N311 Care Plan 4

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N311: Foundations of Professional Practice

Kristal Henry

10/31/2024

Demographics (5 points)

Date of Admission 10/27/2024	**Client Initials** J.H.	**Age** 40 years old	**Gender** **Male**
Race/Ethnicity Race: Black or African American. Ethnicity: not Hispanic, Latino/a, or Spanish origin	**Occupation** Unemployed	**Marital Status** Single	**Allergies** Fish
Code Status Full	**Height** **5' 8"**	**Weight** **87.1 Kg**	

Medical History (5 Points)

Past Medical History: The patient has no past medical history on file. Continues to deny upon inquiry by student.

Past Surgical History: The patient has no past surgical history on file. Continues to deny upon inquiry by student.

Family History: Mother – small cell lung cancer. Aunt – breast cancer.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): Reports only occasional alcohol or tobacco use, does not utilize smokeless tobacco. Endorses drug use of crack cocaine and regular marijuana use.

Admission Assessment

Chief Complaint (2 points): Sudden onset of abdominal pain with nausea and vomiting.

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

Patient reports onset of pain was on Saturday, with significant worsening by Sunday. Pain was highly localized to his abdomen, and very sharp in quality. The pain has changed, but has not

subsided since onset, as now he is suffering from surgery-related abdominal pain following the perforations repair. This pain is sharp in quality, and initially presented with significant nausea and vomiting as well. It is aggravated by movement through the abdomen, making repositioning and mobility very difficult, and he notes that he experiences it most when he needs to cough to clear his breathing, which places significant pain through his abdomen. Bedrest and pain medications administered by nursing have been primary sources of relief for this abdominal pain and he has found coughing slightly more tolerable once educated on hugging pillow against abdomen when he needs to cough. Additional treatments for his pain and discomfort that he currently notes are the application of saturated oral sponges to moisten his mouth, which he reports is also starting to get sore from thirst and dryness while he is NPO. Rates current abdominal pain at a 6/10 but notes that it was a 10/10 during admission.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Perforated viscus

Secondary Diagnosis (if applicable): Elevated lipase, acute colitis, diverticulitis.

Pathophysiology

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

PATHOLOGY

A perforated viscus is the opening of a portal outward of any normally closed hollow bodily organ due to internal forces breaking open in outward fashion, or internal forces puncturing inward. In relation to penetrative external forces, this is usually related to a trauma of some kind involving a foreign object penetrating the body and underlying organ. But with internal

precipitators of this breach there are numerous potential sources, with causative agents often being chronic, combinative, and cumulative. These contributing factors largely stem from one of two primary etiologies – either a bowel motility dysfunction or a chronic inflammatory condition of the gastrointestinal (GI) tract. With a perforation from within, we will often see both of these macro categories involved. Diet and what you put in your body can also be significant contributors or precursors with these categorizations as well.

CAUSES

Starting from a cellular level we must recognize that the inner lining for the gastrointestinal (GI) tract is comprised of specialized epithelial cells that play a role in absorption of nutrients in the passing digesting content, which is being mobilized by specialize micro-villi “hairs” that stem from these epithelial cells. In connection with our prior two major categories of motility dysfunction or chronic inflammation –it is when the movement of these hairs, and subsequently the movement of the digestive contents are disrupted, or when the cells themselves are chronically inflamed that we see degradation of this lining and the substrate beneath it. Often one begets the other, with inflammation impacting villi movement, and villi dysfunction leading to slow moving content that invokes inflammation in the area. When these conditions persist long enough, we start to see these issues becoming increasingly pronounced and lead to a deterioration of these cells and the lining that they compose, with the rate of damage exceeding that of the rate of repair the body can manage. As such, this pipeline, as it were, continues to break down. This then leads to the formation of various categories of damage to the inner walls of the gastrointestinal (GI) tract. Key to this patient's presentation is the formation of what are known as “diverticula” - small pockets or pouches that form in the wall and begin to accumulate waste. In the condition of diverticulitis, we see the formation of these pouches become an

increasing cause for significant pain and further inflammatory response. Motility further slows, pressure therefor increases, more waste is caught up in diverticula, more inflammation sets in, and cumulatively – if exacerbated frequently and significantly enough – there may be a perforation of space through the wall, or worse a catastrophic rupture.

