N431 CARE PLAN #1

Student Name: Lindsey Burnett

Lakeview College of Nursing

N441: Adult Health 3

Clinical Instructor Name: Robin Potts

Date:2/10/25

Demographics

Date of Admission	Client Initials	Age	Biological Gender
2/7/25	BH	81	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Widowed	Morphine, valsartan, lisinopril, losartan
Code Status	**Height**	**Weight**	
Full	160 cm (5’2.99 in.)	112kg (247lb)	

Medical History

Past Medical History: The patient has a past medical history of breast cancer, cardiomyopathy, diverticulosis, GERD, HLD HTN, CAD, OSA, and CKD.

Past Surgical History: The patient has a past surgical history of stomach stapling, double breast lumpectomy, EGD, and colonoscopy.

Family History: The patient’s family history includes cancer of the mother, father, brother, and grandmother.

Social History (tobacco/alcohol/drugs including frequency, quantity and duration of use): The patient’s social history includes no tobacco, drugs, or alcohol use, the patient used to be a prior smoker, no documentation of how long the patient was a smoker for or how many packs they smoked a day.

Education: N/A

Living Situation: The patient is currently living in an extended care facility. Her two daughters visit and help her out as well.

Assistive devices: The patient uses a walker to get around.

Admission History

Chief Complaint: Hematemesis and epigastric pain

History of Present Illness (HPI)– OLD CARTS: The patient is an 81-year-old female. The patient presented to the emergency department two days ago from an extended care facility where she is living with complaints of epigastric pain and hematemesis. The family is with the patient and states that this has been going on for the last several days. The patient has presented to the emergency department due to worsening symptoms of epigastric pain and coffee-ground emesis at this point. The patient was assessed by the doctor and was intubated due to needing a scope. The patient was then admitted to the ICU, where she was intubated and sedated due to needing multiple scopes done to find the source of the bleeding. I attempted to interview the patient, but she was sedated and unable to interview well, patient's daughters and nurse were able to provide the information.

Admission Diagnosis

Primary Diagnosis: GI Bleed

Secondary Diagnosis (if applicable): N/A

Pathophysiology

Gastrointestinal bleeding is likely the sign of a disorder within the digestive tract (Mayo Clinic, 2023). Blood typically shows up in stool or vomiting, but it's not always noticeable or obvious, as the stool is usually black and tarry. Bleeding will range anywhere from mild to severe and can be life-threatening. Imaging or an endoscopy usually locates the cause of bleeding, and treatment depends on where the bleeding is and how severe it is (Mayo Clinic, 2023). There are two different types of gastrointestinal bleeds, upper and lower GI bleeds, and they present with

different signs and symptoms and are caused by different reasons. Causes of upper GI bleeds include peptic ulcers, tears in the lining of the tube that connects your throat to your stomach, called the esophagus, esophageal varices, portal hypert4ensigve gastropathy, esophagitis, abnormal blood vessels, hiatal hernia, and growths (Mayo Clinic, 2023). Causes for lower GI bleeds include diverticular disease, inflammatory bowel disease, proctitis (inflammation of the lining of the rectum can cause rectal bleeding), tumors, colon polyps, hemorrhoids, and anal fissures (Mayo Clinic, 2023). Upper gastrointestinal bleeding is more common than lower gastrointestinal bleeding, lower gastrointestinal bleeding is more common in men than women due to vascular disease, and diverticulosis is more common in men (DiGregorio, 2023). Lab tests to help identify the cause of GI bleeding include Complete blood count, hemoglobin/hematocrit, International normalized ratio/prothrombin time/activated partial thromboplastin time, lactate, and liver function tests. This patient has had multiple blood tests done since being in the hospital and is currently having her hemoglobin and hematocrit monitored and taken every six hours. Diagnostic studies that help to identify causes of GI bleeding include upper GI endoscopy, lower GI endoscopy/colonoscopy, push enteroscopy, deep small bowel enteroscopy, nuclear scintigraphy, CT angiography, and Meckel scan. This patient had multiple endoscopies done in the two days she has been at the hospital, and she has also had a CT to help identify where the bleed is coming from. Acute management of GI bleeds involves assessment of appropriate setting treatment followed by resuscitation and supportive therapy while identifying possible underlying causes and correcting them (DiGregorio, 2023). Patients who have hemodynamic instability are candidates for ICU monitoring; there are calculations pre-endoscopy and post-endoscopy to see how much of a risk the patient is for overall re-bleeding risks (DiGregorio, 2023). This patient was intubated and sedated for her endoscopy and was

placed in the ICU for continuous monitoring, which included a diet of nothing by mouth, blood work of hematocrit and hemoglobin every six hours, supplemental oxygen, adequate IV access of at least two large peripheral IV'S this patient had two 20 gauge IV'S one in her left and right AC, in addition to a third 20 gauge IV in her right thumb, IV fluid resuscitation of lactated ringers, and a cross and type match, all of these are included in treatments and this patient was receiving all of these while in the ICU.

