

N311 Care Plan 3

Taylor Lowe

Lakeview College of Nursing

N311: Foundations of Professional Practice

Professor Linda Scribner

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Demographics (5 points)

Date of Admission 10-14-24	Client Initials PC	Age 81	Gender Female
Race/Ethnicity White	Occupation Retired from being an artist	Marital Status Widowed	Allergies No known allergies
Code Status Attempt CPR/Full treatment	Height 165.1 cm (5'5 ft)	Weight 74.5 kg (164 lb. 3.9 oz)	

Medical History (5 Points)

Past Medical History: Acute blood less anemia. Astigmatism of the eye. Coronary artery disease. Cataract. Closed T1 fracture. Hypertension. Myocardial infarction. Right carpal tunnel syndrome. Small intestinal bacteria overgrowth.

Past Surgical History: Ventral hernia repair. Appendectomy. CABG with aortic valve replacement. Cardiac catheterization. Colonoscopy. EGD/ colonoscopy. Median nerve neuroplasty. R/L heart catheterization.

Family History: Dad has a heart attack at thirty-eight and another one at fifty-six. He also had hypertension. Mom had a heart attack at age 85. Her sister has bipolar.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Patient smoked four packs a day for ten years. She started smoking in 1962 and quit in 1972. She does not vape. She does not drink alcohol and reported no use of drugs.

Admission Assessment

Chief Complaint (2 points): Abdominal pain

History of Present Illness – OLD CARTS (10 points): Patient went to the emergency department on October 14, 2024, because she has nausea, vomiting, diarrhea, and pain in her abdomen. She had been having nausea, vomiting, and diarrhea for several days. She described

her pain as dull, achy, crampy, throbbing, and dispersed. Nothing was making it better and palpating it was making it worse. She did rate her pain a seven out of ten, which makes this pretty severe.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Small bowel obstruction due to adhesions

Secondary Diagnosis (if applicable): N/A

Small Bowel Obstruction

There are a few different types of small bowel obstructions. An acute obstruction simply means that it happened suddenly. It could be from a hernia or adhesions. A chronic obstruction can be seen with tumors or some type of inflammatory disease. A partial obstruction means that some things can pass, but a complete is a medical emergency because that means that nothing is able to get passed (Capriotti, 2024, pg. 747).

When someone gets surgery, adhesions form between the organs and the tissue. It is essentially connective tissue. The adhesions that bond and form tend to cause a blockage or alter the normal function of the small intestine. When this blockage forms, it can cause increased peristalsis and mucus accumulates, which only makes the blockage worse (Capriotti, 2024, pg. 747).

The signs and symptoms vary depending on the type of obstruction that it present. The more intense symptoms result from a bigger obstruction. Those who experience an obstruction might feel pain, nausea, vomiting, distension, and loud bowel sounds. The pain that people experience describe it as sharp, cramping, and coming and going. Sometimes, the pain can increase if the bowels get tangled up. When this occurs, it can cut off the oxygen to them. This then becomes a medical emergency in which the patient will need surgery (Capriotti, 2024, pg. 747).

Another major concern with small bowel obstructions is the diarrhea. Fluids are able to seep around the blockage. However, this can cause them to lose a lot of fluid and mess up their electrolytes, which is also very serious (Capriotti, 2024, pg. 747).

To diagnose and treat such a condition, a doctor made order an X-Ray, a CT scan, an ultrasound, or even a air or barium enema. These different specialized camera will give images of the abdominal area to see. The enema is achieved by putting air or liquid into the colon. The

treatments vary depending on the type of obstruction. It may involve putting a nasogastric tube down the throat to suck out any air trapped in the small intestine. A doctor may prescribe a low fiber diet. If these solutions still do not work, the patient may need to have surgery (Mayo Clinic, 2021).

References

Capriotti, T. (2024). *Pathophysiology: Introductory Concepts and Clinical Perspectives*. F.A.

Davis.

Mayo Clinic Staff. (2021, January 20). *Intestinal obstruction*. Mayo Clinic.

<https://www.mayoclinic.org/diseases-conditions/intestinal-obstruction/diagnosis-treatment/drc-20351465>.

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

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	4.73	N/A	Does not apply
Hgb	11.0-16.0	13.4	N/A	Does not apply
Hct	34.0-47.0	40.7	N/A	Does not apply
Platelets	140-400	203	N/A	Does not apply
WBC	4-11	12.89	N/A	They respond to infection and inflammation, which makes sense given her history (Capriotti, 2024, pg. 240).
Neutrophils	N/A	N/A	N/A	Does not apply
Lymphocytes	1-4.9	6.4	N/A	Because she has small intestinal bacteria overgrowth, it would explain why her lymphocyte levels were high (Pagana et al., 2023, pg. 950).
Monocytes	0-1.1	3.9	N/A	Because right carpal tunnel syndrome is considered an inflammatory disorder, this could explain why these levels were elevated (Pagana et al., 2023, pg. 950).
Eosinophils	0-0.5	0.1	N/A	Does not apply
Bands	N/A	N/A	N/A	Does not apply

