration No erythema nor drainage from the IV site Dressing dry and intact Right Arm infiltrate with Lactated ringers infusing at being of clinical shift. Removed IV from patient. When assessed arm patients' hand was cold but above infiltrate was warm. Radial pulse was 2+. Capillary refill was less than 2 seconds. Moderate swelling noted on right arm. Arm was hard up to elbow.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
IV Fluids Lactated Ringer's: 1,200 mL Water: 475 mL Milk: 240 mL Ice: 120 mL Total: 2035 mL	Urinated into the urinal 5 times for a total of 1500 mL.

Nursing Care

Summary of Care (2 points)

Overview of care: After morning rounds, I checked my patient's vital signs when I noticed that his IV had infiltrated. I went to get my instructor and nurse to alert them that a new IV was needed. I attempted to put an IV in the patient's forearm; however, when I aspirated, there was no blood return, so I pulled out the IV catheter and tried again. The

second time I successfully placed the IV catheter in the patient's lower left hand. At 0800, I passed pancrelipase and sucralfate orally. I offered my patient fresh water when I gave him his medications. At 0830, I assessed my patient's vital signs, pain assessment, and IV site. At 0900, the patient requested an extra blanket, so I obtained one for him. Around 1300 I gave the patient the bath wipes that he requested. At 1400 I changed all of his bedding. At 1500 I obtained a heating pad.

Procedures/testing done: The patient did not have any procedure or test throughout clinical shift.

Complaints/Issues: The patient complained of back pain throughout the shift and rated his pain 2-3 out of 10. When I re-assessed him at the end of the shift, he stated that it was now a 5 out of 10. The heating pad was given for pain.

Vital signs (stable/unstable): The patient's stable vital signs were his temperature, heart rate, and respiration. The patient's unstable vital signs were his blood pressure and oxygen saturation.

Tolerating diet, activity, etc.: The patient’s diet was moved from a liquid diet to a regular diet throughout clinical shift. Patient got up and walked around room and bathroom. Patient was awake and was eager to talk and have a conversation.

Physician notifications: The physician was notified to advance the patient’s diet from a liquid to a regular diet.

Future plans for client: The patient will be discharged with his daughter. We want to see the patient can tolerate regular diet and have no signs or symptoms of infection.

Discharge Planning (2 points)

Discharge location: The patient will be discharged to home with daughter.

Home health needs (if applicable): The patient does not have any home health needs.

Equipment needs (if applicable): The patient does not have any equipment needs.

Follow up plan: The follow up plan is to make sure the patient goes to all follow-up appointments. Also, to make sure he remains complaint with taking his medications.

Education needs: The patient needs educated about how important it is to remain compliant with taking his medications.

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 • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to infection of the urinary tract as evidence by spasms in the lower back.	This nursing diagnosis was chosen for my client because when he was first admitted to the hospital, he was in intractable pain.	1.Apply heating pad to the lower back to help relieve pain and muscle spasms (Martin, 2021). 2.Instruct client to avoid coffee, spicy foods, alcohol, and soda because these foods and drinks are	1. The patient will use pharmacologic and nonpharmacologic pain relief strategies to keep his pain manageable and will express that his pain is at a 0-2 on the numeric pain scale by the end of the shift.	Goal met: The patient will express that his pain is well managed and that his activities of daily living are no longer interrupted by his pain.