Pathophysiology References (2) (APA):

DiGregorio, A. M. (2023, June). *Gastrointestinal bleeding*. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK537291/

Mayo Clinic. Mayo Foundation for Medical Education and Research. (2023, October). *Gastrointestinal bleeding*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/gastrointestinal-bleeding/symptoms-causes/syc-20372729

Laboratory/Diagnostic Data

Lab Name	Admission Value	Today's Value	Normal Range	Reasons for Abnormal
PaO2	195.3	196.5	80-100	Labs are within normal limits.
Potassium	3.8	3.3	3.5-5.1	Labs are within normal limits.
Chloride	106	108	98-107	Admission value is within normal limits, but today's value is sightly high due to history of chronic kidney disease and possible dehydration (Pagana, 2024).
BUN	15	22	8-26	Labs are within normal limits.
Calcium	9.3	8.5	8.9-10.6	Admission value is within normal limits, but today's value is sightly low this could be due to patient having chronic kidney disease (Pagana, 2024).
WBC	13.07	14.2	0-25	Labs are within normal limits.

Diagnostic Test & Purpose	Clients Signs and Symptoms	Results
Q6 H&H (hematocrit and hemoglobin)	Patient presents with hematemesis and GI bleed.	Hemoglobin and hematocrit are trending good and showing no significant blood loss that needs replaced at this time (Pagana, 2024).
CT abdomen and pelvis	Patient presents with epigastric pain.	Reflux obstruction (Pagana, 2024).

Diagnostic Test Reference (1) (APA):

Pagana, K.D., Pagana, T. J., & Pagana, T. N., (2024). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO-Elsevier.

Active Orders

Active Orders	Rationale
Delirium order set	Patient is very confused and hasn't slept in days due to problems at the extended care facility she is living at.
Extubated	Patient was intubated for scopes, she was responding and following commands and was able to be extubated.
Type and cross PRBC	Patient is being seen for GI bleed and due to blood loss, a type and screen is needed in the even that blood is needing to be given.
Fl upper GI with small bowel	To assess the anatomy of a GI bleed.
Speech eval	Needed since patient was intubated longer than 24 hours.
LR 75 ml/hr.	To replace and replenish for fluids and electrolyte imbalance.

Medications

Home Medications (Must List ALL)

Medication	Reason for taking
Aspirin 81 mg tablet	Taken to reduce risk of CVD (cardiovascular disease) due to history of CAD (coronary artery disease).
Carvedilol 25 mg tablet taken twice daily	To lower blood pressure due to history of CAD (coronary artery disease) and hypertension.
Senokot 8.6-50 mg tablet taken twice daily as needed	To help with constipation when needed.
Simvastatin 50 mg tablet taken once daily	Lower cholesterol due to history of HLD (hyperlipidemia).
Zinc sulfate 50mg tablet taken once daily	To assist with immune function due to history of CKD (chronic kidney disease).

Hospital Medications (Must List ALL)

Brand/ Generic	Insulin lispro/Humalog	Chloramphenicol ointment/eye ointment	Mupirocin/ Bactroban	Pantoprazole/ Protonix
Classification	Pharmacological classification: Rapid acting insulin. Therapeutic classification: Modified fast acting insulin.	Pharmacological classification: Antimicrobials Therapeutic classification: Antimicrobials	Pharmacological classification: monoxycarbolic acids Therapeutic classification: anti-infectives	Pharmacological classification: Proton pump inhibitor Therapeutic classification: Antiulcer
Reason Client Taking	To help control high blood sugars related to diabetes type 2.	Due to patient being intubated they could get an eye infection from an abrasion.	To get rid of bacteria in the nasal.	To treat gerd.
List two teaching needs for the medication pertinent to the client	Do not start any new medicines, over the counter drugs or herbal remedies without talking to your doctor first.	Eyes should be examined before each application of eye ointment. Eyes should be bathed with warm water and	Do not let ointment get into your eyes, nose, or mouth, and do now swallow. Do not apply bandage or anything else to the area being treated.	Instruct patient to swallow tablets whole and not to chew or crush them. Warn patient not to exceed dosage or take for longer than prescribed, as long-

	Humalog can cause low blood sugar, always keep a source of sugar handy for times when your sugar gets to low.	soft cloth each morning prior to first administration.		term use increases risk of serious adverse reactions.
Key nursing assessment(s) prior to administration	Assess for contraindications or cautions so that appropriate monitoring and dose adjustments can be completed. Obtain blood glucose to monitor response to insulin. Inspect and assess skin that may interfere with the absorption of insulin.	Eye assessment every time prior to administering eye ointment. Ensure to wash the eyes if there is any crusted on or around the eye.	Monitor for upper respiratory symptoms, contact provider if symptoms are prolonged. Monitor and look for any new skin lesions or rashes, any type of new skin reaction.	Ensure the continuity of gastric acid suppression during transition from oral to IV because even a brief interruption of effective suppression can lead to serious complications. Flush IV line with D5W, normal saline solution, or lactated ringers before and after giving the drug. When giving IV over 2 minutes, reconstitute solution with 10ml of normal saline injection.