SIGNS & SYMPTOMS

When a perforation or rupture occurs, it is readily apparent within hours, or in severe cases immediately. This is a development that will be accompanied by a profound amount of pain and is often accompanied by violet bouts of vomiting or diarrhea as the body attempts to expel existing content to eliminate it from leaking internally into body cavities it is not meant to reside. Patients who experience a viscus perforation such as this will undoubtedly be bound for the hospital in short order. This issue progresses very quickly, with the described signs and symptoms initiating within the first couple hours, and if untreated leading to sepsis, organ failure, shock, and death within days.

DIAGNOSIS

Once the patient arrives at a hospital emergency department, the severity of symptoms will often triage a patient quickly to the front of line, and the patient will be expedited into imaging procedures. Computerized tomography scans are the gold standard for diagnosing the presence of any number of sudden-onset organ dysfunctions characterized by severe signs and symptoms such as we have described. As such, this would undoubtedly be the next step taken. Once available, these images will not only quickly provide confirmation of the suspected internal disruption but can also confirm where such a perforation has occurred.

TREATMENT

Once the suspected nature of the client's problem is confirmed, and the location of such a

perforation is identified – emergency surgery can be performed. In such an operation the goal is twofold: One - irrigate the region of the body where the contents of the hollow organ have spilled into, as these contents are often highly toxic and will cause an infection to these areas not equipped to be inundated with them. Two – surgically close and repair this portal opening between hollow organ and surrounding cavity. Once this has been completed, the patient will be sure to be placed on NPO status (nothing to eat or drink, in layman's terms) to allow the "pipeline" to rest and recovery by preventing content moving through it, and be placed on a multi-day regiment of antibiotics to combat what is sure to be an accompanying infection. In this specific case, antifungals were also administered prophylactically as an extra measure. The client will remain admitted to the hospital in an acute state where their condition may continue to be fragile in the following days. IV fluids will be utilized to restore blood and fluid volume loss and provide electrolytes and nourishment while NPO. Naso-gastric (NPO) tubing may be utilized with suction to continue to empty the content of the digestive tract to eliminate any content disrupting the repair site – particularly highly acidic digestive juices which could ulcerate the healing repair. Anti-acidic medications like proton pump inhibitors may be employed to aid in neutralizing the acidity of these secretions as well. Eventually the patient will be taken off NPO status and their diet will have to resume under very strict limitations that will gradually step down in degree of restriction, allowing for the body's continued recovery while minimizing re-injury. This patient may end up with certain limits to their diet permanently. With diverticulitis as an underlying cause we would expect that this patient will have to consider the overall acidity of his meals going forward and eliminate nuts and seeds from his diet which may become lodged in the pouches along the wall and lead to additional perforations and recurrence of emergency

and surgical interventions to address them. As such, the patient will need to take care going forward in order to prevent a repeat scenario of everything we have described.

Pathophysiology References (2) (APA):

Capriotti, T. (2024). *Davis Advantage for Pathophysiology* (3rd ed.). F. A. Davis Company. https://bookshelf.vitalsource.com/books/9781719650533

Jones, M. W., Kashyap, S., & Zabbo, C. P. (2023, April 24). *Bowel perforation*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK537224/

Lee, N. K., et al. (2019, December 17). CT diagnosis of non-traumatic gastrointestinal perforation: An emphasis on the causes - Japanese journal of radiology. SpringerLink. https://link.springer.com/article/10.1007/s11604-019-00910-7

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	4.4 - 5.8 mc/L	5.67 mc/L	4.95 mc/L	N/A
Hgb	13 – 16.5 g/dL	17.5 g/dL	15.9 g/dL	Most likely related to the internal bleed occurring with the bowel

