N321 Care Plan #1

Lakeview College of Nursing

Name Berich Mpoy

Demographics (3 points)

Date of Admission 10/03/22	**Client Initials** MW	**Age** 62	**Gender** M
Race/Ethnicity Caucasian	**Occupation** Security Guard	**Marital Status** Married	**Allergies** Morphine, Lisinopril, Metoprolol
Code Status Full Code	**Height** 66inches	**Weight** 136lbs	

Medical History (5 Points)

Past Medical History: Acute pancreatitis 2000 to 2006, anxiety, depression, hypertension, skin cancer, chronic kidney disease, chronic pancreatitis, coronary artery disease, cyst of kidney, coronary atherosclerosis, diabetes mellitus, disk degeneration, dyslipidemia, hyperlipidemia, hypertension, ischemic heart disease, strabismus, type 2 diabetes, spinal stenosis of lumbar, syncope, chronic thrombosis of splenic vein, and episodic hypotension.

Past Surgical History: stent 03/30/2001, cardiac pacemaker 2021, cataract surgery, skin biopsy, colonoscopy 05/11/22.

Family History: Father's side: cancer, heart disease, coronary artery disease, dementia.

Mother'sside: coronary artery disease

Grandfather's side: prostate cancer.

Grandmother's side: diabetes mellitus and heart disease

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

The patient stated that he smoked three to four packs of smokes daily until the age of 60. The patient stated he occasionally has a bottle of wine.

Assistive Devices: Walker and glasses.

Living Situation: The patient lives with his wife, who is also partially disabled.

Education Level: The patient has a master's degree in American history and a minor in British history.

Admission Assessment

Chief Complaint (2 points): The client complained of abdominal pain and discomfort.

History of Present Illness – OLD CARTS (10 points):

On Sunday morning 62 years old patient woke up and prepared chicken noodle soup out of a can as usual. After the patient ate some of the soup, he experienced abdominal discomfort. The patient stated that the pain he felt lasted all day and only grew worse. The patient stated that the pain was deep, sharp, and stabbing. The pain is not relieved by anything but is worsened by any kind of food that's eaten. Sunday night, the patient could no longer take the pain and was driven to Sarah Bush by his wife. The patient was admitted and given pain medication to relieve the pain. The patient states that the pain medication helped, but the pain comes back slowly if no medication is administered continuously.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Pancreatitis

Secondary Diagnosis (if applicable): N/A

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

Pancreatitis is inflammation of the pancreas. Pancreatitis is caused by many different factors; some of the common causes of pancreatitis are biliary tract disease and alcohol abuse. Obstructing the pancreatic duct and autodigestion is the main cause of pancreatitis in patients with biliary tract disease. Microscopic size gallstones are lodged in the ampulla of Vater, creating pressure in the pancreas. In patients with alcohol abuse disorders, pancreatitis is caused

by the accumulation of digestive enzymes due to increased levels of ethanol. Accumulation of digestive enzymes and autodigestion of the parenchyma gland destroys pancreatic cells. Autodigestion leads to edema, vascular insufficiency, and ischemia of the pancreas (Capriotti,2020, p.790). Increased levels of ethanol decrease bicarbonate and hinder trypsin inhibitor. Because of the lack of bicarbonate and trypsin, acids destroy the parenchyma. Destruction of the parenchyma causes pancreatic outflow, edema, and inflammation. Pancreatitis is characterized by two categories acute pancreatitis and chronic pancreatitis. Acute pancreatitis causes retroperitoneal blood accumulation, while chronic pancreatitis causes permanent changes in the structure and function of the pancreas. An individual, after an episode of pancreatitis, becomes deficient in digestive enzymes and insulin (Capriotti, 2020, p. 791). Severe pancreatitis can have systemic complications. Systemic complications of pancreatitis include cardiovascular, renal, and respiratory failure (Capriotti, 2020, p. 792). Renal failure in pancreatitis is caused by hypovolemia and decreased renal perfusion, while respiratory failure is caused by the splinting of respiration and atelectasis. Respiratory failure improves as inflammation of the pancreas decreases.