Prioritize Three Hospital Medications

Medications	Why this medication was chosen	List 2 side effects. These must correlate to your client
1.Pantoprazole	Patient has a history of GERD, and this is to help with GERD.	**1.**Stomach pain **2.**Increased urination
2.Insulin lispro	Due to patient having type 2 diabetes.	**1.**Swelling in hands and feet **2.**Sore throat

3. eye ointment	Patient has been intubated for days and could get a possible infection of the eyes from having them shut for a long period of time.	**1.**Unusual tiredness/weakness **2.** Pale skin

Medications Reference (1) (APA)

Jones & Bartlett Learning (2021). 2021 Nurses' Drug Handbook. Burlington, MA

Physical Exam

HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS

GENERAL: **Alertness:** **Orientation:** **Distress:** **Overall appearance:** **Infection Control precautions:** **Client Complaints or Concerns:**	Patient is alert and oriented times one to person. Patient doesn't appear to be in any kind of distress. Overall appearance patient looks clean and well kept, her hair has been taken care of and she has been changed as needed. There is no infection control precautions for this patient. Patient is sedated and unable to answer if there are any concerns, when she is awake, she is only awake for a few seconds but doesn't state any concerns.
VITAL SIGNS: **Temp:** **Resp rate:** **Pulse:** **B/P:** **Oxygen:** **Delivery Method:**	Temperature: 98.9 axillary O2: 100% on 2L of nasal cannula Respirations: 16 Pulse: 78 B/P: 110/78
PAIN ASSESSMENT: **Time:** **Scale:** **Location:** **Severity:** **Characteristics:** **Interventions:**	Patient is initially intubated and sedated and only response to pain is if there are grimacing and poor vital signs. Once patient was extubated, she complains of a sore throat, but this is due to being intubated pain scaled used is 1-10, this was done at 10am after the extubating, patient unable to rate pain and is able to sleep; and patient is provided with ice chips after speech therapy came to assess.
IV ASSESSMENT: **Size of IV:** **Location of IV:** **Date on IV:**	Patient has a 20 g IV on her right thumb and a 20 g IV on her right and left AC, the date on all the IVs are 2/8/25. No pain, erythema, or drainage at the IV site. IV dressing is clean, dry, and intact.

Patency of IV: **Signs of erythema, drainage, etc.:** **IV dressing assessment:** **Fluid Type/Rate or Saline Lock:**	Fluid type is LR 75 ml/hr.
INTEGUMENTARY: **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 7** **Drains present: Y☐ N ☒** **Type:**	Skin is warm to the touch. Overall appearance is good, skin turgor is good, the capillary refill is good at less than 3 seconds, there are no apparent rashes or wounds on the body, there is a bruise on the left and right arm where IV'S were attempted, no drains present. Braden score is 7
HEENT: **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head and neck are symmetrical No discharge from ears, patient was able to hear clearly and responded appropriately when asked to move hands or feet patient was able to, eyes symmetrical, nose symmetrical, no deviation, all teeth are present, and patient takes good care of them.
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:**	Heart sounds are normal, no murmurs are heard. Capillary refill is less than 3 seconds. Cardiac rhythm on the monitor shows normal sinus rhythm, peripheral pulses are 2+ in all extremities upper and lower. No present neck vein distention or edema.
RESPIRATORY: **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	Respirations are regular, nonlabored, no wheezing, and no use of accessory muscles.
GASTROINTESTINAL: **Diet at home:** **Current Diet:** **Is Client Tolerating Diet?** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:**	Patients' daughter states that this patient is on a cardiac diet at home. Current diet in the hospital is NPO, tolerating well. Height: 160 cm (5.299 in.) Weight: 112kg (247 lb) Bowel sounds are heard and normal in all four quadrants.