				perforation, causing an elevation in hemoglobin. Later we see it has reduced, suggestive that the bleeding has been controlled.
Hct	38-50%	53.8%	47.3%	As with above, we see a rise related to the internal bleed, here more specifically as it relates to the bodies attempt to emphasize clot formation to combat the bleed.
Platelets	140 – 440 /mcl	401 /mcl	323 /mcl	N/A
WBC	4 – 12 /mcl	19.80 /mcl	26.80 /mcl	With patient's bowel contents spilling into the abdominal cavity, this presents a profoundly infectious scenario. WBC count is extremely elevated and reflective of the body working overtime to combat this infection.
Neutrophils	40 - 68%	91.9%	91.5%	For both neutrophils and lymphocytes below, the elevation is likely much like the elevated WBC's - a response to infection. However, with both of these values, we may also see this elevated as it pertains to their role in the inflammatory response with tissue damage as a result of the bowel perforation wound site itself.
Lymphocytes	19 – 49%	2.3%	3.4%	Same as Neutrophils above.
Monocytes	3 – 13%	5.5%	5.0%	N/A
Eosinophils	0 – 8%	0.0	0.0	N/A
Bands	N/A	N/A	N/A	N/A

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

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	136 – 145 mmol/L	138 mmol/L	138 mmol/L	N/A
K+	3.5 - 5.1 mmol/L	4.4 mmol/L	4.4 mmol/L	N/A

Cl-	98 - 107 mmol/L	103 mmol/L	108 mmol/L	With patient's bowel perforation, there will be a global fluid loss from the intravascular medium, levels such as this, and glucose below, may be related to an elevated solute to solvent ratio from loss of fluid volume.
CO2	22 - 30 mmol/L	23 mmol/L	21 mmol/L	Patient respirations were elevated = hyperventilation = decreased carbon dioxide (CO2) concentrations in blood stream.
Glucose	70 – 99 mg/dL	114 mg/dL	104 mg/dL	Same as with chlorine (Cl-).
BUN	9 – 21 mg/dL	7 mg/dL	11 mg/dL	N/A
Creatinine	0.7 - 1.3 mg/dL	0.94 mg/dL	0.87 mg/dL	N/A
Albumin	3.5 - 5.0 g/dL	4.4 g/dL	N/A	N/A
Calcium	8.7 - 10.5 mg/dL	10.5 mg/dL	9.1 mg/dL	N/A
Mag	1.6 - 2.6 mg/dL	1.6 mg/dL	2.4 mg/dL	N/A
Phosphate	N/A *	N/A	N/A	N/A
Bilirubin	0.0 - 0.5 mg/dL	N/A	N/A	N/A
Alk Phos	40-150 IU/L	97 IU/L	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	N/A	N/A	N/A
pH	5.0 - 9.0	N/A	N/A	N/A
Specific Gravity	1.003-1.03	N/A	N/A	N/A
Glucose	Negative	N/A	N/A	N/A

Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	N/A	N/A	N/A	N/A
RBC	N/A	N/A	N/A	N/A
Leukoesterase	N/A	N/A	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	In process	In process	Blood samples taken, currently being cultured to assess for presence/absence of bacteria. High probability following bowel contents emptying into abdominal cavity and presence of other infectious markers.
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, A. (2023). *Mosby's diagnostic and laboratory test reference* (6th ed.). Elsevier.

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Computerized Tomography (CT) performed on 10/28 of abdomen and pelvis:

IMPRESSION:

1. Significant pneumoperitoneum, with mild ascites.

2. Small bowel mid abdomen diffuse edematous walls.

3. Mild diverticular disease of left hemicolon.

4. Preserved normal opacification of mesenteric vessels.

X-ray performed on 10/28 on chest:

IMPRESSION:

Nasogastric tube tip in good position. Several artifacts superimposed on the chest, including safety pins.

Imaging Justifications:

The patient's CT was performed to assess patients' significant pain, nausea, and vomiting that admitting him into the hospital. A viscus perforation was located along the descending colon which was utilized to confirm the cause and warrant emergency surgery, as well as localized where surgery would need to be performed. The imaging and surgery also found notable loss of bowel content into the peritoneal cavity, which was irrigated out as best as able per the surgical notes.

During clinical time the patient began to report significant concerns that he felt as though the naso-gastric (NG) tube was coming out. The RN responsible for this patient requests a stat chest X-ray to confirm patency of the naso-gastric (NG) tube. Imaging was shared with the student and clinical instructor and was observed to extend all the way down into the patients' stomach. Diagnostic professionals assigned to assess this image confirmed in reporting as well that they observed the naso-gastric (NG) tube to be in an appropriate position.