Expected findings and signs and symptoms of pancreatitis. Pancreatitis presents with severe abdominal pain, nausea, vomiting, and diarrhea. According to Capriotti (2020, p. 791), the pain associated with pancreatitis suddenly intensifies in severity and is characterized as dull, penetrating, and steady. Some other signs and symptoms associated with pancreatitis are anorexia, fever, tachycardia, hypertension, dyspnoea, tachypnea, and diaphragm irritation. Expected findings of pancreatitis include abdominal tenderness, distention, diminished or absent bowel sounds, Cullen sign, and grey turner sign.

Pancreatitis is diagnosed with several tests involving blood work and noninvasive imaging. Blood work, along with the ransom criteria, reveals the severity of pancreatitis. Blood work includes complete blood count, blood glucose levels, serum calcium lactic dehydrogenase, blood urea nitrogen, lipase, and amylase. Amylase levels in pancreatitis are 10 to 20 times greater than normal, and serum lipase levels are elevated after 72 hours. According to Gapp & Chandra (2022), diagnosis of pancreatitis requires at least two criteria, such as lipase or amylase levels being three times the normal level and a physical exam consistent with pancreatitis or imaging showing findings that are consistent with pancreatitis. Noninvasive images include CT scans, MRCP, and abdominal and endoscopic ultrasounds. Particular tests and labs performed on the patient to support the diagnosis of pancreatitis are a CBC and a CT scan of the abdomen and pelvis without contrast.

Treatments for pancreatitis are dependent on the severity of the disorder. According to Capriotti (2020, p. 793), no treatment can completely eradicate pancreatic inflammation, but the main goal of treatment is providing supportive care and minimizing pancreatic stimulation. Patients are given pain medication such as analgesics for pain control because pancreatic pain is intense. According to Gapp & Chandra (2022), lactated ringer's solution is recommended for patients with pancreatitis, along with 24/7 monitoring of blood urea nitrogen, hematocrit, and urine output. Patients with pancreatitis may undergo fluid resuscitation and nasogastric suction, and in patients with gallstones impacting the ampulla, ERCP sphincterotomy with stone extraction is required. In severe pancreatitis, surgery may be necessary to remove part of the pancreas or block the nerves in the abdominal area causing the pain (Capriotti, 2020, p. 793). My patient has not received treatments other than supportive care and minimizing pancreatic stimulation. My patient was provided with analgesics for pain as needed. Listed clinical data that

correlate with the patient are the pain assessment and the abdominal and pelvis CT scan that show signs of pancreatitis.

Pathophysiology References (2) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis].

Gapp, J., & Chandra, S. (2022). Acute Pancreatitis. In *StatPearls*. StatPearls Publishing.

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	4.28-5.56k/ mcl	5.66k/mcl	N/A	Elevated red blood cells in the patient are caused by a history of chronic kidney disease and ischemic heart disease. An increase in red blood cells is a marker of pancreatitis, according to Capriotti (2020, p. 791)
Hgb	13.0-17.0g/dl	16.6g/dl	N/A	N/A
Hct	38.1-48.9%	47.9%	N/A	N/A
Platelets	149-393k/mcl	200k/mcl	N/A	N/A
WBC	4.0-11.7k/mcl	7.8k/mcl	N/A	N/A
Neutrophils	2.4-8.4mcl	5.9k/mcl	N/A	N/A
Lymphocytes	0.8-3.7mcl	1.1mcl	N/A	N/A
Monocytes	0.3-1.1mcl	0.6mcl	N/A	N/A
Eosinophils	0.0-0.5mcl	0.1mcl	N/A	N/A
Bands	0-6.0	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-	136-145mmol/l	136mmol/l	138mmol/l	N/A
K+	3.5-5.1mmol/l	4.0mmol/l	3.5mmol/l	N/A
Cl-	98-107mmol/l	98mmol/l	104mmol/l	N/A
CO2	21-31mmol/l	24mmol/l	24mmol/l	N/A
Glucose	74-109mg/dl	324mg/dl	152mg/dl	The elevated glucose level in this patient is caused by pancreatitis affecting the amount of insulin the body produces (Capriotti, 2020, p. 792). The high glucose level in this patient could also be because of the patient's history of type 2 diabetes.
BUN	7-25mg/dl	31mg/dl	27mg/dl	The patient's elevated bond level is related to the patient's history of chronic kidney disease (Pagana, 2018).
Creatinine	0.70-1.30mg/dl	1.34mg/dl	1.24mg/dl	The patient's elevated creatinine levels could be due to the patient's history of hypertension and chronic kidney disease (Pagana, 2018).
Albumin	3.5-5.2g/dl	4.7g/dl	N/A	N/A
Calcium	8.6-10.3mg/dl	12.7mg/dl	10.2mg/dl	The patient's elevated calcium level is related to pancreatitis (Pagana, 2018).
Mag	1.6-2.4mg/dl	N/A	2.1mg/dl	N/A
Phosphate	34-104mg/dl	75mg/dl	N/A	N/A
Bilirubin	0.3-1.0mg/dl	1.2mg/dl	N/A	the patient elevated bilirubin level is related to pancreatitis because of pancreatic edema causing compression of the bile duct (Capriotti, 2020, p. 792).
Alk Phos	13-104units/l	75units/l	N/A	N/A
AST	13-39units/l	14unit/l	N/A	N/A

