N311 Care Plan 4

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Lakeview College of Nursing

N311: Foundations of Professional Practice

Linda Scribner

November 1, 2024

Demographics (5 points)

Date of Admission 10/10/2024	Client Initials DW	Age 54	Gender Female
Race/Ethnicity Black	Occupation Unemployed	Marital Status Single	Allergies Metoclopramide
Code Status Full	Height 160 cm	Weight 72.3 kg	

Medical History

Past Medical History: Acute cerebrovascular accident, CHF 7/18/2019, Ischemic stroke, metabolic encephalopathy, Chronic heart failure with reduced ejection fraction 3/17/2020, Atrial Fibrillation, Anemia, Arteriovenous fistula stenosis, chronic kidney disease stage 5 renal failure, Diabetes mellitus type 2, diabetic gastroparesis, Dialysis, GERD, GI Bleed, Hypertension, ICD (implantable cardioverter-defibrillator, Obstructive Sleep Apnea.

Past Surgical History: A-V Fistula Creation, Cholecystectomy 05/2018, Ectopic Pregnancy Surgery, Facial Soft Tissue Procedure 10/25/2017, ICD Insertion 8/20/2020, IR Tunneled Dialysis 8/28/2020, L Heart Catheterization 7/25/2019, L Leg amputation below the knee 04/2021, Phacoemulsion of cataract L 5/16/2024, R heart catheterization, Revision/Excision of Pseudoaneurysm/revision of AV graft 8/29/2022

Family History: Father- prostate cancer, glaucoma. Maternal Grandfather- Hypertension. Maternal Grandmother- Diabetes. Paternal Grandfather- hypertension. Paternal Grandmother- heart, hypertension.

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

Tobacco use for 2 years, quit 6.5 years ago

Drug use: oral marijuana gummies once/month

Admission Assessment

Chief Complaint (2 points): Vomiting

History of Present Illness – OLD CARTS (10 points)

DW is a 54-year-old black female who came to the ED at 0906 on October 10, 2024 presenting with nausea and vomiting stating it started yesterday which made her not be able to go to her dialysis appointment. Upon admission, DW was tearful and showing signs of discomfort. DW has a history of gastroparesis which has continued to be an issue the entire admission. DW continues to vomit, even with antiemetics being administered, and has struggled to keep her medications down. Gastrojejunostomy tube was placed to administer very slow feeds. GJ tube has helped some, but DW continues to vomit occasionally when something is ingested into her stomach.

Primary Diagnosis

Primary Diagnosis on Admission: Gastroparesis

Secondary Diagnosis (if applicable): Intractable Nausea and Vomiting

Pathophysiology

Gastroparesis means paralysis of the stomach and affects the nerves and muscles of the stomach. (Cleveland Clinic). Gastroparesis is the delayed emptying of stomach contents into the duodenum, which puts additional stress on the lower esophageal sphincter (LES), causing distention of the stomach leading to severe vomiting and nausea. (Capriotti). Gastroparesis is caused by damage to the nerves, often the vagus nerve, which affects your stomach muscles, or damage to the muscles themselves. When a person ingests food or drinks, your stomach muscles

churn the food and squeeze it through your LES to enter the duodenum for digestion and absorption through the digestion process in the intestine. (Cleveland Clinic) With gastroparesis, your stomach is unsuccessful in performing this task, and the food sits in your stomach longer than it is supposed to. (Capriotti).

The most commonly known cause of gastroparesis is from diabetes type one or two, which is called diabetes-related gastroparesis, and accounts for about one-third of all cases. However, the most common overall cause is referred to as idiopathic because it is unknown what makes some people develop this., and this accounts for a quarter to half of all cases. (Cleveland Clinic). Surgery in the abdomen close to the stomach can damage the vagus nerve, which can cause or contribute to developing gastroparesis. Alternatively, some people can develop this without having any of these causes at all. Other causes include infections, medications, autoimmune disease, neurological diseases, collagen-vascular disease, endocrine disorders, and cystic fibrosis. (Cleveland Clinic).