		urinary tract irritants (Martin, 2021).		
2. Risk of spread of infection related to acute pyelonephritis as evidence by elevated WBC count.	I chose this nursing diagnosis because my client has an upper kidney infection with elevated blood cells; therefore, if the infection is not treated correctly, the infection could spread, and the patient could become septic.	1. Maintain strict asepsis for intravenous therapy to decrease the chances of spreading pathogens to or between patients (Vera, 2019). 2.Monitor urine characteristics regularly for protein and hematuria (Vera, 2019).	**1.** The patient's infection will not spread and will be resolved as evidenced by a decrease in his serum WBC count and clear, pale-yellow urine with no detectable levels of RBCs nor WBCs by the end of the week (06/12/2022).	Goal met: The infection will not spread and will be resolved as evidenced by the patient's serum WBC count lowering to the accepted ranges, and the patient's urine analysis will show no WBCs or RBS. The urine will be clear and pale yellow with no foul order.
3. Risk for fluid imbalance: fluid volume excess related to renal insufficiency as evidence by input exceeding output**.**	I choose this nursing diagnosis because my patient is not excreting all the fluid he is taking in, which can lead to worsening signs and symptoms of hypervolemia such as pulmonary edema, tachycardia, and BP changes**.**	1.Limit sodium intake as prescribed to decrease the amount of fluid retention (Wayne, 2020). 2Monitor fluid intake and output regularly to enhance compliance of any fluid restriction ordered by prescriber (Wayne,	**1.** The client will no longer be retaining fluid, as evidenced by his intake of fluids equaling his outtake of fluids by the end of the week (06/10/2022).	The goal is met when the patient realizes that salty foods will increase water retention and that his intake and outtake volumes are balanced.

		2020).		

Other References (APA):

Martin, P. (2021, October 14). *6 Urinary Tract Infection Nursing Care Plans*. Nurseslabs. https://nurseslabs.com/urinary-tract-infection-nursing-care-plans/

Vera, M. (2019, March 20). *Risk for Infection – Nursing Diagnosis & Care Plan*. Nurseslabs. https://nurseslabs.com/risk-for-infection/

Wayne, G. (2020, September 8). *Excess Fluid Volume – Nursing Diagnosis & Care Plan*. Nurseslabs. https://nurseslabs.com/excess-fluid-volume/

Concept Map (20 Points):

Subjective Data

The patient told me that he has been experiencing symptoms of abdominal pain for 2 weeks
The patient describes his pain as achy
Patient expressed a want to be on a regular diet
Patient stated, “My lower back is killing me”.

Nursing Diagnosis/Outcomes

Acute pain related to infection of the urinary tract as evidence by spasms in the lower back
Goal: The patient will use pharmacologic and nonpharmacologic pain relief strategies to keep his pain manageable and will express that his pain is at a 0-2 on the numeric pain scale by the end of the shift.
Risk of spread of infection related to acute pyelonephritis as evidence by elevated WBC count.
Goal: The patient’s infection will not spread and will be resolved as evidenced by a decrease in his serum WBC count and clear, pale-yellow urine with no detectable levels of RBCs nor WBCs by the end of the week (06/12/2022).
Risk for fluid imbalance: fluid volume excess related to renal insufficiency as evidence by input exceeding output.
Goal: The client will no longer be retaining fluid, as evidenced by his intake of fluids equaling his outtake of fluids by the end of the week (06/10/2022).

Objective Data

Vital signs: 0830: Pulse: 72 bpm, BP: 136/77 mmHg, RR: 16 breaths/minute, oxygen: 96% on room air. At 1120: pulse: 72 bpm, BP 135/80 mmHg, RR: 17 breaths/minute, oxygen 93% on room air
Braden score: 21
Morse fall Score: 20
Diagnostic Test: CT abdomen/pelvis with contrast and upper endoscopy

Client Information

The patient was a 53-year-old Caucasian male who has a past medical history of Calculus of Kidney and Disease of pancreas. He has a surgical history of Appendectomy and tailbone removal (1992).

Nursing Interventions

Nursing diagnosis 1:

1. Apply heating pad to the lower back to help relieve pain and muscle spasms.
2. Instruct client to avoid coffee, spicy foods, alcohol, and soda because these foods and drinks are urinary tract irritants.

Nursing diagnosis 2:

1. Maintain strict asepsis for intravenous therapy to decrease the chances of spreading pathogens to or between patients.
2. Monitor urine characteristics regularly for protein and hematuria.

Nursing diagnosis 3:

1. Limit sodium intake as prescribed to decrease the amount of fluid retention
2. Monitor fluid intake and output regularly to enhance compliance of any fluid restriction ordered by prescriber