ALT	7-52unit/l	19unit/l	N/A	N/A
Amylase	29-103 unit/l	N/A	N/A	N/A
Lipase	11-82unit/l	26unit/l	N/A	N/A
Lactic Acid	<2.5mmol/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	0.86- 1.4	N/A	N/A	N/A
PT	11.9- 15	N/A	N/A	N/A
PTT	22.6 - 35.3	N/A	N/A	N/A
D-Dimer	0.00 - 0.62g/l	N/A	N/A	N/A
BNP	0-100pg/ml	N/A	N/A	N/A
HDL	23-92mg/dl	N/A	N/A	N/A
LDL	75 -193mg/dl	N/A	N/A	N/A
Cholesterol	<199mg/dl	N/A	N/A	N/A
Triglycerides	<150mg/dl	N/A	N/A	N/A
Hgb A1c	<5.7%	N/A	N/A	N/A
TSH	0. 45 - 5.33uU/ml	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	colorless	N/A	N/A	N/A
pH	5.0-8.0	5.5	N/A	N/A
Specific Gravity	1.005-1.034	N/A	N/A	N/A
Glucose	>1000	>1000	N/A	N/A
Protein	Negative	Negative	N/A	N/A
Ketones	Negative	Negative	N/A	N/A
WBC	<= 5/HPF	< 1	N/A	N/A
RBC	0-3 HPF	< 1	N/A	N/A
Leukoesterase	Negative	Negative	N/A	N/A

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

Test	**Normal Range**	**Value on Admission**	**Today's Value**	**Explanation of Findings**
Urine Culture	Negative	N/A	N/A	N/A
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Capriotti, T. M. (2020). *Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives*. [FADavis].

Pagana, K.D., Pagana, T.J., & Pagana, T.N. (2018). *Mosby's Diagnostic and Laboratory Test Reference* (14th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

EKG 10/02/22

EKG test showed sinus tachycardia with premature ventricular complexes. Sinus tachycardia is possibly caused by pain.

Nuclear stress test 9/13/22

Results of the test: The patient is stressed with a resting heart rate of 98 BPM, which has risen to 109 BPM. The patient's blood pressure is 112/72, with a normal sinus rhythm. PVC and PAC are frequent with nonspecific St and T wave changes. Functional capacity could not be assessed.

Echo test 09/12/22

echo showed a normal ejection fraction of 25 to 30% with a Grade 1 diastolic dysfunction and impaired relaxation without increased left ventricular feeling pressure. The test also showed Frequent PVCS and a bundle branch block. The right atrium and right ventricular pacemaker were visualized. The test also showed mild mitral regurgitations along with tricuspid valve regurgitation. The inferior vena cava was normal.

CT of the abdomen and pelvis without contrast 2/16/22

The CT scan showed limited atherosclerosis without an aneurysm, chronic occlusion of the splenic vein with extensive collateral circulation, and gastric varices with the risk of a hemorrhage. Another finding of the abdominal CT scan is peripancreatic fat consistent with pancreatitis and no pseudocysts The CT scan of the pelvis showed a mildly enlarged prostate.

Diagnostic Test Correlation (5 points):

This EKG test was done to examine if the patient's primary diagnosis affected the patient’s cardiovascular system. Severe pancreatitis can affect the cardiovascular system.

The nuclear stress test was done to assess the damage done to the heart and diagnose coronary artery disease. The test measures blood flow during rest and activity. It shows areas with poor blood flow and any damage to the heart.