Gastroparesis can be a very debilitating ailment. It commonly causes severe vomiting and nausea. This can cause malnutrition, dehydration, severe electrolyte imbalances, and make blood glucose drastically fluctuate. (Cleveland Clinic). When your electrolytes become severely imbalanced for an extended period, this can cause your body to go haywire so to speak, being so severe to cause myocardial infarctions and strokes. (Alao). The persistent nausea and vomiting can also lead to GERD (gastroesophageal reflux disease), causing heartburn, dysphagia, pain, and frequent regurgitation. Frequent regurgitation, over an extended period, erodes normal esophageal cells and causes a precancerous change, increasing the likelihood of esophageal cancer. (Capriotti). More signs and symptoms of gastroparesis are abdominal pain, bloating,

feeling very full very quickly, and feeling fuller than you should after eating for longer than normal, and unintended weight loss. (Sievert).

Gastroparesis can be a very debilitating and exhausting disease for patients and families. It can be somewhat difficult to finally get a diagnosis for gastroparesis, because it is commonly misdiagnosed as other ailments, and it can occur in “flare ups”, so each time you go to the hospital, you’re seeing a different doctor. (Ayonote). Because there can be a delay in diagnosis, this is often incredibly frustrating for patients and families. Some patients can go months or years before being correctly diagnosed and receiving treatment. This often leads to mental health problems.

One patient stated the following: “You reach a point when you just are so depressed and want to give up. I hate to say it but I started to feel like I’d rather just die than keep living like that. It wasn’t even living at that point because I couldn’t enjoy anything. I never got quality time with the grandbabies, I couldn’t spend time with dad or you kids, I missed holidays, I couldn’t go to church most days, and I couldn’t even leave my bed most days. Well Ash, you remember, because you had to take care of me and even give me a shower. It was terrible. I wasn’t living anymore but was just existing. I wouldn’t wish that on my worst enemy. And look how long it took before Dr. Alao and Dr. Ayonte finally figured it out. It was almost three years if I remember right.” (Ronda Duncan. Personal interview. 2024, November 3).

However, there are tests and diagnostics that can be performed to reach a correct diagnosis. Medical history, physical exam, upper endoscopy, barium swallow study, and gastric emptying study are all performed in steps to reach the diagnosis for gastroparesis. (Sievert).

Treatment for gastroparesis can be extensive and take time to get down. Identifying diet choices that aggravate it takes time but can make a significant difference in the condition. Medications are available such as antiemetics and promotility drugs. Surgery is an option for some if the problem stems from the pylorus section of the stomach, where they remove that portion called a pyloroplasty. Having a gastric pacemaker implanted can also help. Enteral nutrition treatment allows for the patient to receive nutrient dense supplementation at a slow enough rate for the stomach to process. (Sievert).

Pathophysiology References (APA):

Alao, F. (2020, January 4). Personal conversation. Sarah Bush Lincoln Health Center Neurology.

Ayonote, A. (2020, January 4). Personal conversation. Sarah Bush Lincoln Health Center Gastroenterology.

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

Duncan, R. (2024, November 3). Personal Interview.

Gastroparesis. Cleveland Clinic. (2024, May 1). https://my.clevelandclinic.org/health/diseases/15522-gastroparesis

Sievert, D. (2024, February 5). *Gastroparesis symptoms, treatment, causes*. UCLA Medical School. https://medschool.ucla.edu/news-article/gastroparesis-symptoms-treatment-and-causes#:~:text=What%20Are%20the%20Symptoms%20of,the%20meal%20the%20night%20before.%E2%80%9D