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	134	141	The initial admission value was low because the patient was dehydrated. When one loses water, they also lose sodium (Capriotti, 2024, pg. 123).
K+	3.5-5.1	3.4	3.5	Those who are on diuretics experience this issue the most

				(Capriotti, 2024, pg. 126).
Cl-	98-107	98	111	Chloride levels can rise when a patient is dehydrated (Pagana et al., 2023, pg. 221). This checks out as she was dehydrated.
CO2	22-29	26.0	24.0	Does not apply
Glucose	74-100	144	120	She was on diuretics and she did overall have a bad diet (Pagana et al., 2023, pg. 453).
BUN	10-20	22	7	The initial increase was because of her dehydration. The sudden drop had a lot to do with her diet. She did not really eat any food (Pagana et al., 2023, pg. 151).
Creatinine	0.55-1.02	1.19	0.82	Her initial raise of her creatinine levels were due to her dehydration (Pagana et al., 2023, pg. 297).
Albumin	3.4-4.8	4.4	N/A	Does not apply
Calcium	8.9-10.6	9.9	8.3	Again, her lack of eating dropped her calcium levels because she was not intaking vitamin D (Pagana et al., 2023, pg. 181).
Mag	1.6-2.6	2.2	2.0	Does not apply
Phosphate	2.3-4.7	1.9	2.3	Phosphate is absorbed in the intestines. Because of the blockage that happened, her body was not able to absorb phosphate well (Pagana et al., 2023, pg. 675).
Bilirubin	Negative	Negative	N/A	Does not apply
Alk Phos	N/A	N/A	N/A	Does not apply

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

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Yellow and clear	Yellow and clear	N/A	Does not apply

pH	4.5-8.0	5.5	N/A	Does not apply
Specific Gravity	1.003-1.035	1.045	N/A	A high specific gravity is caused by a dehydrated person. It can be expected that they will have an abnormally large value (Pagana et al., 2023, pg. 909).
Glucose	Negative	Negative	N/A	Does not apply
Protein	Negative	Trace	N/A	A positive indicator would mean that her kidneys are essentially not working ((Pagana et al., 2023, pg.908). However, because it was a trace amount, more tests would need to be run to see this occurred.
Ketones	Negative	Trace	N/A	A positive indicator would mean that she may have diabetes (Pagana et al., 2023, pg. 910. However, because it was a trace amount, more tests would need to be run to explain this result.
WBC	0-5	0-3	N/A	Does not apply
RBC	0-4	0-2	N/A	Does not apply
Leukocyte esterase	Negative	Trace	N/A	Oftentimes, a positive indicator means a UTI (Pagana et al., 2023, pg. 909). However, because she had a trace amount, that does not mean that she has an infection. There needs to be more tests run to indicate why this abnormality happened.

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	N/A	N/A	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
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References

Epic Systems Corporation. (2024). *Epic*.

Pagana et al. (2023). *Mosby's Diagnostic & Laboratory Test Reference*. Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (10 points): They did an X-Ray of her kidney, ureter, and bladder. They made sure the NG tube was placed correctly. They also did a CT scan to see if the Isovue would pass through her intestines and into her rectum. The results showed that it did!

Diagnostic Imaging Reference (1) (APA):

Epic Systems Corporation. (2024). *Epic*.

Assessment

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

General, Psychosocial/Cultural, and ONE focused assessment specific to the client is required.

The student and instructor may complete these assessments together.

<p>GENERAL:</p> <p>Alertness:</p> <p>Orientation:</p> <p>Distress:</p> <p>Overall appearance:</p>	<p>Patient is alert and oriented to self and time. It took her a few minutes to say where she was. She did not know why she was here. No signs of distress and is well-groomed.</p>
<p>INTEGUMENTARY:</p> <p>Skin color:</p>	<p>Patient has warm, ivory skin. Most of her skin was a bronzy color. Her right shin was gray from bruising</p>

<p>Character:</p> <p>Temperature:</p> <p>Turgor:</p> <p>Rashes:</p> <p>Bruises:</p> <p>Wounds: .</p> <p>Braden Score:</p> <p>Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p> <p>Type:</p>	<p>that happened a while ago when she fell off a bike. Her skin was shiny in some parts like her shins. She was warm to the touch. It took her skin about three to four seconds to return to normal with the skin turgor. Patient had a wound on her right knee. She did not remember how she got that. On her right shin, it was bruised and scarred. She fell off a bike a long time ago. Her left bicep had a cut mark. She did not know how she got it. She had an abdominal scar around her bellybutton. She did not remember what that was from. It appeared to be from surgery. She scored a nineteen on the Braden score. She has no drains present.</p>
<p>HEENT:</p> <p>Head/Neck:</p> <p>Ears:</p> <p>Eyes:</p> <p>Nose:</p> <p>Teeth:</p>	<p>.</p>
<p>CARDIOVASCULAR:</p> <p>Heart sounds:</p> <p>S1, S2, S3, S4, murmur etc.</p> <p>Cardiac rhythm (if applicable):</p> <p>Peripheral Pulses:</p> <p>Capillary refill:</p> <p>Neck Vein Distention: Y <input type="checkbox"/> N <input type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Location of Edema:</p>	<p>.</p>
<p>RESPIRATORY:</p> <p>Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Breath Sounds: Location, character</p>	<p>.</p>