The echocardiogram was ordered for the patient to determine whether all parts of the heart were functioning. The patient has a history of coronary artery disease and heart failure.

A CT scan of the abdomen and pelvis was done to examine if there were any abnormal functions or growth. The CT scan of the stomach is performed to assess the abdomen and pelvis for tumors, lesions, injuries, bleeding, unexplained abdominal pain, and obstructions. A CT scan of the abdomen and pelvis can diagnose kidney stones, hernias, aneurysms, infections, pancreatitis, and many other conditions.

Diagnostic Test Reference (1) (APA):

Capriotti, T. M. (2020). Davis Advantage for Pathophysiology Introductory Concepts and Clinical Perspectives. [FADavis].

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

Home Medications (5 required)

Brand/ Generic	Atorvastatin/ Lipitor	Insulin detemir/levemir	Buspirone/ bustab	Enoxaparin/ Lovenox	Furosemide/ lasix
Dose	80mg/tab	30 units	10mg/tab	40mg	20mg/tab
Frequency	At bedtime	At bedtime	Twice daily	Daily	Every 48 hours
Route	Oral	Subcutaneous	Oral	subcutaneous	Oral
Classification	Pharmacological class; HMG-COA reductase inhibiter. Therapeutic class; Antihyperlipidemic.	Pharmacological class; insulin, long-acting. Therapeutic class; Antidiabetic.	Pharmacological class; Azaspirone. Therapeutic class; Anxiolytic	Pharmacological class; Lower molecular weight heparin. Therapeutic class; anticoagulant.	Pharmacological class: loop diuretic. Therapeutic class: antihypertensive, diuretic.
Mechanism of Action	This medication reduces plasma cholesterol	This medication binds to insulin receptors.	This medication acts as a partial agonist at	Enoxaparin is a coagulation inhibitor. It rapidly binds with	This medication inhibits sodium and water

	and lipoprotein levels by inhibiting HMG-COA reductase and cholesterol synthesis in the liver and by increasing the number of LDL receptors on liver cells to enhance LDL uptake and breakdown (Jones, 2020).	Receptor-bound insulin lowers blood glucose by facilitating the cellular uptake of glucose into skeletal muscle and fat by inhibiting the output of glucose from the liver (Jones, 2020).	serotonin five hydroxytryptamine 1A receptors in the brain, producing anti-anxiety effects(Jones, 2020).	antithrombin 3 and inactivates clotting factors (Jones, 2020).	reabsorption in the loop of Henle and increases urine formation (Jones, 2020). “It increases the execution of calcium, magnesium, bicarbonate, ammonium, and phosphate” (Jones, 2020). It also reduces intracellular and extracellular fluid volume by reducing blood pressure and decreasing cardiac output (Jones, 2020).
Reason Client Taking	The patient is taking this medication for this lipidemia.	The patient is taking this medication because of his history of type 2 diabetes.	The patient is taking this medication to reduce anxiety caused by unknown abdominal pain.	The patient is taking this medication to prevent any formation of DVT.	The patient is taking this medication to reduce edema caused by pancreatitis.
Contraindications (2)	This medication is contraindicate	This medication is	This medication is contraindicat	This medication is contraindicated	This medication is

	d in patients with active hepatic disease and breastfeeding patients. This medication is also contraindicated in patients with hypersensitivity to atorvastatin (Jones, 2020).	contraindicated in patients with decreased kidney function and liver problems (Jones, 2020).	ed in patients with hypersensitivity to buspirone and its components and in patients with severe hepatic or renal impairment (Jones, 2020).	in patients that eat pork products and patients with active major bleeding or who have a history of immune-mediated heparin-induced thrombocytopenia (Jones, 2020).	contraindicated in patients with anuria and hypersensitivity to previous furosemide or its components.
Side Effects/Adverse Reactions (2)	Hypoglycemia and thrombocytopenia.	Low blood sugar and severe headache.	Chest pain and blurred vision.	Confusion and spinal hematoma.	Hyperglycemia and Constipation.
Nursing Considerations (2)	Be aware that atorvastatin may be used with colestipol or cholestyramine for additive antihyperlipidemic effects. Use atorvastatin cautiously in patients who consume substantial quantities of alcohol or have a history of liver disease because atorvastatin use increases the risk of liver dysfunction	The patient should be assessed for symptoms of hypoglycemia or hypoglycemia. Ensure the injection site is rotated to avoid subcutaneous atrophy (Jones, 2020).	This medication should be used cautiously in patients with hepatic or renal impairment. Patients should be educated to take this medication always, with or without food, consistently (Jones, 2020).	This medication should be used cautiously in patients with diabetic retinopathy, hepatic or renal impairment, GI hemorrhaging, ulceration, and uncontrolled hypertension (Jones, 2020).	“Furosemide must be used cautiously in patients with advanced hepatic cirrhosis, especially those who have a history of electrolyte imbalance or hepatic encephalopathy. This drug may lead to lethal hepatic coma” (Jones, 2020).

