## Medications

**Atorvastatin (Lipitor) tablet 20mg oral daily**

***Pharmacologic class: HMG-CoA reductase inhibitor (NDH, 2023). Therapeutic class: Antihyperlipidemic (NDH,2023).***

**Rationale: To control lipid levels as an adjunct to diet primary (heterozygous familial and non-familial) hypercholesterolemia and mixed dyslipidemia (NDH,2023).**

**Key Nursing Assessment: Monitor diabetic patients' blood glucose levels because atorvastatin therapy can affect blood glucose control (NDH,2023).**

**Gabapentin (Neurontin) capsule 300mg QID**

## Lab Values/Diagnostics

Sodium 135 Normal 136-145 mEq/L Abnormal due to diarrhea and vomiting (Pagana et al., 2023)

Chloride 109 Normal 98-106 mEq/L Abnormal due to dehydration (Pagana et al., 2023)

CO2 Venous 21 Normal 23-30 mEq/L Abnormal due diabetic ketoacidosis or metabolic acidosis Pagana et al., 2023)

Calcium 8.4 Normal 9-10.5 mg/dL Abnormal due to possible malabsorption (Pagana et al., 2023)

Bun/Creatinine 23 Normal 0.5-1.1 mg/dL 44-97 umol/L Abnormal due to decreased muscle mass (Pagana et al., 2023)

WBC 12.8 Normal 5000-10000/mm3 Abnormal due to infection, stress, leukemic neoplasia (Pagana et al., 2023)

MPV 9.0 Normal 7.4-10.4 fL Abnormal due to diagnosis of leukemia (Pagana et

## Demographic Data

**Date of Admission: 02/24/2024**
**Admission Diagnosis/Chief Complaint: Abdominal pain and loose stool**
**Age: 55**
**Gender: F**
**Race/Ethnicity: Caucasian/ White**
**Allergies: Adhesive Tape /Bandage**
**Code Status: FULL**
**Height in cm: 167.7 cm**
**Weight in kg: 49 kg**
**Psychosocial Developmental Stage: Generativity vs. Stagnation**
**Cognitive Developmental Stage: Formal Operational Stage**
**Braden Score: 23**
**Morse Fall Score: 75**
**Infection Control Precautions: At admission, the client was on contact precautions but was changed to standard soon after.**

## Admission History

**The 55-year-old Caucasian female presents to the ED via EMS with complaints of dehydration, nausea, vomiting, and abdominal pain. The patient states she's had 4 days of nausea, vomiting, and diarrhea. The patient says that there are no aggravating or alleviating factors. The client stated she came to the hospital because no one could assist her at home.**

## Medical History

**Previous Medical History: COPD, Acid reflux, Leukemia, Hemorrhoids, Colom polyps, Chronic abdominal pain, chronic headaches, Hypokalemia, Gastroenteritis, Type 2 diabetes, Leukocytosis, Peripheral Artery Disease, Mixed hyperlipidemia, Bipolar 1 disorder, Systemic mastocytosis, PID, Asthma, Pneumonia, Severe malnutrition, Osteomyelitis of left ankle**

**Prior Hospitalizations: 07/16/2022 Diabetic Foot Ulcer, 04/02/2023 Ischemic Stroke, 02/24/2024 Gastroenteritis**

**Previous Surgical History: Bone marrow biopsy w/ aspirate**

## Pathophysiology

**Disease process: Gastroenteritis occurs from an irrigation to the lining of the stomach, small intestine, or large intestine by pathogen or toxin. The disease can occur from a virus, bacteria, parasite, or chemical toxin (Capriotti, 2022). There was no clear answer on how the client encountered this disease based on the client needing to be more forthcoming with her medical care. However, it would be safe to assume that the client was either in close proximity to someone who recently had the disease or it was transmitted through the fecal-oral route. Our textbook shows that if norovirus or rotavirus were the causative agents, the disease was transmitted by fecal-oral route. Infectious microorganisms are usually responsible for acute gastroenteritis**

## Active Orders

Consult with Dietary/Nutrition: Nausea and vomiting on admission.

I&O Q8: To monitor for electrolyte imbalances.

Stool culture 1 occurrence: To check for C. Diff due to the 4 days of diarrhea.

CBC w/ Diff- draw for 3 days: Checking for any indication of electrolyte imbalances and signs of infection.

Basic Metabolic Panel with calcium total: The patient experienced vomiting and diarrhea. This test was done to check her fluid balance, kidney function, and electrolyte level and to measure the amount of calcium in the blood.

Pulse Ox: to check oxygen levels.

**Physical Exam/Assessment**

**General: Alert and oriented x4 to person, place, situation, and time. No acute distress. Client is disheveled, only dressed on a pink sweatshirt, and hospital net underwear. The client is visibly irritated.**

**Integument: Usual for ethnicity, dry and intact, elastic skin turgor, warm, dry intact. Void of rashes, lesions, and bruising. The client is missing her left great toe and has scaring from a debridement.**

**HEENT: The trachea has a midline void of deviation, the head and neck are symmetrical, and both carotid pulses are palpable and 2+. Both the bilateral EOMs and PERRLA are intact. Both eyes have a pink conjunctiva, a white sclera, a clean cornea, and no obvious eye discharge. Both lids are pink, wet, and free of discharge or sores. There is no obvious bleeding or polyps, the septum is midline, and the turbinates' are pink and wet on both sides. Palpation of the bilateral frontal sinuses reveals no tenderness.**

**Cardiovascular: Clear S1 and S2 void of murmurs, gallops, or rubs. PMI is palpable at the 5$^{th}$ intercostal space at MCL. Standard rate and rhythm. Cap refill +3 seconds**