Diagnostic Imaging Reference (1) (APA):

Lee, N. K., et al. (2019, December 17). CT diagnosis of non-traumatic gastrointestinal perforation: An emphasis on the causes - Japanese journal of radiology. SpringerLink. https://link.springer.com/article/10.1007/s11604-019-00910-7

Taylor, S., & Manara, A. R. (2021, July 8). X-ray checks of ng tube position: A case for guided tube placement. OUP Academic. https://academic.oup.com/bjr/article/94/1124/20210432/7474980

Current Medications (10 points, 2 points per completed med)

5 <u>different</u> medications must be completed

Medications (5 required)

Brand/ Generic	Lactated ringers/ Ringers Lactate	LOVENOX/ enoxparin	DIFLUCAN/ fluconazole	PROTONIX/ pantoprazole	ZOSYN/ pipercillin-tazobactim
Dose	125 mL/hour	40 mg	400 mg	40 mg	3.375 g in 100mL of 0.9% concentration sodium-chloride

					solution at 25ml/hr rate
Frequency	Continuous	Daily	Daily	Daily	Every 4 hours
Route	IV	Subcutaneous injection	IV	IV	IV
Classification	Electrolyte solution	Anticoagulant	Antifungal	Proton pump inhibitor	Antibiotic
Mechanism of Action	Provides body with supplemental fluid volume with variable concentrations of electrolytes as well.	Inhibits key clotting factors to prevent clot formation.	Prevents synthesis of ergosterol, necessary for fungal cell wall integrity, leading to fungal cell death	Blocks the stomach lining from producing highly acidic protons, thereby reducing net acidity in the stomach.	Disrupts formation of peptidoglycan, which is necessary for bacterial wall synthesis, leading to bacterial cell death.
Reason Client Taking	Patient is NPO and will require IV supplementation of fluids and electrolytes as a replacement for oral intake.	Prevent onset of deep vein thrombosis during prolonged bedrest during recovery; a standard practice with inpatient clients in a hospital.	Intra-abdominal infection due to perforation of bowels.	The patient had a surgical repair of the perforated bowel. This medication will reduce acid concentrations causing additional irritation to the area of healing, as well as reduce the risk of re-injury from additional/further ulceration(s).	Intra-abdominal infection due to perforation of bowels.
Contraindications (2)	Respiratory Alkalosis – Our patient is currently	“Active major bleeding” (*Nurses Drug Handbook*,	“Use fluconazole cautiously in patients with	“Concurrent therapy with rilpivirine-containing	“Patients with a history of allergic reactions to any of the penicillins,

	exhibiting a rapid and shallow breathing pattern with complications from fluid congestion around the lungs which will contribute to a basic pH alteration. Our labs are also trending this was and have already begun to evidence abnormally low CO2 concentrations in the blood. This solution will contribute lactate that will be metabolized into bicarbonates that will further drive up our client's pH level to increasingly basic conditions. Metabolic alkalosis – Much as we just noted with our breathing, our client is already trending basic and is on a	2024) – We would want to be certain our client did not dehisce the repaired perforation, or there is a significant risk of profuse bleeding. “Hypersensitivity to enoxaparin” (*Nurses Drug Handbook*, 2024) - Given that our patient is taking this medication, there remains a risk for an adverse reaction to this medication developing.	potentially proarrhythmic conditions because drug may prolong the QT interval, which can lead to life-threatening torsade's de pointes” (*Nurses Drug Handbook*, 2024) - Torasades de Pointes is a critical cardiac occurence with tachycardia between 150-200 BPM. If our patient possessed any undiagnosed cardiac abnormalities or arrythmias, there is the potential for this occurrence. “Monitor coagulation test results and assess patient for bleeding if patient is receiving an	products” (*Nurses Drug Handbook*, 2024) - Our patient was not forthcoming with his medical history. Rilpivirine is an anti-retroviral medication commonly utilized to treat HIV. If our patient was withholding information about this this condition and/or taking these medications, we would have a conflict with these drugs as this medication is decreasing acidic conditions and rilpivirine requires those conditions to work. Generalized low electrolyte	cephalosporins, or β-lactamase inhibitors.” (U.S. Food and Drug Administration, 2017) - If our patient possesses undisclosed or undiscovered allergies to these anti-biotic categories we would induce a significant reaction. “Hematological effects (including bleeding, leukopenia and neutropenia) have occurred. Monitor hematologic tests during prolonged therapy.” (U.S. Food and Drug Administration, 2017) - Our patient is already at an elevated bleed risk, and given that he is fighting a severe infection the diminishing effect of his immune cells would impair his immune systems fight against the infection.