	(Jones, 2020).				

Hospital Medications (5 required)

Brand/ Generic	Pragabli n/Lyrica	Ticagrelor/ Brilinta	Tramadol/ Conzip, Ultram, Ultram ER	Hydromorphone/ Dilaudid, dilaudid-HP, Exalgo	Promethazine/ Promethegan
Dose	150mg/cap	90mg/tab	50mg/tab	0.5mg	12.5mg
Frequency	Twice daily	Twice daily	As needed	As needed	As needed
Route	Oral	Oral	Oral	Intravenous push	Intramuscular
Classificati on	Pharmacolo gical class; gamma-aminobutyr ic acid analogs. Therapeutic class; anticonvuls ant.	Pharmacol ogical class; P2Y 12 platelet inhibitor. Therapeuti c class; antiplatelet .	Pharmacolo gical class; opioid agonist. Therapeutic class; opioid analgesic.	Pharmacological class; opioid. Therapeutic class; opiod analgesic.	Pharmacological class; Phenothiazine. Therapeutic class; antiemetic, antihistamine, antivertigo, sedative-hypnotic.

Mechanism of Action	This medication binds presynaptically to the A2D subunit of voltage-gated calcium channels in the central nervous system and modulates the release of several excitatory neurotransmitters.	This medication reversibly interacts with the platelet P2Y 12 ADP receptor to prevent platelet activation (Jones, 2020).	This medication binds with immune receptors and inhibits the reuptake of norepinephrine and serotonin (Jones, 2020).	This medication binds with opioid receptors in the spinal cord and at higher levels in the CNS. It stimulates Kappa and MU receptors, thus altering the perception of and emotional response to pain (Jones, 2020).	this medication competes with histamine for H1 receptor sites, thereby antagonizing many histamine effects and reducing allergy signs and symptoms. It also prevents motion sickness, nausea, and vertigo by acting centrally on the medullary chemoreceptive trigger zone and decreasing vestibular stimulation and labyrinthine function in the inner ear (Jones, 2020).
Reason Client Taking	This patient is taking this medication for pain.	This patient takes this medication to prevent thrombotic cardiovascular events and reduce thrombosis due to stent placement (Jones, 2020).	The patient is taking this medication to relieve severe pain from pancreatitis.	The patient is also taking this medication to relieve severe pain caused by pancreatitis.	The patient is taking this medication for nausea and vomiting.
Contraindications (2)	This medication is contraindicated in patients	This medication is contraindicated in patients	This medication is contraindicated in patients	This medication is contraindicated in patients with a history of narrowing of the	This is medication contraindicated in patients with hypersensitivity promethazine and

	with hypersensitivity to the medication and in patients with a history of angioedema.	with active bleeding and a history of intracranial hemorrhaging.	with acute or severe bronchial asthma without resuscitative equipment. This medication is also contraindicated in patients with gastrointestinal obstructions such as paralytic ileus.	GI tract or presence of blind loops in the GI tract, or GI obstruction, including paralytic ileus. This medication is also contraindicated in patients with acute asthma in an unmonitored setting or in the absence of resuscitative equipment (Jones, 2020).	its components. This medication is also contraindicated in comatose patients.
Side Effects/Adverse Reactions (2)	Suicidal ideations and GI bleeding.	Intracranial bleeding and coughing.	Seizures and adrenal insufficiency.	Hepatotoxicity and laryngeal edema.	Hypertension and anorexia.
Nursing Considerations (2)	This medication should not be abruptly stopped or discontinued but by tapering over a minimum of one week, and patients with diabetes should be monitored for incidences of	Nurses should be aware that this medication is not given to patients with active pathological bleeding or a history of intracranial hemorrhage. This medication should also not be	Nurses should be aware that tramadol should not be given to patients with a history of anaphylactoid reactions to codeine or other opioids. Nurses should also avoid giving tramadol to patients	Nurses should be aware that hydro morphine therapy increases the risk of abuse, addiction, and misuse. Patients should be monitored closely throughout the therapy for abuse, addiction, or misuse. Hydro morphine should be used cautiously in patients whose ability to maintain normal	Nurses should inject I.M. form of the medication deep into large muscle mass and rotate sites. Nurses should monitor respiratory function because this medication can cause cough reflex and cause thickening of bronchial secretions (Jones, 2020).