Laboratory Data

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 10^6/uL	3.08 10^6/uL	2.89 10^6/uL	DW had low RBC levels likely due to renal failure, anemia, and dietary deficiency related to gastroparesis. (Pagana).
Hgb	11.0-16.0 g/dL	9.4 g/dL	8.6 g/dL	DW had low hemoglobin levels due to anemia and nutritional deficiency. (Pagana).
Hct	34.0-47.0%	28.8%	24.9%	DW had low hematocrit levels likely due to renal failure, anemia, and dietary deficiency. (Pagana).
Platelets	140-400 10^3/uL	181 10^3/uL	199 10^3/uL	
WBC	4.00-11.00 10^3/uL	11.38 10^3/uL	8.87 10^3/uL	Stress can elevate WBC counts and DW was very sick with gastroparesis which was putting a lot of stress on her body. (Pagana).
Neutrophils	1.60-7.70 10^3/uL	9.72 10^3/uL	6.99 10^3/uL	Stress can cause the body to elevate neutrophil levels and DW was under a lot of stress from being sick with gastroparesis. (Pagana).
Lymphocytes	1.00-4.90 10^3/uL	0.67 10^3/uL	0.65 10^3/uL	Certain drugs, such as steroids, can cause lymphocyte levels to decrease, and DW was receiving steroids. (Pagana).
Monocytes	0.00-1.10 10^3/uL	0.75 10^3/uL	0.79 10^3/uL	
Eosinophils	0.00-0.50 10^3/uL	0.14 10^3/uL	0.26 10^3/uL	
Bands	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	143	129	DW has renal disease, vomiting,

	mmol/L	**mmol/L**	**mmol/L**	**CHF, and was given laxatives which can all cause decreased sodium levels. (Pagana).**
K+	**3.5-5.1 mmol/L**	**2.9 mmol/L**	**4.2 mmol/L**	**Deficient dietary intake can cause decreased potassium levels, and DW had been unable to ingest nutrition when she was admitted due to gastroparesis. (Pagana).**
Cl-	**98-107 mmol/L**	**101 mmol/L**	**100 mmol/L**	
CO2	**22.0-29.0 mmol/L**	**26.0 mmol/L**	**21.0 mmol/L**	**DW has renal failure which can decrease CO2 levels. (Pagana).**
Glucose	**74-100 mg/dL**	**89 mg/dL**	**161 mg/dL**	**Chronic renal failure can cause elevated blood glucose levels which DW has. (Pagana)**
BUN	**10-20 mg/dL**	**10 mg/dL**	**72 mg/dL**	**Tube feeding and CHF can increase BUN levels, and both of these apply to DW. (Pagana).**
Creatinine	**0.55-1.02 mg/dL**	**5.65 mg/dL**	**3.92 mg/dL**	**Hypokalemia and hyponatremia both cause elevated creatinine levels. (Pagana).**
Albumin	**3.5-5.0 g/dL**	**3.2 g/dL**	**N/A**	**Stress can lower albumin levels, and having gastroparesis and renal failure put a great deal of stress on the body. (Pagana).**
Calcium	**8.9-10.6 mg/dL**	**8.9 mg/dL**	**8.1 mg/dL**	**Renal failure and hypoalbuminemia cause decreased calcium levels. (Pagana).**
Mag	**1.6-2.6 mg/dL**	**2.0 mg/dL**	**1.9 mg/dL**	
Phosphate	**2.5-4.5 mg/dl**	**N/A**	**3.4 mg/dL**	
Bilirubin	**0.2-1.2 mg/dL**	**0.9 mg/dL**	**N/A**	
Alk Phos	**40-150 U/L**	**111 U/L**	**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	**N/A**	**N/A**	**N/A**	**N/A**
pH	**N/A**	**N/A**	**N/A**	**N/A**
Specific Gravity	**N/A**	**N/A**	**N/A**	**N/A**
Glucose	**N/A**	**N/A**	**N/A**	**N/A**
Protein	**N/A**	**N/A**	**N/A**	**N/A**
Ketones	**N/A**	**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	**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**

Lab Correlations Reference (1) (APA):

Epic. (31 October 2024). Carle Foundation Hospital.

Pagana, K. D., Pagana, T. N., & Pagana, T. J. (2023). *Mosby's Diagnostic and laboratory test reference: 16th edition*. Elsevier.