	fluid that will elevate basic conditions. Even without the breathing component, this will also need to be monitored from the metabolic standpoint as our kidneys continue to be overwhelmed with their role in cleaning the residual intestinal contents not able to be irrigated out in surgery. This is further compounded by the proton pump inhibitors on this meds list, further creating a basic condition in our patient.		oral anticoagulant" (*Nurses Drug Handbook*, 2024) - Our patient is taking Lovenox at this same time as this medication, both of which may increase the risk of bleeding, and our patient is also recovering from a perforation which engenders bleeding.	levels – This medication interferes with absorption broadly and has been known to result in hypo: kalemia/natremia/magnesemia/and calcemia. Given that our patient is NPO for some time, and on medications that affect absorption of these critical electrolytes, we need to be extremely cognizant of the balance of these substances, as he is primed to possess deficits in concentration of all of them, and each can result in life-threatening complications	
Side Effects/ Adverse Reactions (2)	Hyperkalemia – a possible side effect of lactated ringers is driving up potassium levels which can lead to adverse cardiac events. However, our risk is	GI: Ascites – Patient already has complications imposed by loss of bowel contents into abdominal cavity. Further fluid accumulation into this space engenders	CNS: Potentially for increased agitation and anxiety – a valuable consideration given our patient's anxiety and substance/withdrawal related	ENDO: Hyperglycemia – Patient already presents with abnormal levels of elevated blood sugar concentrations. This medication would	Risk of Acute Kidney Injury/nephrotoxicity/renal failure – Our patient is already at high risk for sepsis given the severity of infectious potential from his bowel content exiting into the abdominal cavity. The kidney (among other

	relatively low given that our patient is NPO currently and therefore not experiencing many other significantly contributing potassium sources from diet. Swelling & edema – As with any form of fluid resuscitation, which can be a great thing in the right amount, we run the risk of overloading the body. Proper care and monitoring will be paramount in order to balance input and output to prevent this.	further complications with these areas existing inundation of material that should not be present in the cavity. HEME: Decreased platelet count – Our patient is currently dealing with numerous medical and pharmacologi cal considerations related to blood thinning and bleed potential. This combined with these drugs additional potential for GI bleeding creates an increasingly concerning risk for excessive internal bleeding of the repaired perforation site.	factors. EENT: Potential for dry mouth. - Another consideration worth noting, given our patients lengthy NPO status and existing reported dry mouth/irritati on.	promote further issues in this regard. Will need to regularly monitor blood sugar. GI: Pancreatitis and hepatitis – Our patient demonstrates an abdominal cavity infection because of bowel contents spilling into the space. All organs anticipated to be struggling with inflammatio n at this time, particularly with pancreatic inflammatio n being commonly associated with this condition. This medication may exacerbate this inflammator	organs) will be highly stressed in its role to filter this material out of the body. High-powered antibiotics like this will further stress the kidney and may result in potential kidney damage. “Clostridium difficile associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents, including ZOSYN, and may range in severity from mild diarrhea to fatal colitis... antibacterial agents alters the normal flora of the colon leading to overgrowth of C. difficile.” (U.S. Food and Drug Administration, 2017 - Our patient will possess on ongoing risk for secondary infection with Clostridium Difficile bacteria during lengthy IV antibiotic regiment for his existing abdominal cavity infection.

				y concern.	

Medications Reference (1) (APA):

Nursing Drug Handbook. (2024). *Nurses Drug Handbook* (2024 ed.). Wolters Kluwer.