	hypoglycemia.	studied in patients who are undergoing coronary artery bypass graft surgery or patients with severe hepatic impairment (Jones, 2020).	with acute abdominal conditions because it may mask evidence and disrupt assessment of the abdomen (Jones, 2020).	blood pressure is already compromised by reduced blood volume or concurrent administration of CNS depressant drugs (Jones, 2020).	

Medications Reference (1) (APA):

Jones, D.W. (2021). *Nurse's drug handbook.* (A. Bartlett, Ed.) (19th ed.). Jones & Bartlett Learning.

Assessment

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

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A&O X4 is oriented to person, place, situation, and time. Fall risk scores less than 25. Braden scale 13-14. the patient has a moderate risk for pressure ulcers. The patient shows no sign of distress now. The patient is appropriately dressed
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	The patient skin color is usual for ethnicity no sign of cyanosis, rash, lesions, bruises, or wounds. The skin is dry, warm, and intact. The patient skin turgor is less than three seconds. Braden's score is 13 to 14. The patient's temperature was 97.1 upon assessment. The patient had no drains present upon assessment. The patient skin was warm with no sign of edema.
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	The patient's head is normal cephalic, and the neck is symmetrical with the trachea at the midline. The carotid pulse is +2 bilaterally. There are no scarring, depressions, or palpable masses. The patient's hair has a normal texture and is evenly distributed. The patient's eyes are symmetrical, with no sign of exudates or hemorrhage. The eyes are perrla, and extraocular movements are intact. The eyes have no sign of nystagmus. The ears are symmetrical with no sign of discharge and no tenderness. That tympanic membrane is normal in appearance, and hearing is intact. The nasal mucosa is pink and moist. The nasal septum is midline, and the nares are patent bilaterally. The patient's oral mucosa is pink and moist End the pharynx is normal in appearance without tonsillar swelling or exudates. .
CARDIOVASCULAR: **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒**	The patient had sinus rhythm with S1 and S2 upon auscultation. Peripheral pulses are 3+ normal. The patient's capillary refill is less than two seconds. No neck vein distention or edema is present.

Edema Y ☐ N ☒ **Location of Edema:**	
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	The patient has normal lung sounds. The diaphragm rises and falls symmetrically bilaterally. Normal lung sounds anteriorly and posteriorly. Respirations are intact. Respirations 18 per min. The patient did not use accessory muscles when breathing.
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 is on a heart healthy diet at the hospital. the patient's height is 66 inches and weighs 136 pounds. The patient's bowel sounds were hyperactive in the right and left abdomen and normal or active sound in the lower right and left abdomen. the patient's last bowel movement was the night of 10/1/22 at night. The patient felt tenderness upon palpation of the upper right and left region of the abdomen. The abdomen did not appear to be distended and no masses or wounds were present. The patient's abdomen had no scars, incision or lesions upon observation. The patient has no ostomy or nasogastric or feeding tubes present.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:N/A** **Size:N/A**	The patient's urine was yellow and clear with no abnormal odor. The patient voided x1 equal to 350ml in 5 hours. The patient has no pain with urination. The patient had no dialysis or catheter in place. No urgency or frequency with urination.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐**	The patient's new vascular status is intact, and all senses are intact. The patient uses a walker to get around. The patient has both active and passive range of motion in all extremities. Upper extremity strength is 5/5 bilaterally. Lower