Palpation: Pain, Mass etc.: **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Unable to determine when patients last bowel movement was, she has not had one since being in the hospital the last three days. No distention, incision, scars, wounds or drains present There is no ostomy, ng tube, or peg tube.
GENITOURINARY: **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:**	Urine is dark yellow and clear No odor or abnormal discharge from urine No pain or difficulties urinating Patient urinating a normal amount No abnormalities on the genitalia, no discharge No catheter is present and not currently on dialysis
Intake (in mLs) **Output (in mLs)**	Patient is given continuous lactated ringers at 75 ml/hr. I was on the unit for 12 hours which equals 900 ml during the time I was there, and was given 15 cc of ice chips. Total of 915ml. Patient doesn't have a catheter only a depends on and unable to monitor output status.
MUSCULOSKELETAL: **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score:** 21 **Activity/Mobility Status:** **Activity Tolerance:** **Independent (up ad lib)** **Needs assistance with equipment** **Needs support to stand and walk**	Normal ROM slightly slow to movement Neurovascular status is good Strength is weak in both upper and lower extremities but able to grasp fingers and move legs. Patient must use a walker at the extended care facility to get around but is able to move around good with it. Fall risk score of 21 Currently the patient is unable to get up and move around and needs assistance with changing positions in bed.
NEUROLOGICAL: **MAEW: Y ☒ N☐**	Cognitive to self Stable

PERLA: Y ☒ N☐ **Strength Equal: Y ☒ N ☐ if no -** **Legs ☐ Arms ☐ Both ☒** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Alert and oriented to person, this is patient's baseline. Speech is hard to hear patient speaks very softly and is unsure of the questions she is asking, or what she is saying. LOC patient is confused and only knows her name, but is unaware of her surroundings.
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):**	Due to patient being sedated and not being able to answer questions coping methods were not able to be established, there is no information provided about development level or religion in the family's chart, patient has two daughters who come to check on her and assist with taking care of her.

Discharge Planning

Discharge location: Extended care facility

Home health needs: Home health needs will be utilized at the extended care facility.

Equipment needs: The patient already uses a walker to get around, there is no other equipment needed.

Follow-up plan: At this time there is no follow-up plan, this patient is in the ICU and has been downgraded to a medical/surgical floor to be monitored.

Education needs: Education needs will need to be talked about with the patient's daughters and the extended care facility that the patient is staying at, this includes monitoring for signs and symptoms of continuing epigastric pain and hematemesis.

Nursing Process
Must be NANDA approved nursing diagnosis and listed in order of priority

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	**Outcome Goal (1 per dx)**	**Interventions (2 per goal)**	**Evaluation of interventions**
1. Ineffective Tissue Perfusion related to upper GI bleeding as evidenced by hematemesis.	Due to the patient being intubated and sedated for a couple of days the patient couldn't get up and move around, therefore decreasing tissue perfusion.	Patient will be able to demonstrate effective tissue perfusion as evidenced by hemoglobin and hematocrit within normal limits and know when to contact healthcare provider.	**1.** Prepare for endoscopy or surgery. **2.**Administer fluids, electrolytes, and blood as prescribed.	Patient had a couple of endoscopies and was able to be extubated, and also had fluids going to help ensure electrolytes didn't get out of balance and ensure patient didn't become dehydrated.
2. Risk for decreased cardiac output related to blood loss as evidenced by prevention of signs and symptoms.	Due to patient having hematemesis her body is having to work harder to maintain vitals.	Patient will maintain vital signs within normal limits, adequate urine output, and adequate tissue perfusion.	**1.** Monitor urine output. **2.**Administer supplemental oxygen as needed.	Patient was placed on 2 liters of nasal cannula for comfort after being extubated to ensure that her oxygen was at a good level.
3. Deficient fluid volumes related to bleeding ulcers	Patient is unable to keep sufficient fluids down do to	Patient will be able to maintain adequate	**1.** Assist the healthcare provider in treating	Patient is being given pain medicine as needed and is

as evidenced by hematemesis.	hematemesis and having epigastric pain.	fluid volume by stable vital signs, balanced intake and output, and capillary refill less than three seconds.	underlying issues. **2**. Review and administer prescribed medications.	being given LR through IV.
4. Imbalanced nutrition: less than body requirements related to NPO status as evidenced by abdominal pain.	Patient was NPO duet to be intubated and is still NPO after being extubated until patient can tolerated keeping ice chips down.	Patient will not experience alterations in albumin, iron levels, and electrolytes.	**1.** Administer fluid and electrolyte replacement. **2.** Provide small frequent feedings	Patient is given ice chips and once she is able to tolerate that, patient will be placed on a liquid diet to ensure she is able to keep that down and is also given LR through IV to ensure adequate hydration and electrolyte balance.
5. Acute pain related to gastrointestinal perforation as evidenced by report of abdominal pain.	Patient had reported having epigastric pain for days.	Patient will be able to appear relaxed and able to sleep or rest appropriately.	1. Plan rest periods and create a conductive environment for sleeping and resting. 2. Provide comfort measures and non-pharmacologic pain management.	Patient was placed on a delirium order set to ensure that nobody would interrupt her resting unless necessary.

Other References (APA):

Snyder, Julie S. and Sump, Christine A. Swearingen's All–in–One Nursing Care Planning Resource (2023). St. Louis, MO.