<p>GASTROINTESTINAL:</p> <p>Diet at home:</p> <p>Current Diet</p> <p>Height:</p> <p>Weight:</p> <p>Auscultation Bowel sounds:</p> <p>Last BM:</p> <p>Palpation: Pain, Mass etc.:</p> <p>Inspection:</p> <p> Distention:</p> <p> Incisions:</p> <p> Scars:</p> <p> Drains:</p> <p> Wounds:</p> <p>Ostomy: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p> Size:</p> <p>Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/></p> <p> Type:</p>	.
<p>GENITOURINARY:</p> <p>Color:</p> <p>Character:</p> <p>Quantity of urine:</p> <p>Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p>Inspection of genitals:</p> <p>Catheter: Y <input type="checkbox"/> N <input type="checkbox"/></p> <p> Type:</p>	

Size:	
MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/>	<p>Her fall score was a twelve which puts her at a moderate fall risk.</p>
NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:	<p>.</p>
PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: HELP Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	<p>When asked about her coping mechanisms, she said she didn't have any. When asked about her religion, she said it "meant nothing to her." She does have a cat but lives on her own. She said she did not have family around. In regards to Maslow's hierarchy of needs, she would be at self-actualization. She desires and meets the need of physical needs, safety needs, love and belonging, esteem, and self-actualization. She eats on her own. She lives on her own. She has</p>

	friends. She recognizes herself and has self-esteem. Even at her age, she still lives on her own.
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Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:46	63	142/76	14	36.7 °C	92% room air

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
9:53	Number scale	None	None	None	Keep monitoring the patient

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
-120 mL of decaf coffee	Patient had a bowel and urination movement.
-600 mL of water	Was not able to measure.

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
<ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components Listed in order by priority – highest 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 			<ul style="list-style-type: none"> How did the client/family respond to the nurse’s actions? <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications

priority to lowest priority pertinent to this client				to plan.
<p>1. Deficient fluid volume related to insufficient fluid intake as evidenced by altered skin turgor.</p>	<p>I chose this nursing diagnosis because being dehydrated can cause major issues to the body, so it is important that this was ranked first.</p>	<ol style="list-style-type: none"> 1. Administer IV fluids to the patient. Because she is not the biggest fan of actually drinking fluids, an IV will help. 2. Help her find ways to flavor the water- fruits, flavors, herbs. 	<p>1. By the time she is discharged, she will two large cups of water a day by using some type of sweetener to encourage her to drink more water.</p>	<p>1. When I told her about water flavoring, she told me that she did not know that was a thing and loved that idea. She recognized herself that she needed to drink more water.</p>
<p>2. Acute pain related to incomplete emptying of bowel as evidenced by cramping and pain in abdominal area.</p>	<p>She rated her pain a seven out of ten when she was first admitted. Her suffering in pain is not an acceptable state of being, so this is why I picked this diagnosis.</p>	<ol style="list-style-type: none"> 1. Give her pain medication that will help the pain. 2. Make sure that her body is well supported and cushioned. This way, it ensures her body is in the best comfortable spot to help ease the pain (Phelps, 2023, pg. 465). 	<p>1. By the time she leaves the hospital, the pain will be well managed that her pain scale number is lower than when she entered the emergency room.</p>	<p>1. I did encourage and helped her with her level of comfortability. I gave her pillows and blankets and made sure to support her where it hurt. She was very appreciative and was able to have a relaxing morning.</p>

Other References (APA):

Phelps, Linda L. (2023). *Nursing Diagnosis Reference Manual*. Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

-small bowel obstruction due to adhesions
 -nausea, vomiting, diarrhea, and pain in her abdomen
 -abnormal CBC, abnormal chemistry test, abnormal urinalysis, and abnormal blood pressure
 -pain is dull, achy, crampy, throbbing, and dispersed

-pain is 7/10
 -CT scan done with Isovue
Objective Data

Nursing Diagnosis/Outcomes

Deficient Fluid

1.) Deficient fluid volume related to insufficient fluid intake as evidenced by skin turgor. a. Outcome: By the time she is discharged, she will drink two large cups of water a day by using some type of help or reminder to encourage her to drink more.

2.) Acute pain related to incomplete emptying of bowel as evidenced by cramping and pain in abdominal area.

Abdominal Pain Nursing Interventions

1.) By the time she leaves the hospital, the pain will be well managed that her pain scale number is lower than when she entered the unit to help her pain.
 2.) Make sure that her body is well supported and cushioned. This way, it ensures her body is in the best comfortable spot to help ease the pain

Client Information

-Admission: 10-14-2024
 -Initials: PC
 -81 years old
 -Female
 -White
 -Retired from being an artist
 -Widowed
 -No known allergies
 -Full code
 -165.1 cm and 74.5 kg