Fall Risk: Y ☒ N☐ **Fall Score: 25** **Activity/Mobility Status:** **Independent (up ad lib) ☐** **Needs assistance with equipment ☐** **Needs support to stand and walk☐**	extremity strength is left side at 5/5, and the right side is at 4/5. The patient receives help with activities of daily living. The patient scored 25 on a fall risk scale. The patient requires minimal assistance transferring. This patient can bear weight and requires assistive devices such as a walker.
NEUROLOGICAL: **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☒ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	The patient has 5/5 strength in the upper left extremity and 4/5 strength in the right lower extremity. The patient's pupils are equally reactive to light and accommodation. The patient is oriented to time, person, place, and situation. The patient has normal cognition and is alert and communicating frequently. The patient's speech is clear and intact. The patient is hyper-alert and awake, answering questions appropriately. The patient communicates continuously.
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 stated that he has no coping methods and does not cope well. The patient stated that religion means nothing to him but if there's anything that he believes in it would be the cosmos. The patient lives with his wife, who is also partially disabled. The patient stated that he and his wife receive home care Monday and Wednesday for five hours and Tuesday, Thursday Friday for one to two hours. The patient stated that "the home help helps with laundry, cooking, and cleaning around the house".

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:15am	99	125 / 98	18	98.24	99
10:25am	135	135 / 90	22	98	100

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:20 am	0/10	abdomen	7	sharp, stabbing, and deep pain	The patient received pain medication intravenously.
11:00 am	0/10	N/A	0	N/A	N/A

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:**	Peripheral IV Location: Left Hand Date/Time: 10/2/22; 02:50 Size: 20 Gauge Dry, clean, and intact. No erythema, drainage, etc. Lactated ringer's running at the moment

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
by mouth 16ml jello,12ml sprite zero IV 500ml lactated ringers	350ml of urine

Nursing Care

Summary of Care (2 points)

Overview of care: The student nurse entered the patient's room at around 7:00 am. The student nurse introduced himself to the patient. The patient was alert and oriented to the time,

place, and situation when the student entered the room, and throughout the time the student was present. The student nurse, at around 7:40 am, begins a head-to-toe assessment of the patient. The student assessed the patient for pain at around 8:20. The patient complained of abdominal pain. The patient claimed his pain was 7 on a scale of 0 to 10. The student nurse informed the registered nurse assigned to the patient about the patient's pain level. The registered nurse administered pain medication to the patient around that time. The student nurse provides the patient with two jellos and one Sprite zero after administering the patient's daily medications. The respiratory nurse walks in at about 10:300 AM and performs breathing exercises with the patient. The patient begins experiencing difficulty breathing around 11 AM. The student knows informs the registered nurse about the patient having difficulty breathing. The registered nurse assesses the patient and advises the patient to breathe in and out. The student nurse also takes the second set of vitals on the patient around this time. The patient stops complaining of difficulty breathing after the set of vitals is taken. The physical therapist walks in at noon and walks the patient along the hallway with another student nurse. The physical therapist returns the patient to the room at around 12:15 AM. The patient uses the restroom, and 350ml of urine is measured. The patient is placed in a chair but the physical therapist and the student nurse. The student nurse leaves the patient around 12:30 AM.

Procedures/testing done: The patient only received breathing exercises during the student nurse’s shift.

Complaints/Issues: The patient complained of pain at 8:20. The registered nurse administered pain medication to the patient. The patient also complained of difficulty breathing. The registered nurse advised the patient to breathe in and out to help with breathing.

Vital signs (stable/unstable): The patient’s vital signs were stable throughout the day.

Tolerating diet, activity, etc.: The patient is on a heart-healthy diet. He was provided with 2 jellos and one Sprite zero. The patient stated that he could not have food because he gets nauseous at the sight of food.

Physician notifications: The physician did not have any orders for the patient. The physician stated that he would talk to the patient's primary care physician to see if there was anything he could do about ordering an inhaler that was fitted for the patient.

Future plans for the client: The patient will need to stay overnight for continuous monitoring because the patient experienced high pain levels in the abdomen and difficulty breathing. The respiratory nurse should continue breathing exercises with the patient.

Discharge Planning (2 points)

Discharge location: The patient will go home to his wife.

Home health needs (if applicable): the patient does not need further home health help. The patient already receives home health help every day of the week.

Equipment needs (if applicable): The patient needs a walker to get around.

Follow-up plan: The patient needs to follow up with his primary care physician for an abdominal assessment.

Education needs: the patient needs to be educated about maintaining a heart-healthy diet and the complications of misusing or relying on opioid medications. The patient should also be advised to rest after discharge.