U.S. Food and Drug Administration. (2019). *FDA label: Fluconazole* (NDA 050684, NDA 050750). https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/050684s88s89s90_050750s37s38s39lbl.pdf

Singh, S., Kerndt, C. C., & Davis, D. (2023, August 14). Ringer's lactate. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK500033/

Assessment

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

General, Psychosocial/Cultural, and TWO focused assessment specific to the client.

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	Alerted and oriented x4, well groomed & no signs of distress. Reports pain rating 6/10 abdominally. Overall appearance is generally cooperative but endorses high anxiety and is visibly uncomfortable and exhausted.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** .	Not assessed.

Braden Score: **Drains present: Y☐ N ☐** **Type:**	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth**:	Not assessed.
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 without murmurs gallops or rubs. PMI palpable at 5th intercostal space at MCL. Slightly elevated rate and normal rhythm. All extremities are normal in color, warm, dry and symmetrical. Pulses 2+ throughout bilaterally. Capillary refill less than 3 seconds fingers and toes bilaterally. No edema inspected or palpated in all extremities. Epitrochlear lymph nodes are nonpalpable bilaterally. Homan's signs negative bilaterally. No neck vein distention.
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	Patient does not evidence any accessory muscle use or respiratory distress at this time. No retractions. No wheezing, rattle, but some audible ronchi noted in Bilat lungs suggestive of some congestion present but is otherwise normal of lung sounds in all fields. Slight elevation of respiratory rate and shallower/shorter breaths being taken. Symmetrical in movement anterior to posterior and left to right.
GASTROINTESTINAL: **Diet at home:** **Current Diet** **Height:** **Weight:**	Diet: Patient notes "regular" diet but provides no greater insight into specifics. Discussed/educated the patient in relation to diverticulitis diagnosis, and the agitating food/drink/and substance use related to this condition, its involvement in subsequent perforation, as well as the associated rationale for current NPO status. Patient confirms understanding of this education.

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:**	Hypoactive high-pitch bowel sounds in all 4 abdominal quadrants. Notes significant pain, with significant hypersensitivity to touch/pressure in abdominal region subsequent to recent surgery. As such, limited capacity for assessment of palpable masses or distention. Midline abdominal incision present with significant bandaging occluding visibility, and x2 Jackson-Pratt drains present. No ostomy, enteral/parenteral tubes present at this time, but the patient does have a naso-gastric tube in place that is attached to intermittent suction at this time. No CVA tenderness noted bilaterally. Patients' last bowel movement was reported to have been on Friday of last week (x3 days prior) before incarceration and onset of bowel perforation.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	Not assessed.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:**	Not assessed.

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**☐	
NEUROLOGICAL: **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Not assessed.
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):**	Patient states his primary coping mechanism is his drug use "I get high", and notes that he is struggling with the stress of not using and recent incarceration. Patient reports he lives in Danville in an apartment with his spouse (present in room during assessment). Reports highest level of education is high school diploma. Is not particularly religious, does not feel religions is of importance to him. His mother also lives in the area, and works for Veterans Affairs. He is currently unemployed.

Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1516	87 BPM	144/97 BP	22 RR	96 *f (Patient had a fan	96% SpO2

				blowing on his head)	

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1516	0-10	Abdomen	6/10	Sharp, "hurts to move or cough".	Bedrest, pain medication.

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
Patient is NPO, all fluids through intravenous at this time. 2271 mL intake via intravenous fluids at this time.	600 mL measured from nasogastric suction canister. Approx 200ml in urinary catheter.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rationale	Interventions (2 per dx)	Outcome Goal (1 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest	• Explain why the nursing diagnosis was chosen			• How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.