All Other Diagnostic Tests:

X-rays provide a radiologic examination in the form of pictures/images of the inside of a body. (Taylor). DW had a chest x-ray to confirm a Dobhoff (nasogastric tube) placement. She required parental nutrition at a very slow rate due to a gastroparesis diagnosis to allow nutrition to be ingested and processed slower in the hopes her body would be able to absorb it. DW complained of constipation, and had very little bowel sounds so she also received a CT (computed tomography) scan to check for a bowel obstruction. A CT scan has thin beams of x-rays directed at and moved around, resulting in computer-manipulated pictures that are not obscured by overlying anatomy. (Taylor). DW had a GJ (Gastrojejunostomy) tube placement, which are more stable and often used in long-term feeding situations in which gastric problems exist. (Taylor). DW had an echocardiogram to check her heart function. An echocardiogram is a type of non-invasive sonogram that can demonstrate the activity and structures of the heart. It is commonly used to evaluate the size and function of the ventricles, as well as valve structure and function. (Capriotti)

Diagnostic Imaging Reference (1) (APA):

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

Epic. (31 October 2024). Carle Foundation Hospital.

Taylor, C., Lynn, P. 1., & Bartlett, J. L. (2023). *Fundamentals of nursing: the art and science of person-centered care.* Tenth edition. Philadelphia, Wolters Kluwer.

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

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

Medications (5 required)

Brand/Generic	**Aspirin**	**Carvedilol/ Coreg**	**Folic Acid**	**Pantoprazole/ Protonix**	**FT ClearLax/ Polyethylene**
Dose	**81 mg**	**3.125 mg tablet**	**1 mg**	**40 mg**	**17 g**
Frequency	**Once daily**	**Twice daily**	**Once daily**	**Twice daily**	**Twice daily**
Route	**Oral**	**GI Tube**	**GI Tube**	**IV**	**Oral**
Classification	**Analgesic/ antipyretics/ salicylates, platelet aggregation inhibitors**	**Antihypertensive/ Alpha-Beta Adrenergic Blocking Agent**	**Folic Acid Preparations, Vitamin**	**Proton Pump Inhibitor**	**Laxative/ Cathartic**
Mechanism of Action	**Blocks enzyme cyclooxygenase, reducing the inflammation response.**	**Reduces cardiac output and tachycardia, causes vasodilation, and decreases peripheral vascular resistance, which reduces blood pressure and cardiac workload.**	**Biochemically inactive**	**Interferes with gastric acid secretion by inhibiting the hydrogen-potassium-adenosine triphosphate enzyme system in gastric parietal cells.**	**Osmotic Agent**
Reason Client Taking	**Blood Blot Preventative**	**Hypertension**	**Anemia/ Folic Acid Deficiency**	**Gastroparesis**	**Constipation**
Contraindications (2)	**Active bleeding or coagulation disorders and breastfeeding mothers.**	**Bronchial asthma or related bronchospastic conditions and cardiogenic shock**	**Previous Intolleranc e to drug**	**Hypersensitivity Drug Interactions- dose/frequency adjust/ avoidance**	**Hypersensitivity/ OTC Labeling- do not use if you have renal failure**
Side Effects/Adverse Reactions (2)	**Confusion- CNS depression. Hearing loss-**	**Asthenia, Depression**	**Bloating and loss of appetite**	**Carcinoma Hepatic Effects**	**Electrolyte Imbalance Hypersensitivity**

	tinnitus				

Medications Reference (1) (APA):

2024 NDH nurse's drug handbook (Twenty fourth edition.). (2024). Jones & Bartlett Learning.

Epic. (31 October 2024). Carle Foundation Hospital.