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 "related to" and	• Explain why the nursing diagnosis			• How did the client/family respond to the nurse's

"as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	was chosen			actions? • Client response, status of goals and outcomes, modifications to plan.
1. Acute pain related to biological injury agent as evidenced by abdominal pain	The patient has been diagnosed with pancreatitis and is complaining of abdominal of 7 on a scale of 0/10	1. Asses the patient's signs and symptoms of pain behavioral cues and administer pain medication as prescribed. Monitor and record the medication's effectiveness and adverse effects. 2. Provide the patient with information to help increase pain tolerance; for example, reasons for pain and the length of time it will last.	1. The patient will express relief from pain within a reasonable time after the intervention.	1. The patient reports achieving pain relief with analgesia and other measures. 2. The patient states satisfaction with the pain management regimen.
2. Imbalanced nutrition: less than the body requirement related to insufficient dietary intake evidenced	The patient complained of an inability to digest food stating, " I ate a chicken soup and threw up everyone.	1. Provide a diet prescribed for a patient-specific condition to improve the patient's nutritional status and increased	1. Patient and family members will communicate understanding of special dietary needs.	1. Patient and family members have demonstrated the ability to plan diet after discharge. 2. Patient doesn't develop adverse reactions from feedings, such as

by nausea and vomiting		weight. 2. Determine food preferences and provide them within the limitations of patients' prescribed diet.		aspiration of food particles into lungs, diarrhea, and hyperglycemia.
3. Risk for falls related to impaired mobility as evidenced by use of assistive devices.		1. Assess the patient's ability to use the call light and all other safety emergency systems. Remove anything from the environment that will increase the risk of falls; For example, throw rugs, cords, and furniture blocking the patient's path to the bathroom. 2 Review medications with patient and family. Help the patient understand which medications put the patient at risk for falls. Knowing the risk may help the patient take more care in	1. Patient and/or family will identify the factors that increase potential for falls.	1. Patient and family can point out things in the environment that put them at risk. 2. Patient and family members assist in making the changes necessary to promote fall prevention.

		moving about. It may also call for reviewing with the primary care physician.		

Other References (APA): Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual* (11th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

The patient said, “My pain was a seven on a scale of 0 to 10 last night.”
The patient said, “my is sharp, stabbing, and deep.”
The patient said,” I had some canned chicken soup the night before the pain started but I couldn't hold the food down I vomited everywhere. “

Nursing Diagnosis/Outcomes

1. Acute pain related to biological injury agent as evidenced by abdominal pain
   Outcome: The patient will express relief from pain within a reasonable time after the intervention.
2. Imbalanced nutrition: less than the body requirement related to insufficient dietary intake evidenced by nausea and vomiting
   Outcome: Patient and family members will communicate understanding of special dietary needs.
3. Risk for falls related to impaired mobility as evidenced by use of assistive devices.
   Outcome: Patient and/or family will identify the factors that increase potential for falls.

Nursing Interventions

1.a.) Asses the patient’s signs and symptoms of pain behavioral cues and administer pain medication as prescribed. Monitor and record the medication’s effectiveness and adverse effects.
b.) Provide the patient with information to help increase pain tolerance; for example, reasons for pain and the length of time it will last.
2.a.) Provide a diet prescribed for a patient-specific condition to improve the patient’s nutritional status and increased weight.
b.) Determine food preferences and provide them within the limitations of patients’ prescribed diet.
3.a.) Assess the patient’s ability to use the call light and all other safety emergency systems. Remove anything from the environment that will increase the risk of falls; For example, throw rugs, cords, and furniture blocking the patient’s path to the bathroom.
b.) Review medications with patient and family. Help the patient understand which medications put the patient at risk for falls. Knowing the risk may help the patient take more care in moving about. It may also call for reviewing with the primary care physician.

Objective Data

CT of the abdomen and pelvis without contrast 2/16/22
Another finding of the abdominal CT scan is peripancreatic fat consistent with pancreatitis and no pseudocysts
Vital signs: BP 135/90
Labs: Glucose admission: 324mgdl and today: 152mg/dl. Bilirubin admission 1.2mg/dl.

Client Information

A 62-year-old Caucasian male with a history of acute pancreatitis, type 2 diabetes, chronic pancreatitis, and hypertension was admitted for pancreatitis. The patient is alert and oriented to time, place, and situation. The patient is alert and answering questions appropriately.