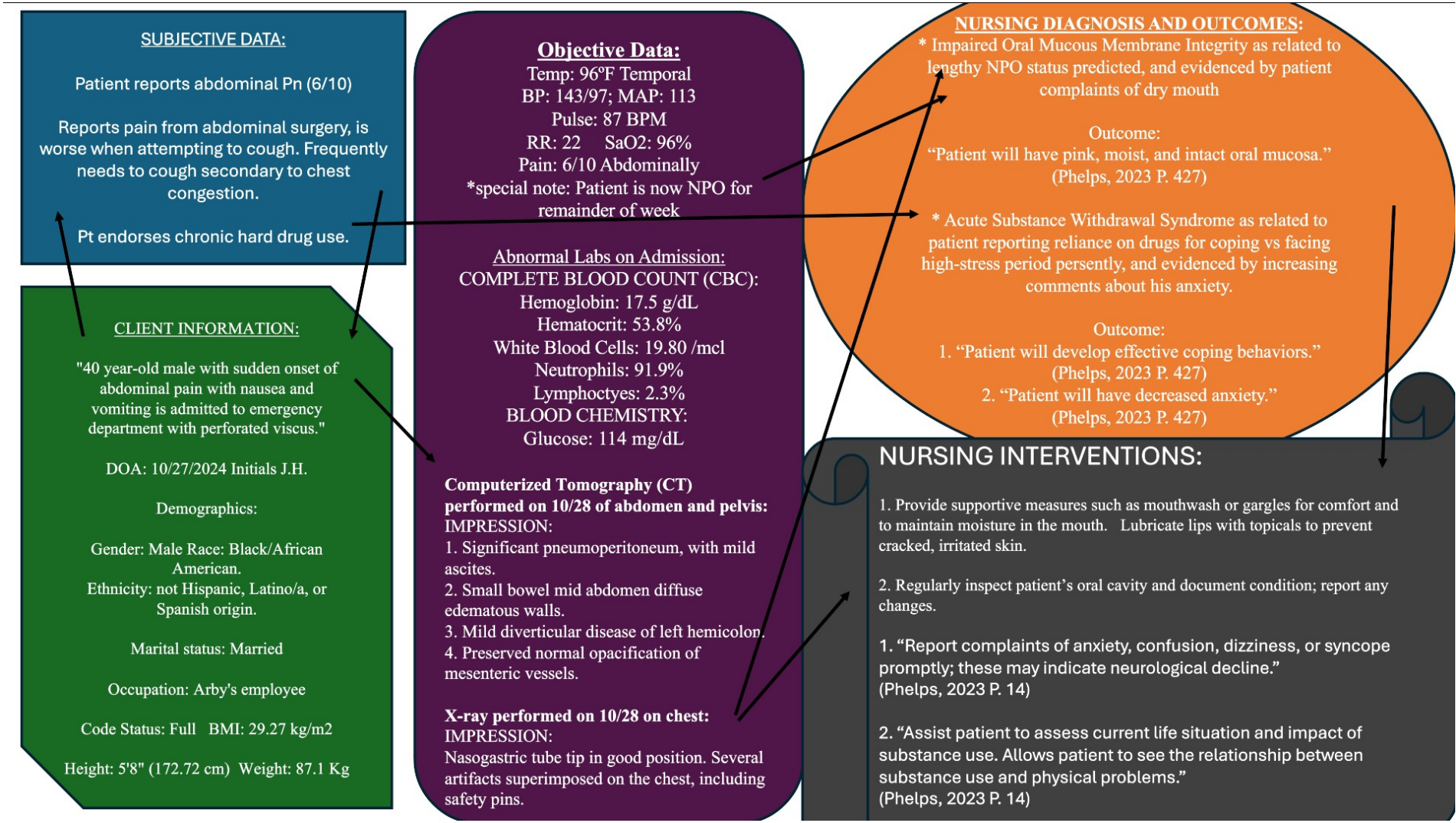
priority to lowest priority pertinent to this client				
1. Impaired Oral Mucous Membrane Integrity related to NPO status and as evidenced by patient complaints of dry/irritated mouth and throat.	NPO greater than 24 hours. Patient complains of dry & irritated mouth/throat.	1. Provide supportive measures such as mouthwash or gargles for comfort and to maintain moisture in the mouth. Lubricate lips with topicals to prevent cracked, irritated skin. 2. Regularly inspect patient's oral cavity and document condition; report any changes.	1. "Patient will have pink, moist, and intact oral mucosa." (Phelps, 2023 P. 427)	The patient was provided with sponged brush to soak in small amount of water in order to moisturize oral mucosa. The nurse placed an inquiry with the surgeon as to whether ice chips would be permissible. Patient reports sponge brush is helping. Nursing was still awaiting surgeons' approval of ice chips at end of this shift.
2. Acute Substance Withdrawal Syndrome as related to patients reported frequent drug use and evidenced by	Patient endorses use of illicit substances with profoundly high addictive potential in order to manage stress and endorses high stress at this time. Demonstrates anxiety he	1. "Report complaints of anxiety, confusion, dizziness, or syncope promptly; these may indicate neurological decline." (Phelps, 2023 P. 14) 2. "Assist	1. "Patient will develop effective coping behaviors." (Phelps, 2023 P. 14) 2. "Patient will have decreased anxiety." (Phelps, 2023 P. 14)	Patient's struggle with substance abuse will extend beyond the duration of my clinical shift today and will likely require significant support and weeks/months of lifestyle change. Goal ongoing.