**Respiratory: Patient is on room air; Reparations have a normal rate and pattern. Reparations are symmetrical and non-labored; lung sounds are clear. Void of wheezes, Crackles/Crepitus, and rhonchi. Client does have a dry smokers cough.**

**Genitourinary: Urine output WDL; urine is Amber/Gold; cannot assess beyond color because the client flushed the toilet while the student nurse was trying to complete the assessment. Stool is still a loose liquid consistency.**

**Gastrointestinal: Regular Diet as tolerated, no ostomy, NG, or feeding tube. Abdomen is soft, non-tender, no organomegaly or masses noted upon palpation of all four quadrants. Bowel sounds are hyperactive in the RLQ and RUQ quadrants. Last BM 2/26/24, no CVA tenderness was noted bilaterally.**

**Musculoskeletal: All extremities have full ROM. The client is malnourished. Hand grips and pedal pushers and pulls demonstrate normal and equal strength. The client stands with 1 assist and a gait belt. The client is unsteady on her feet and refuses to have staff assist her, opting to stumble to the bathroom and verbally abusing staff who attempt to help. The client is missing her left great toe and has scaring from a debridement.**

**Neurological: Pt is alert and awake, judgment is poor, and behavior is erratic; the client indicates syncope/dizzy spells, and headache.**

**Most recent VS (include date/time and highlight if abnormal): Temp: 97.6 BP: 157/72 HR 57 RR18 SPO2 99**

**Pain and pain scale used: On a scale of 0-10, the patient rated her pain a 6. She stated the pain was in her right lower abdomen.**

<table>
<tr>
<td>Nursing Diagnosis 1<br>Risk for Electrolyte Imbalance as related to diarrhea and vomiting as made evident by the client's history of gastrointestinal disorders and imbalance electrolytes, i.e., chronic abdominal pain, acid reflux, and hypokalemia (Phelps, 2023).</td>
<td>Nursing Diagnosis 2<br>Imbalanced Nutrition: Less than body requirements related to food aversion, as made evident by the patient admitting to reducing her oral intake over the last month and abdominal pain (Phelps, 2023).</td>
<td>Nursing Diagnosis 3<br>Self-neglect related to lifestyle choice, substance misuse, and medical noncompliance are made evident by nonadherence to health activity (Phelps, 2023).</td>
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<tr>
<td>Rationale<br><br>A Prompt diagnosis can assist in treatment, as electrolyte imbalances can cause poor coordination, weakness, and altered gait (Phelps, 2023).</td>
<td>Rationale<br>A dietician or nutritional support team can help the client and health care team individualize patients' diets within prescribed restrictions (Phelps, 2023).</td>
<td>Rationale<br>Neglected self-care may be the first sign of diminishing cognitive function (Phelps, 2023).</td>
</tr>
<tr>
<td>Interventions<br>Intervention 1: Collect and evaluate serum electrolyte results as ordered (Phelps, 2023).<ul><li>Rationale: To allow prompt diagnosis and abnormalities (Phelps, 2023).</li></ul>Intervention 2: Monitor patients for physical signs of electrolyte imbalance (Phelps, 2023).<ul><li>Rationale: Many cardiac neurologic and musculoskeletal symptoms indicate specific electrolyte abnormalities (Phelps, 2023).</li></ul></td>
<td>Interventions<br>Intervention 1: Determine food preferences and provide them within the limitations of the patient's prescribed diet (Phelps, 2023).<ul><li>Rationale: This enhances compliance with the diet regimen (Phelps, 2023).</li></ul>Intervention 2: Monitor electrolyte levels and repeat abnormal values (Phelps, 2023).<ul><li>Rationale: Poor nutritional status may cause electrolyte imbalances (Phelps, 2023).</li></ul></td>
<td>Interventions<br>Intervention 1: Assess patients with complex health issues for adequate coping abilities (Phelps, 2023).<ul><li>Rationale: Poor coping skills may lead to unintentional self-neglect (Phelps, 2023).</li></ul>Intervention 2: Encourage to identify internally motivating factors for adhering to health regiment (Phelps, 2023).<ul><li>Rationale: Persons who intentionally neglect self-care as a lifestyle choice will fare better if the decision to improve self-care was their decision (Phelps, 2023).</li></ul></td>
</tr>
<tr>
<td>Evaluation of Interventions<br><br>The patient’s electrolytes will remain within normal limits and safe from injury associated with electrolyte imbalances. The patient will also verbalize signs and symptoms that require interventions by a healthcare provider (Phelps,</td>
<td>Evaluation of Interventions<br>The patient will consume a specified number of calories daily and can identify the emotional and psychological factors that interfere with eating. The patient will be able to identify factors that create adverse effects from eating. The patient will also be</td>
<td>Evaluation of Interventions<br>The patient will adhere to the prescribed health activities by demonstrating the ability to maintain her health circumstances. The patient will utilize a diabetic diet to keep a healthy BG reading and will follow up with the PCP and specialist to prevent medical emergencies</td>
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</table>

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|---|---|---|
| **2023).** | **open about the factors contributing to her current BMI being less than 19 (Phelps, 2023).** | **regarding her acute and chronic diagnosis (Phelps, 2023).** |

**References (3) (APA):**


Capriotti, T. (2022). *Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives*. F.A. Davis Company.

Frandsen, G., & Pennington, S. S. (2021). *Abrams' clinical drug therapy: Rationales for Nursing Practice*. Wolters Kluwer Health.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2023). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

Phelps, L. L. (2023). *Nursing diagnosis reference manual*. Wolters Kluwer.

*2023 Nurse's Drug Handbook*. (2023). Jones & Bartlett Learning.