Assessment

(this was performed on a different patient)

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:**	**Patient is A&O x 4. No signs of distress. Overall appearance was somewhat disheveled and poor.**
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 15** **Drains present: Y☐ N ☐**	

Type:	
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	.
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 sounds, no murmur detected. Peripheral pulses normal, 2+ bilaterally for upper and lower extremities. Capillary refills >2 seconds. Zero neck distention or edema noted.**
RESPIRATORY: **Accessory muscle use: Y☐ N ☐** **Breath Sounds: Location, character**	.
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:**	
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☐** **Dialysis: Y ☐ N ☐** **Inspection of genitals:** **Catheter: Y ☐ N ☐** **Type:** **Size:**	
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ☐ N☐**	Patient has a fall risk score of 12.

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:**	**Patient A&O x 4. Clear mental status and speech. Patient is fully conscious and aware of his situation and what is going on. Patient stated he is legally blind. He did not clearly see down and to the left during the assessment.**
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 he uses alcohol to cope with everything in his life. He is Stage 7- Generativity vs. Stagnation. He is an atheist. Patient has a sister in Champaign who he doesn't talk to often and he does not have friends, but more acquaintances he knows from the homeless shelter, but he said "you can't actually trust any of those people, so they aren't really your friends.

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

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1100	90	142/72	18	36.8 C Oral	99% Room Air

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1135	**0-10 Scale**	**Back**	**6**	**Sharp/Achy**	**Pain Medication/ Reposition**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
N/A	**N/A**

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

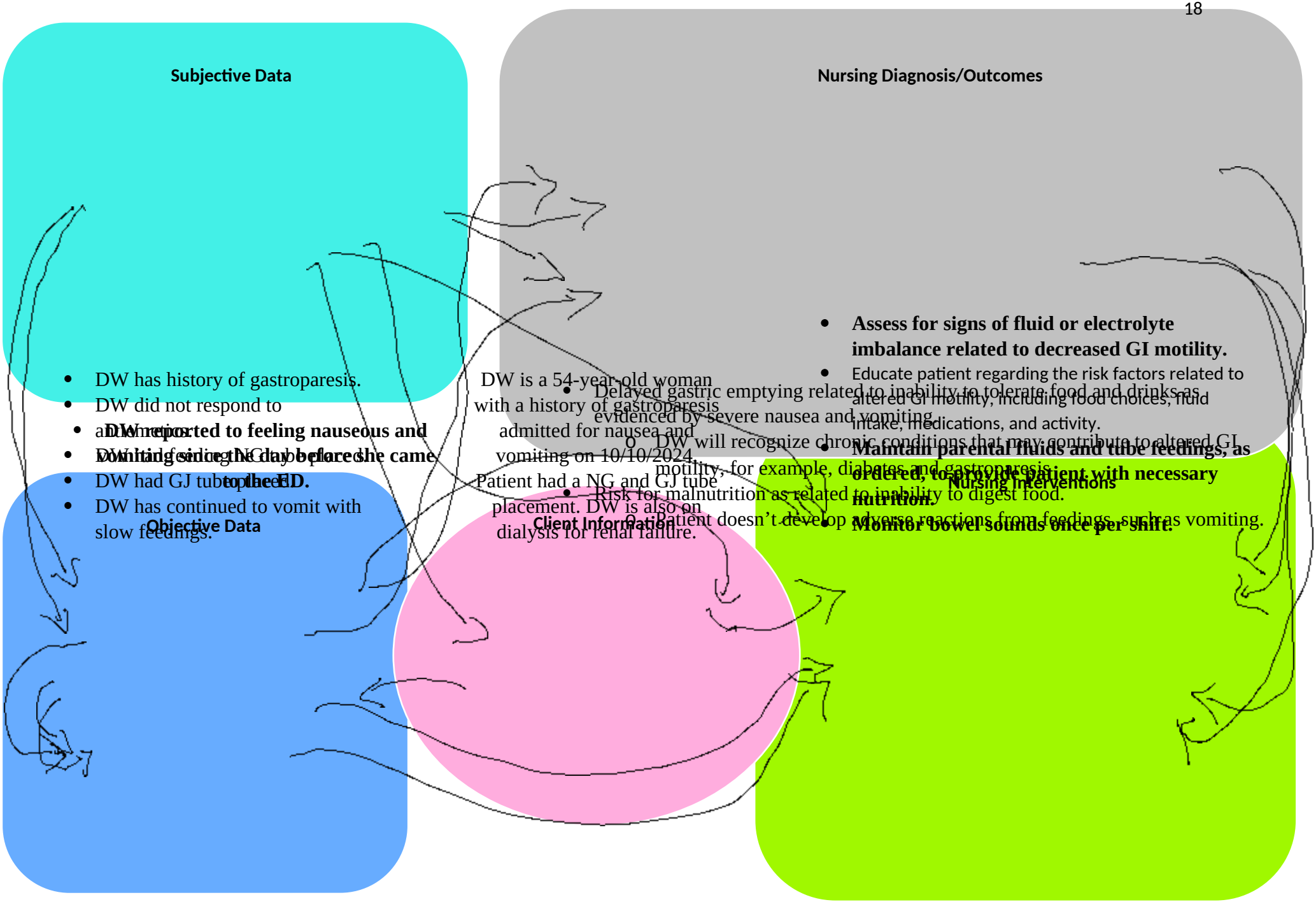
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components • Listed in order by priority – highest priority to lowest priority pertinent to this client	**Rationale** • Explain why the nursing diagnosis was chosen	**Interventions (2 per dx)**	**Outcome Goal (1 per dx)**	**Evaluation** • How did the client/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
1. Delayed gastric emptying related to inability to tolerate food and drinks as evidenced by	**DW has been vomiting for 22 days and continues to not tolerate anything being**	**1.Assess for signs of fluid or electrolyte imbalance related to decreased GI motility.**	**1. DW will recognize chronic conditions that may contribute to altered GI motility, for example, diabetes**	**DW is aware of her condition and would very much want to get better. (This is an assumption by me considering I was**