	resulting bowel perforation	relates specifically to this. Recent incarceration and hospitalization have resulted in sudden cessation of use, a precursor to potential withdrawal.	patient to assess current life situation and impact of substance use. Allows patient to see the relationship between substance use and physical problems." (Phelps, 2023 P. 14)		

Other References (APA):

Phelps, L. L. (2023a). *Nursing diagnosis reference manual* (12th ed.). Wolters Kluwer.

Concept Map (23 Points):


SUBJECTIVE DATA:
Patient reports abdominal Pn (6/10)
Reports pain from abdominal surgery, is worse when attempting to cough. Frequently needs to cough secondary to chest congestion.
Pt endorses chronic hard drug use.
CLIENT INFORMATION:
"40 year-old male with sudden onset of abdominal pain with nausea and vomiting is admitted to emergency department with perforated viscus."
DOA: 10/27/2024 Initials J.H.
Demographics:
Gender: Male Race: Black/African American.
Ethnicity: not Hispanic, Latino/a, or Spanish origin.
Marital status: Married
Occupation: Arby's employee
Code Status: Full BMI: 29.27 kg/m2
Height: 5'8" (172.72 cm) Weight: 87.1 Kg
Objective Data:
Temp: 96°F Temporal
BP: 143/97; MAP: 113
Pulse: 87 BPM
RR: 22 SaO2: 96%
Pain: 6/10 Abdominally
*special note: Patient is now NPO for remainder of week
Abnormal Labs on Admission:
COMPLETE BLOOD COUNT (CBC):
Hemoglobin: 17.5 g/dL
Hematocrit: 53.8%
White Blood Cells: 19.80 /mcl
Neutrophils: 91.9%
Lymphoctyes: 2.3%
BLOOD CHEMISTRY:
Glucose: 114 mg/dL
Computerized Tomography (CT) performed on 10/28 of abdomen and pelvis:
IMPRESSION:
1. Significant pneumoperitoneum, with mild ascites.
2. Small bowel mid abdomen diffuse edematous walls.
3. Mild diverticular disease of left hemicolon.
4. Preserved normal opacification of mesenteric vessels.
X-ray performed on 10/28 on chest:
IMPRESSION:
Nasogastric tube tip in good position. Several artifacts superimposed on the chest, including safety pins.
NURSING DIAGNOSIS AND OUTCOMES:
* Impaired Oral Mucous Membrane Integrity as related to lengthy NPO status predicted, and evidenced by patient complaints of dry mouth
Outcome:
"Patient will have pink, moist, and intact oral mucosa."
(Phelps, 2023 P. 427)
* Acute Substance Withdrawal Syndrome as related to patient reporting reliance on drugs for coping vs facing high-stress period persently, and evidenced by increasing comments about his anxiety.
Outcome:
1. "Patient will develop effective coping behaviors."
(Phelps, 2023 P. 427)
2. "Patient will have decreased anxiety."
(Phelps, 2023 P. 427)
NURSING INTERVENTIONS:
1. Provide supportive measures such as mouthwash or gargles for comfort and to maintain moisture in the mouth. Lubricate lips with topicals to prevent cracked, irritated skin.
2. Regularly inspect patient's oral cavity and document condition; report any changes.
1. "Report complaints of anxiety, confusion, dizziness, or syncope promptly; these may indicate neurological decline."
(Phelps, 2023 P. 14)
2. "Assist patient to assess current life situation and impact of substance use. Allows patient to see the relationship between substance use and physical problems."
(Phelps, 2023 P. 14)