severe nausea and vomiting.	**ingested through the stomach well.**	**2.Educate patient regarding the risk factors related to altered GI motility, including food choices, fluid intake, medications, and activity.**	**and gastroparesis.**	**unable to speak with her about it)**
1.Risk for malnutrition as related to inability to digest food..	**DW has been vomiting for 22 days and was diagnosed with gastroparesis.**	**1. Maintain parental fluids and tube feedings, as ordered, to provide patient with necessary nutrition.** **2.Monitor bowel sounds once per shift.**	**1. Patient doesn't develop adverse reactions from feedings, such as vomiting.**	**I have no idea if this patient would agree to this or not considering she has a "mood disorder" and is generally fairly uncooperative with the staff and care.**

Other References (APA):

Phelps, L.L. (2023). *Nursing Diagnosis Reference Manual* 12th ed. Philadelphia, Wolters Kluwer Health/Lippincott Williams & Wilkins.

Concept Map (23 Points):


Subjective Data
DW has history of gastroparesis.
DW did not respond to
DW reported to feeling nauseous and
vomiting since the day before she came
to the ED.
DW has continued to vomit with
slow feedings.
Objective Data
DW is a 54-year-old woman
with a history of gastroparesis
admitted for nausea and
vomiting on 10/10/2024.
Patient had a NG and GJ tube
placement. DW is also on
dialysis for renal failure.
Client Information
Nursing Diagnosis/Outcomes
Delayed gastric emptying related to inability to tolerate food and drinks as evidenced by severe nausea and vomiting.
Risk for malnutrition as related to inability to digest food.
DW will recognize chronic conditions that may contribute to altered GI motility, for example, diabetes and gastroparesis.
Patient doesn't develop adverse reactions from feedings, such as vomiting.
Nursing Interventions
Assess for signs of fluid or electrolyte imbalance related to decreased GI motility.
Educate patient regarding the risk factors related to altered GI motility, including food choices, fluid intake, medications, and activity.
Maintain parental fluids and tube feedings, as ordered, to provide patient with necessary nutrition.
Monitor bowel sounds once per shift.